June 2023

OfficeLink Updates™

Welcome to the latest edition of OfficeLink Updates (OLU). As always, we provide you with relevant news for your office.

HIGHLIGHTS IN THIS ISSUE

Your questions answered

Thanks to all those who responded to our recent surveys. In this article, we answer a few of the most common questions you asked.

An automated way to share patient discharge information

Answer no more than two questions on our new inpatient clinical questionnaire, which you can access on our Availity provider portal.

Take accredited health equity courses

Help meet the cultural and linguistic needs of your diverse patients.

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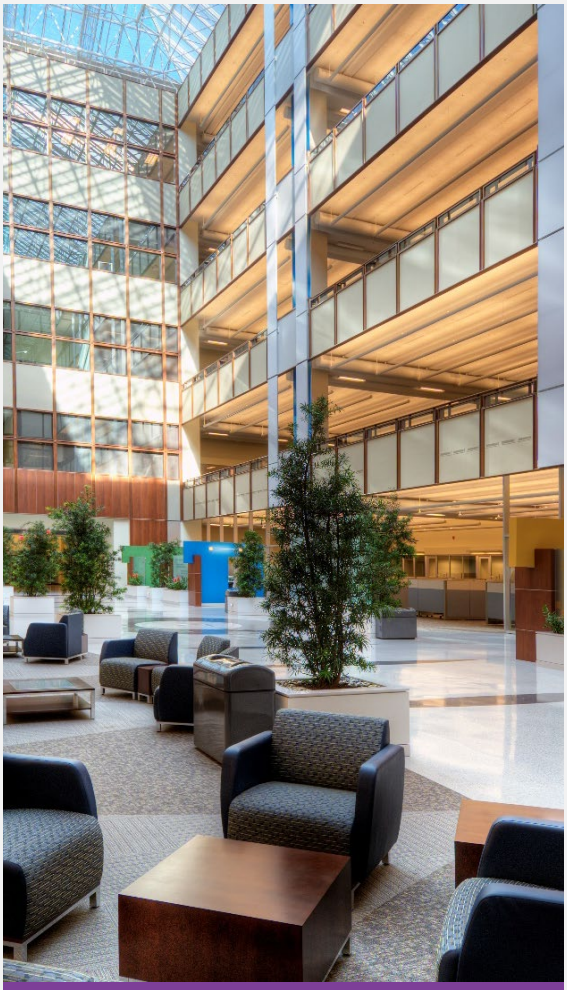

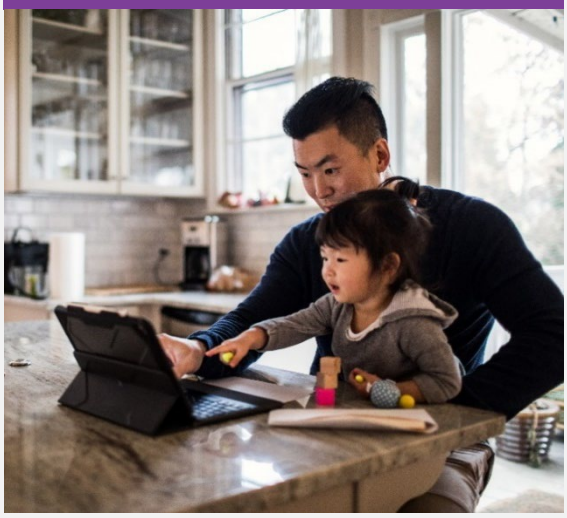

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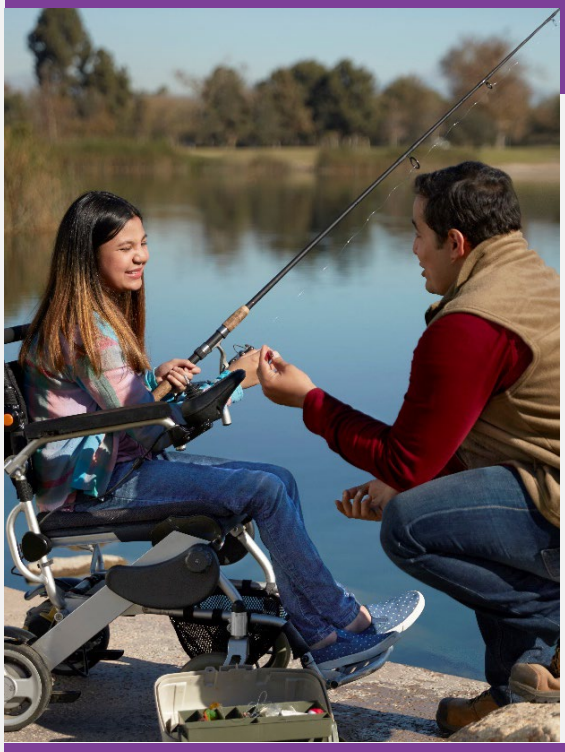
[OfficeLink Updates responds to feedback from two surveys]



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Complete your required Medicare training by December 31

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Plans and programs

Your City of New York Aetna MA patients have a new plan

Provider profile updating

Keep your data updated in NPPES

90-day notices and related reminders

We regularly adjust our clinical, payment and coding policy positions as part of our ongoing policy review processes. Our standard payment policies identify services that may be incidental to other services and, therefore, ineligible for payment.

We're required to notify you of any change that could affect you either financially or administratively at least 90 days before the effective date of the change. These changes may not be considered material changes in all states.

Unless otherwise stated, policy changes apply to both Commercial and Medicare lines of business.

Changes to our National Precertification List (NPL)

We now require precertification for spinal hardware removal.

This update applies to both our commercial and Medicare members.

Effective September 1, 2023, we'll require precertification for spinal hardware removal, including the following:

- Posterior nonsegmental and segmental instrumentation
- Anterior instrumentation

Effective September 1, 2023, we'll require precertification for this drug:

- Monoferric® (ferric derisomaltose) — we will add a new drug category for iron replacement agents

Submitting precertification requests

Be sure to submit precertification requests at least two weeks in advance. To save time, request precertification online. Doing so is fast, secure and simple.

You can submit most requests online through our **Availity provider portal**.* Or you can use your practice's Electronic Medical Record (EMR) system if it's set up for electronic precertification requests. Use our "Search by CPT® code" search function on our **precertification lists** page to find out if the code requires precertification.**

Learn more about **precertification**.

Are you asking for precertification on a specialty drug for a commercial or Medicare member? Then submit your request through Novologix®, also available on Availity®.

Not registered for Availity? Go to **Availity** to register and learn more.

*Availity is available only to providers in the U.S. and its territories.

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Claim and Code Review Program (CCRP) update

We might have new claim edits for our commercial, Medicare and Student Health members. You can view them on Availity®.

This update applies to our commercial, Medicare and Student Health members.

Beginning September 1, 2023, you may see new claim edits. These are part of our CCRP. These edits support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. You can view these edits on our **Availity provider portal**.*

For coding changes, go to Aetna Payer Space > Resources > Expanded Claim Edits.

With the exception of Student Health, you'll also have access to our code edit lookup tools. To find out if our new claim edits will apply to your claim, log in to the **Availity provider portal**. You'll need to know your Aetna® provider ID number (PIN) to access our code edit lookup tools.

We may request medical records for certain claims, such as high-dollar claims, implant claims, anesthesia claims and bundled services claims, to help confirm coding accuracy.

Note to Washington State providers: Your effective date for changes described in this article will be communicated following regulatory review.

*Availity is available only to providers in the U.S. and its territories.

Improper billing for treatment of endometriosis

We will deny certain codes starting on September 1.

This update applies to our commercial members.

Effective September 1, 2023, Aetna® will deny unbundled services identified by CPT® codes 45499, 49329, 49650, 50715, 50949, 58578, 58679 and 64999 as incidental when billed with 58662 for the treatment of endometriosis.*

Note to Washington State providers: Your effective date for changes described in this article will be communicated following regulatory review.

Service codes update

Q0249, Q2054, M0249 and M0250 will be removed from the IMMVAC contract service group. These codes may already be included in various drug groupings.

We are assigning or reassigning individual service codes within contract service groups. Changes to a provider's compensation depends on the presence of specific service groupings in their contract. You'll find the changes below.

Unless noted, all updates take effect on September 1, 2023.

Codes

Q0249, Q2054, M0249, M0250

Provider types affected

- Facilities, including acute short-term hospitals, ambulatory surgery centers, and skilled nursing facilities
- Physician contracts

What's changing

The codes will be removed from the Immunization/Vaccination (IMMVAC) contract service group. These codes may already be included in various drug groupings and are not considered Immunization and Vaccines.

Note to Washington State providers: Your effective date for changes described in this article will be communicated following regulatory review.

Changes to commercial drug lists begin on October 1

Find out about drug list changes and how to request drug prior authorizations.

On October 1, 2023, we'll update our pharmacy drug lists. Changes may affect all drug lists, precertification, step therapy and quantity limit programs.

You'll be able to view the changes as early as August 1. They'll be on our **Formularies and Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug prior authorization

- Submit your completed request form through our **Availity provider portal**.*
- For requests for non-specialty drugs, call **1-800-294-5979 (TTY: 711)**. Or fax your **authorization request form (PDF)** to **1-888-836-0730**.
- For requests for drugs on the Aetna Specialty Drug List, call **1-866-814-5506 (TTY: 711)** or go to our **Forms for Health Care Professionals** page and scroll down to the Specialty Pharmacy Precertification (Commercial) drop-down menu. If the specific form you need is not there, scroll to the end of the list and use the generic Specialty Medication Precertification request form. Once you fill out the relevant form, fax it to **1-866-249-6155**.

Medications on the Aetna Drug Guide, precertification, step-therapy and quantity limits lists are subject to change.

More information

For more information, refer to the **Contact Aetna** page. Open the "By phone" tab to find the pharmacy management phone number.

*Availity® is available only to providers in the U.S. and its territories.

Important pharmacy updates

For Medicare, Medicare Part B step therapy, and commercial

Medicare

Visit our **Medicare drug list** to view the most current Medicare plan formularies (drug lists). We update these formulary documents regularly during the benefits year as we add/update additional coverage each month.

Visit our **Medicare Part B step therapy** page to view the most current Preferred Drug Lists for Medicare Advantage (MA) and Medicare Advantage with prescription drug coverage (MAPD) members. These lists are updated regularly throughout the plan year.

Commercial — notice of changes to prior authorization requirements

Visit our **Formularies and Pharmacy Clinical Policy Bulletins** page to view:

- Commercial pharmacy plan drug guides with new-to-market drugs we add monthly
- Clinical policy bulletins with the most current prior authorization requirements for each drug

State-specific updates

Here you'll find state-specific updates on programs, products, services, policies and regulations.

New pre-approval requirements for peripheral arterial disease

Certain peripheral arterial disease services will require pre-approval starting on September 1. Find out how to secure an authorization request through eviCore.

This article applies to all states except Hawaii, Minnesota, North Dakota, New Hampshire, New Mexico and Rhode Island.

Our Enhanced Clinical Review program requires that you get authorization for certain procedures.

The Peripheral Vascular Disease (PVD) program becomes effective on September 1, 2023. This affects fully insured members in our commercial Aetna® products, Individual and Family plans, and our Medicare Advantage plans.

Services that will require pre-approval

Iliac

- 37220 PTA 37221 PTA and Stent
- +37222 PTA, additional vessel
- +37223 PTA and Stent, additional vessel
- 0238T Iliac Atherectomy (no RVUs established)

Femoral/Popliteal

- 37224 PTA
- 37225 PTA with Atherectomy
- 37226 PTA with Stent
- 37227 PTA with Stent and Atherectomy

Tibial/Peroneal

- 37228 PTA
- 37229 PTA with Atherectomy

- 37230 PTA with Stent
- 37231 PTA with Stent and Atherectomy
- +37232 PTA, additional vessel
- +37233 PTA with Atherectomy, additional vessel
- +37234 PTA with Stent, additional vessel
- +37235 PTA with Stent and Atherectomy, additional vessel

Angioplasty

- 37246 Transluminal balloon angioplasty, open or percutaneous; initial artery
- +37247 Transluminal balloon angioplasty, open or percutaneous; each additional artery

Stenting

- 37236 Transcatheter placement of an intravascular stent(s), open or percutaneous; initial artery
- +37237 Transcatheter placement of an intravascular stent(s), open or percutaneous; each additional artery

Ultrasound

- 37252 IVUS, initial vessel
- 37253 IVUS, additional vessel

For a complete list of procedures that need authorization, go to **eviCore.com**.

Authorization requests

Board-certified eviCore physicians need to review authorization requests for medical necessity. In order for you to get paid for services, you must send authorization requests before providing services.

If the date of service for a procedure will be on or after September 1, 2023, and you haven't already requested precertification, contact eviCore right away to request authorization.

For more information, review our **Clinical Policy Bulletins**.

How to secure an authorization

There are several ways to get an authorization:

- Go to **eviCore.com**.
- Call **1-888-622-7329** during normal business hours.
- Fax a request form, which is available online, to **1-800-540-2406**.

Urgent requests

If a member needs services in less than 48 hours due to medically urgent conditions, please call eviCore for a fast review. Tell the representative the request is for urgent care.

What you should know

- We recommend that ordering physicians get authorizations and share the approval numbers with the facility performing the procedure when it is scheduled.
- eviCore will fax their approval decision to the ordering physicians and requested facilities.
- Approvals have authorization numbers and one or more CPT® codes* specific to the approved services.
- If the service you ask for is different from what eviCore approves, the facility must contact eviCore for review and approval before submitting claims.
- If you perform services without approval, we may deny payment. Please don't ask members for payment, as outlined in your agreement with us.
- We'll determine coverage under the applicable policy in accordance with the policy's terms and conditions and with our policies and procedures.

Questions

If you have questions, refer to our **Contact Aetna** page. Under the Precertification menu, use the Medicare plan precertification number or the non-Medicare number, as needed.

You can review eviCore criteria and get request forms at **eviCore.com**.

California: Access standards

These access standards cover appointment availability, exceptions to appointment time frames and criteria for rescheduling.

California law has established appointment availability standards to ensure timely access to necessary health care services. Our members have the right to schedule an appointment within the following time frames:

Appointment type	Time frame
Urgent care (primary care physicians)	48 hours from request
Urgent care (specialists, non-physician mental health)	96 hours from request
Non-urgent doctor appointment (primary care physician)	10 business days
Non-urgent doctor appointment (specialty physician)	15 business days
Non-urgent mental health appointment (non-physician)	10 business days
Non-urgent appointment (ancillary provider)	15 business days
Non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider	10 business days for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition

Note: A referral to a specialist by a primary care provider or another specialist is subject to the relevant time-elapsed standards listed above.

Exceptions to the above appointment time frames

- The above time frames may be extended if the referring or treating provider determines and notes in the appropriate record that a longer wait time will not have a negative impact on the member's health.
- Preventive care services and follow-up care may be scheduled in advance as determined by the treating licensed health care provider.

Rescheduling appointments

If it is necessary for a provider or a member to reschedule an appointment, the appointment must be promptly rescheduled in a manner that is appropriate for the member's health care needs and that ensures continuity of care consistent with good professional practice.

Aetna® does not delegate monitoring and assessment of these standards to any of our contracted provider groups. We will assess our contracted provider network against these standards by conducting an annual provider survey to assess appointment availability and a provider satisfaction survey to solicit concerns and perspectives.

California: Use our interpretation service at no extra cost

This program is for both providers and members, and our hotlines and help centers can provide translations of important medical documents.

Need help giving care to non-English-speaking Aetna® members? Just use our Language Assistance Program (LAP). There is no charge for this interpretation service.

You can call **1-800-525-3148 (TTY: 711)** to reach a qualified interpreter directly.

Members can also request interpretation services from our LAP by calling the number on their ID card. They can contact our LAP for general questions, to file a grievance or to get a grievance form.

Questions?

Get help from your state. Just call the:

- California Department of Insurance Hotline at **1-800-927-4357** for traditional plans
- California Department of Managed Health Care Help Center at **1-888-466-2219 (TDD: 1-877-688-9891)** for HMO and DMO plans

You can reach the **California Department of Managed Care Help Center** 24/7. The department's website is **dmhc.ca.gov**. It provides written translation of independent medical review and complaint forms in Spanish, Chinese and other languages.

You can get paper copies of the forms by submitting a written request to:

California Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725

California: Make member grievance forms available at your office

You can get these forms, which allow members to file grievances with numerous entities, in English or Spanish.

California regulations require providers to make **member grievance forms** for health plans available at all office or facility locations.

Aetna® members may file a grievance with Aetna, the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) for any reason, including delays in timely access to care or timely referrals.

You can download the California HMO and California DMO grievance forms, which include information about member rights and responsibilities, in English or Spanish.

California: 2023 Provider Appointment Availability Survey (PAAS)

We might contact your office with our brief survey questions, and we are required to send your responses to the DMHC and the CDI.

California law requires that health plans survey their network providers annually to ensure that they comply with California time-elapsed standards for urgent and non-urgent appointments.

Aetna® has contracted with the Center for the Study of Services (CSS) to administer the PAAS for 2023. Aetna will assess compliance through the PAAS and report the results to the California Department of Managed Health Care (DMHC) and to the California Department of Insurance (CDI).

Please be aware that your office may be contacted via fax, email or phone for the purposes of this assessment. This survey should take only a few minutes of your time and will be conducted during normal business hours. We appreciate your cooperation in complying with this regulation.

Providers to be surveyed

- Primary Care Physicians (PCPs)
- Specialty physicians
- Psychiatrists
- Non-Physician Mental Health (NPMH) providers and Substance Use Disorder (SUD) providers
- Ancillary providers who offer mammogram appointments and ancillary providers who offer physical therapy appointments

Survey questions

- Urgent appointments: Is the appointment date and time within 48 hours (for a PCP visit request) or within 96 hours (for a specialist/psychiatrist/NPMH or SUD visit request)?

- Non-urgent appointments: Is the appointment date and time within 10 business days (for a PCP/NPMH visit request or a SUD visit request) or within 15 business days (for a specialist/psychiatrist/ancillary visit request)?

Note that both in-person visits and telehealth visits qualify as appointments.

The importance of your response

As a contracted provider, we encourage you to make every effort to respond to the survey. We will report all responses, including non-responses, to the DMHC. Your response should accurately reflect your appointment availability for Aetna members.

California: Individual and family plan (IFP) member language patterns

We're entering the individual market in certain counties in 2023, and we've gathered data on languages spoken.

Aetna® is excited to formally enter the individual market in 2023. We are offering the IFP in the following counties: Sacramento, Yolo, El Dorado, Placer, Fresno, Kings and Madera. We are committed to reducing health disparities in all communities and improving the health of our IFP members.

We collected data on the prevalent languages of our IFP membership, and we believe that sharing this information with you will help improve the quality of the patient-provider relationship and mitigate language barriers. The table below shows the top 5 non-English languages that our IFP members speak.

California individual and family plan (IFP) member language patterns								
	El Dorado	Fresno	Kings	Madera	Placer	Sacramento	Yolo	Total
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Arabic	0%	0%	0%	0%	0%	.3%	0%	.06%
English	97%	92%	74%	78%	97%	92%	96%	94%
Mandarin Chinese	0%	0%	0%	0%	0%	.3%	2%	.1%
Spanish	2%	8%	26%	22%	3%	6%	2%	5%
Vietnamese	.3%	0%	0%	0%	0%	2%	0%	.5%
Yue Chinese	.2%	0%	0%	0%	0%	0%	0%	.06%

Note: Column percentages may not add up to 100% due to rounding.

The language assistance requirement

As a contracted provider, you are required to provide language assistance at the time of the appointment. Please contact our Language Assistance Program (LAP) if a patient needs interpreter services. There is no charge for this interpretation service. You can call **1-800-525-3148 (TTY: 711)** to reach a qualified interpreter directly.

Members who do not receive language assistance services may **file a grievance**.

Meeting the linguistic needs of Aetna's California Individual Family Plan (IFP) members

Attention: Fee-for-service providers

Aetna® is committed to providing equitable, high-quality health care. To help reduce health disparities and promote health equity, Aetna collects member language preferences.

Aetna can provide you with a patient's language preference, if you ask for it, when you call the Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** to verify eligibility.

A member's preferred language is not currently visible in Availity®; please call the Provider Contact Center to help you to anticipate the language needs of your patients.

Call **1-800-525-3148 (TTY: 711)** to reach a qualified interpreter directly.

Diagnosis codes for reproductive services claims

Include the correct diagnosis codes when billing for abortion-related services, such as the ones listed below.

This article applies to California, Maryland, Massachusetts, New York and Oregon.

Abortion coverage may include abortion-related services when they are provided along with a payable abortion procedure. It's important that you use the right diagnosis code when billing the abortion-related-services claim. Including the appropriate abortion diagnosis code(s) will ensure that we correctly process the claim, after review, as abortion-related care.

Examples of abortion-related services may include, but aren't limited to, the following:

- Pre-operative evaluation and examination

- Pre-operative counseling
- Laboratory services, including pregnancy testing, blood type, and Rh factor
- Ultrasounds
- Rho-D immune globulin
- Anesthesia (general or local)
- Post-operative care
- Follow-up
- Advice on contraception or referral to family-planning services

Colorado: Notice of material change to contract

For important information that may affect your payment, compensation or administrative procedures, refer to the "90-day notices and related reminders" section of this newsletter.

Connecticut and Florida: Expanded Aetna Medicare Advantage (MA) program starting July 1, 2023

The Aetna MA program has expanded into Connecticut and Florida, and is working with Carelon Post Acute Solutions (formerly myNEXUS) to manage the network, claims payment and precertification/prior authorization program for home health services.

Our Aetna MA program works with Carelon Post Acute Solutions (formerly myNEXUS), a technology-enabled care management company, to manage the network, claims payment and precertification/prior authorization program for home health services.

This program initially began in Texas on March 1, 2020; expanded to Georgia, Oklahoma and Virginia on August 1, 2021; expanded into Kentucky, Ohio and Missouri effective January 1, 2022; expanded into Pennsylvania and West Virginia effective July 1, 2022; and is now expanding into Connecticut and Florida effective July 1, 2023.

We have also made important changes regarding pre-approval and claims payments.

Pre-approval changes

Starting July 1, 2023, Carelon Post Acute Solutions (formerly myNEXUS) will require advance approval for all home-health-related requests for in-home skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide and medical social work. Aetna MA members who are in Connecticut or Florida and who need to receive services administered in a home or residence will need pre-approval from Carelon Post Acute Solutions (formerly myNEXUS) for those services before they can begin.

View the **Aetna home health care pre-approval list**.

Claims payment changes

Starting July 1, 2023, Carelon Post Acute Solutions (formerly myNEXUS) will pay all claims (participating and nonparticipating) for covered home health services, including those filed with an authorization issued on or after July 1, 2023, for Connecticut and Florida MA members under the rates and terms of their Carelon Post Acute Solutions (formerly myNEXUS) contracted providers.

This change applies only to home health care services for:

- Aetna MA members
- Members residing in the state of Connecticut
- Aetna® Medicare Dual-Eligible Special Needs Plan (DSNP) members in Connecticut
- Members residing in the state of Florida
- Aetna Medicare DSNP members in Florida

This change does not apply to any other plans or members, including but not limited to:

- Medicare members residing outside of the state of Connecticut and Florida
- Aetna and Coventry commercial fully insured HMO/POS/PPO plans
- Aetna administrative services only (ASO) self-funded HMO/POS/PPO plans
- Aetna Student Health℠
- Aetna Global Business
- Coventry Workers' Compensation
- Cofinity®
- First Health®, Meritain® Health, Traditional Choice®
- Aetna Signature Administrators®

Pre-approval requests

- Visit the **Carelon Post Acute Solutions (formerly myNEXUS)** portal (registration required) to get started.
- Fax the **authorization request form** to **1-866-996-0077**.

More information

If you have questions, call Carelon Post Acute Solutions (formerly myNEXUS) Intake (Monday through Friday, 8 AM to 8 PM ET) at **1-833-585-6262**.

Delaware: State of Delaware Group Health Insurance Plan — bariatric surgery benefit change

Effective July 1, 2023, all bariatric surgeries for State of Delaware non-Medicare group health plan members must be completed through the SurgeryPlus benefit and performed by a surgeon in the SurgeryPlus network.

To learn more, contact SurgeryPlus at **1-855-200-2034**.

Tennessee: Providers should register for Availity® to ensure compliance with a new law

Our determination requests now must be sent electronically, which means you will need to use Availity.*

Tennessee amended a **utilization review law** effective January 1, 2023, requiring that our "requests for additional information to make a determination" be made electronically. Aetna® uses our **Availity provider portal** to communicate electronically about authorization requests.

Providers are encouraged to register with Availity and use the portal to ensure compliance with the law and to take advantage of its many other benefits.

Find out about Availity. To register, you will need your physical and billing addresses, tax ID number (TIN), National Provider Identifier (NPI) and primary specialty.

*Availity is available only to providers in the U.S. and its territories.

Washington: Fee schedule change for four IUD codes

Our Aetna Market Fee Schedule (AMFS) allowable rate for Washington was updated for the following codes as of the respective dates below, due to a change in the Wholesale Acquisition Cost.

Code	Description	Effective date	AMFS allowable rate
J7296	Kyleena	2/1/2023	$1,101.70
J7298	Mirena 5 Year	2/1/2023	$1,101.70
J7300	Copper Contraceptive	1/1/2023	$1,025.00
J7301	Skyla 13.5mg	2/1/2023	$917.35

If you have any questions, please visit our **Contact Aetna** page.

News for you

You'll find information — new services, tools and reminders — to help your office comply with regulations and administer plans.

OfficeLink Updates™ (OLU) responds to feedback from two surveys

Last year, Aetna® conducted two surveys. One was specific to your experience of the OLU newsletters and related communications. The other was our yearly provider experience survey.

Thank you to all who took the time to respond.

Here, we answer some of your questions.

Q: I need more information about your telemedicine policies, coverage and reimbursement rates.

Telehealth coverage will remain in effect after the Public Health Emergency (PHE) expiration date of May 11. However, we are currently revising our policies. Watch the pages of OLU for more information as it becomes available.

Q: I need an updated provider manual.

We update our provider manuals — the Office Manual for Health Care Professionals and the Office Manual Supplement (all states) — annually.

You can always find them on our **Provider Manuals** page, and we also run a regular article about them in the OLU quarterly newsletter.

Q: Can I get more updates to medical policies?

We publish medical policy updates in the quarterly OLU (the 90-day-notice section) and sometimes in the monthly OLU. You can also always refer to **past newsletter issues** and the **Clinical Policy Bulletins** page.

If you are not getting the OLU newsletter and the Provider Education Bulletins, you can add yourself to the distribution list. See the information above on how to sign up.

Q: I need to know more about credentialing

Please make sure the following information is up to date in Council for Affordable Quality Healthcare (CAQH) to ensure timely completion of credentialing:

- CAQH ProView application is in "Re-attestation" or "Initial Application Complete" status.
- Aetna® is listed as an authorized health plan.
- CAQH ProView includes current provider Professional Liability Insurance policy information.
- CAQH ProView has all active service locations listed for the state for which the practitioner is requesting participation.
- CAQH ProView includes an active/current DEA and an active/current state license for every state in which the practitioner has active service locations.

The credentialing timeline

Providers interested in participating start at **Aetna.com** and click on **Join the network**. After that, they proceed through the following schedule:

	Welcome to Aetna.com	**Contracting**	**Credentialing**	**Contracting**
Approximate time frame	1 to 30 days	30 to 60 days	60 to 90 days	90 to 120 days
What to expect	Complete the request for participation. Providers will be notified via email if we intend to pursue a contract or if we are unable to accept you into our networks.	The local network operations team will reach out to you to begin the contracting process, if required. The contract is an electronic document that must be signed through the AdobeSign process. Please sign	Once Network receives your signed contract, they'll request that the credentialing process get started. For most states, we use CAQH to obtain your credentialing application.	Once you have been approved in the credentialing process, Aetna will countersign and return your final contract via email through AdobeSign. Aetna systems will reflect your participation effective date, and Aetna members will be able to

		and return the contract through AdobeSign.	Make sure all data is up to date.	see your information in the directory. You can now submit claims.

Requests that have exceeded the above timelines

You can get help by calling the numbers below.

- For assistance with a previously submitted request that has exceeded the timelines referenced above, please contact Aetna's Credentialing Customer Service department by dialing **1-800-353-1232 (TTY: 711)**.
- For assistance with your CAQH credentialing application, please contact CAQH directly by dialing **1-888-599-1771**.
- Washington state: For assistance with your OneHealthPort account (Washington state practitioners only), please contact OneHealthPort directly by dialing **1-800-973-4797**.
- Arkansas: For assistance with your Arkansas credentialing application, please call the Arkansas State Medical Board by dialing **1-501-296-1951**.

Important reminders for existing credentialed providers

If you need to update your TIN within the same state, please go to the **Provider Onboarding Center** on our website. Click on the Existing Provider Resources tab. Then, select the Update Tax ID tile and follow the instructions provided. You do not need to complete a new application.

Q: The Availity® platform is hard to use.

Are you new to our network? Do you need help navigating the claims and payments transactions and/or precertification tools on our **Availity provider portal**?* No worries. We've got a webinar solution for you.

Doing business with Aetna® — our new provider onboarding course

If you're new to our network, start here to kickstart your participation. You'll learn about tools, resources and processes that'll give you more time in your day to focus on what's most important — your patients. This course is open to existing providers and their staff as well.

We'll show you how to:

- Locate provider manuals, clinical policy bulletins and payment policies
- Access online transactions such as those related to eligibility, benefits, precertifications and claim status/disputes

- Register for live instructional webinars
- Access our online forms
- Navigate to our provider referral directory and Medicare directory
- Update your provider data, and much more

This course is offered on the **second Tuesday** and **third Wednesday** of each month from 1:00 PM to 2:15 PM ET. You can also visit our **New Provider Welcome Page** for additional resources to enhance your provider experience.

Working with Aetna on Availity

This super-sized webinar is chock-full of information. It's great for anyone who wants to learn how to use the Availity provider portal to work with us. You'll learn how to register for Availity, contact us electronically (no more phone calls!) and navigate the site. We'll highlight the tools and transactions and how to get the most out of Availity. This course is offered on the **first Tuesday** of every month from 2:00 PM to 3:30 PM ET.

Claims management on Availity

This webinar is great for anyone involved in revenue cycle management. You'll learn how you can use the Availity provider portal to submit claims online, check claim status and view Explanation of Benefits (EOB) statements and Remittances. With our Disputes and Appeals functions, you'll learn how to send supporting documentation electronically and dispute claims. This course is offered on the **third Thursday** of every month from 2:00 PM to 3:15 PM ET.

Authorizations/Precertifications and referrals on Availity

This webinar is for anyone managing the authorization (precertification) process for their practice or facility. We'll show you how to:

- Find out if a procedure needs prior authorization
- Review the Authorization Add and Inquiry transactions
- Complete the clinical questionnaire
- Upload supporting documentation
- Process referrals

This course is offered on the **second Wednesday** of every month from 2:00 PM to 3:15 PM ET.

Submitting drug prior authorizations on Novologix®

This webinar is for anyone who submits specialty drug prior authorizations. We'll show you how to:

- Use the Novologix portal (through Availity) to submit a specialty prior drug authorization
- Initiate a National Comprehensive Cancer Network® (NCCN®) regimen
- Check the status of a pending request

This course is offered on the **second Thursday** of every month from 1:00 PM to 2:00 PM ET.

Visit our **Provider education and manuals** page to stay in the know about our webinars and other educational resources. We hope to see you in an upcoming session.

Need additional assistance? We're here to help. Please use the "Contact Us" form located on Availity.

Q: I know that you want me to update my provider profile on Availity®, but I'm having trouble doing that.

Some of you reported experiencing challenges when updating your provider data. In the March quarterly OLU newsletter, we ran an article about this and provided a link to a newly created **reference guide (PDF)**. Refer to this guide for help.

Q: I'm confused about when to use Availity® versus Aetna.com.

Attend our **Doing business with Aetna® — new provider onboarding** webinar, which will cover this topic. The webinar is available to our existing providers and staff members on the **second Tuesday** and **third Wednesday** of each month from 1:00 PM to 2:15 PM ET.

*Availity® is available only to providers in the U.S. and its territories.

Acute care facilities: Use our provider portal to get real-time status updates for your admitted patients

Starting September 1, we will stop sending you our end-of-day logs. Use the portal to check status and when approved bed days will end. You can also view selected letters in the patient's Inquiry response.

You can get real-time status updates for your admitted patients from our **Availity provider portal**.* Note that on September 1, we will stop sending you our end-of-day logs. This will allow us to focus on you, our valued providers, and our members.

How to check status

Use the Authorization Inquiry transaction to check the status of your admission request or when approved bed days will end. You can even view selected letters within the patient's

Inquiry response. That saves time because all the information you need is right in the response. And the information in the response matches what we have in our systems. There's no need to look for our letters in the mail or wait for end-of-day logs.

You can learn more about the letters we post on Availity®. Log in to Availity, go to the Resources tab on our Payer Space and read the "Digital Authorization Status Letters" user guide.

We'd appreciate if you'd share this information with your Utilization Review area.

Register for Availity

Register for Availity if you haven't already. It's available to all providers. There's no cost to register for or use the site.

*Availity is available only to providers in the U.S. and its territories.

Now available: A new way to share your patients' discharge information with us

Follow these easy instructions to save time.

We're excited to introduce a new, automated way to share your patients' discharge information with us. Answer no more than two questions on our new inpatient clinical questionnaire. As with our prior authorization clinical questionnaires, you can access this new questionnaire on **our Availity provider portal**.* Here's how it works:

1. On the morning of your patient's last covered bed day, we'll send a notification to your Availity Authorization/Referral Dashboard requesting your patient's discharge information. Look for an approved (green) event with a blue triangle requesting you to act.
2. Click the event in your dashboard, then the buttons to go to the clinical questionnaire.
3. Tell us whether you've discharged the patient. If so, let us know the date and where they've been discharged to.

In many cases, completing the clinical questionnaire online means we won't have to contact you to get the same information. If your patient needs additional bed days or services, just tell us that you haven't discharged the patient. We'll contact you for more details, just like we do today. Either way, you won't have to call us or send us end-of-day logs. And that saves you time.

We'd appreciate if you'd share this information with your Utilization Review area.

Coming soon: You'll be able to share concurrent review plans

Obtaining discharge information is just the first phase in the development of our inpatient clinical questionnaire. We're working on asking you questions about concurrent review. Answer those questions, and you may get instant approval for things like additional bed days or services. We'll let you know when we've added those questions. Stay tuned to this space.

See our list of clinical questionnaires

Our inpatient clinical questionnaire is one of several clinical questionnaires we may ask you to complete. **See the full list**.

Find out how the clinical questionnaire works — you're invited to a live webinar

Join us for a live webinar to see how the clinical questionnaire works. Go to **AetnaWebinars.com** for a schedule and to register for our "Authorizations on Availity" webinar. Ask your questions and get answers on the spot.

You can also request training for your facility on how to use the discharge verification clinical questionnaire. Just **send us a message** that includes:

- Your facility name and tax ID
- A contact name, telephone number and email address

Not registered for Availity®? You can register at **Availity.com**.

*Availity is available only to providers in the U.S. and its territories.

Take accredited health equity courses to better serve your patients

Help meet the cultural and linguistic needs of your diverse patients.

Health equity means that everyone has the same opportunity to achieve optimal health. A culture of learning and engagement is key to advancing health equity goals.

Health equity coursework

Sponsored by the Office of Minority Health (OMH), the **Physician's Practical Guide to Culturally Competent Care e-learning program**, which is accredited for physicians, physician assistants and nurse practitioners, is intended to furnish the knowledge, skills and awareness for you to best serve all patients, regardless of their cultural or linguistic background.

There are three courses in the program:

- Course 1: The fundamentals of Culturally and Linguistically Appropriate Services (CLAS), including strategies for delivering patient-centered care
- Course 2: Communication and language assistance, including how to work effectively with an interpreter
- Course 3: Organizational CLAS-related activities, including strategic planning and community assessment

What is CLAS?

CLAS is part of OMH's National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care. These **national standards** advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for health and health care organizations to provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Please take advantage of the free courses. Aetna® wants to help you meet the cultural and linguistic needs of our members.

Cultural competency can help your practice

You can improve your relationship with your patients by taking simple steps, such as directing patients to interpretation services and registering for Continuing Medical Education (CME) courses.

Recognizing that members have diverse views is critical to meeting their needs. The cultural factors that will likely impact your relationships with members include age, gender identity, language, religion, and values, to name a few. It's important to respect and respond to members' distinct values, beliefs, behaviors and needs when caring for them.

Our commitment

We're committed to meeting the National Committee for Quality Assurance (NCQA) standards to ensure that we meet members' cultural and language needs. In addition, each year, we measure our members' perspectives via a health plan survey. The responses help us monitor and track network providers' ability to meet our members' needs, including their cultural, language, racial and ethnic preferences.

Members with limited English proficiency have access to translation and interpretation services. Members also have access to TTY/TDD services for the hearing impaired.

Your Aetna® patients can access interpreter services by calling the number on the back of their ID card.

Practitioner training **on equity, culturally competency, bias, diversity and inclusion**

- The U.S. Department of Health & Human Services, Office of Minority Health, offers free, **continuing education e-learning programs** (Culturally and Linguistically Appropriate Services in Maternal Health Care, Behavioral Health, Oral Health) to help health care professionals provide culturally competent care.
- The American Medical Association **Delivering Care — Health Equity** and the American Academy of Family Physicians **Health Equity CME** websites offer resources and educational opportunities, including Continuing Medical Education (CME) courses, for additional training on multiple topics, including health equity, diversity and inclusion.
- Visit our **Racial and Ethnic Equity page** to find out more about reducing health care disparities.

Want to learn more?

Please watch **Aetna's cultural competency training video**.

Our office manual keeps you informed

Refer to this manual for information about policies, utilization management decisions, medical record documentation, acute care and drug lists.

Visit us online to view a copy of your **Office Manual for Health Care Professionals (PDF)**. The Aetna® office manual applies to the following joint ventures: Allina Health | Aetna, Banner|Aetna, Texas Health Aetna, and Innovation Health.

If you don't have Internet access, call our Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** to get a paper copy.

What's in the manual

The manual contains information on the following:

- Policies and procedures
- Patient management and acute care
- Our complex case management program and how to refer members
- Additional health management programs, including disease management, the Aetna Maternity Program, Healthy Lifestyle Coaching and others
- Member rights and responsibilities
- How we make utilization management decisions, which are based on coverage and appropriateness of care, and include our policy against financial compensation for denials of coverage

- Medical Record Criteria, which is a detailed list of elements we require to be documented in a patient's medical record and is available in the **Office Manual for Health Care Professionals (PDF)**
- The most up-to-date **Aetna Medicare Preferred Drug Lists**, **Commercial (non-Medicare) Preferred Drug Lists** and **Consumer Business Preferred Drug List**, also known as our formularies.

How to reach us

Contact us by **visiting our Contact Aetna page**, calling the Provider Contact Center at **1-888-MD AETNA** **(1-888-632-3862) (TTY: 711)** and selecting the "precertification" phone prompt, or calling patient management and precertification staff using the Member Services number on the member's ID card. Our medical directors are available 24 hours a day for specific utilization management issues.

More information

Visit us online for information on how our quality management program can help you and your patients. We integrate quality management and metrics into all that we do, and we encourage you to take a look at the program goals.

Parkinson's Foundation launches Education Series for Community Providers

The six free courses are open to health care professionals, who can earn continuing medical education (CME) credits.

The Parkinson's Foundation, with support from the CVS Health Foundation, launched a series of accredited online courses to train health care providers to deliver optimal Parkinson's care.

Improve treatment and patient outcomes

More than one million people in the U.S. are living with Parkinson's disease (PD).[1] Most people with Parkinson's do not have access to neurologists or movement disorders specialists. Health care professionals can learn to provide better care for patients with PD and earn CME credits.

The Education Series for Community Providers offers six free online courses for:

- Physicians
- Physician assistants
- Nurses
- Pharmacists

- Psychologists
- Social workers
- Community health providers

Get started today

Register on the **Parkinson's Foundation Learning Lab** page. Share this information to help provide better care for people living with Parkinson's disease.

If you have questions, **send an email message**.

[1]Gilbert R. **What is Parkinson's Disease?** American Parkinson Disease Association. Accessed on March 13, 2023.

New provider onboarding webinar for providers and their staff

Take our "Doing business with Aetna" webinar to get lots of your questions answered.

New to Aetna®? Or do you simply want to find out what's new? Join us in our new provider onboarding webinar — **"**Doing business with Aetna" — to discover tools, processes and resources that'll make your day-to-day tasks with us simple and quick.

We'll show you how to:

- Locate provider manuals, clinical policy bulletins and payment policies
- Access online transactions such as those related to eligibility, benefits, precertifications, and claim status/disputes
- Register for live instructional webinars
- Access our online forms
- Navigate to our provider referral directory and Medicare directory
- Update your provider data, and much more

Register today

The new provider onboarding webinar — **"**Doing business with Aetna" — is offered on the **second Tuesday** and **third Wednesday** of every month, from 1 PM to 2 PM ET.

Questions?

Just **email us** with any questions that you may have. We look forward to seeing you in an upcoming session.

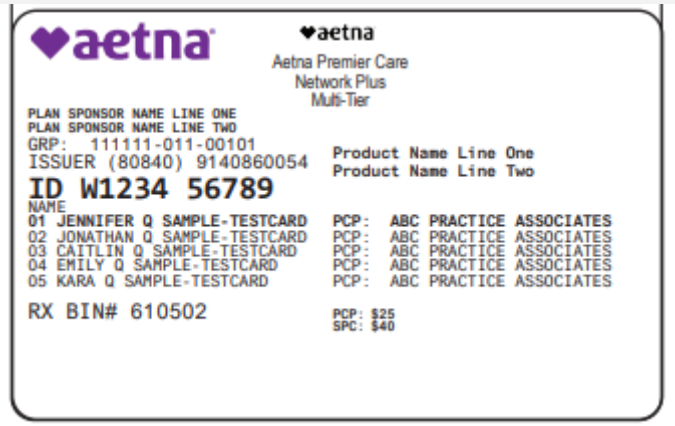
Reminder: The Aetna Premier Care Network (APCN) Plus program is now multi-tiered

How to identify patients who are in this program and find out whether you participate.

Some of your patients might be in our new APCN Plus Multi-Tier program, which started on January 1, 2022. This program is a national performance network offering. Multi-tiered programs sort doctors and facilities into tiers based on their performance and ability to save money. The highest performing and most efficient doctors and facilities are in Tier 1.

How to identify patients who are in the multi-tier program

The member ID card will say “Aetna Premier Care Network Plus Multi-Tier.” Identification cards for members enrolled in the Aetna Whole Health℠ (AWH) network are on gold card stock. Those cards include the “Aetna Premier Care Network Plus Multi-Tier” language but also the name of the AWH network.



Find out whether you participate and what tier you are in

To check your participation and tier status, visit our **provider referral directory**. If a hospital or provider does not participate with Aetna®, it will not appear in the search results.

You can also find out whether you are participating or not participating by looking at the “limitations” section of a transaction.

Tier 1 participation

- Tier 1 hospitals and providers will see “maximum savings” displayed.
- This tier is the APCN Plus network, which is covered at the highest benefits level.

Tier 2 participation

- Tier 2 hospitals and providers will see “standard savings” but could see both “maximum savings” and “standard savings” if both a hospital and doctors are included under the same tax ID (this is referred to as having a “mixed participation” status).
- This tier is Aetna’s broad network of providers and is covered at a reduced benefits level. Most doctors and hospitals not designated as Tier 1 but contracted with Aetna’s broad network will be covered at the Tier 2 benefits level.

Out of network

- If a hospital or provider is out of the network, the system will display this: “We are unable to determine your participation status . . . . Services rendered by providers that are not part of the patient’s network are not covered.”
- A member might still be covered for out-of-network benefits.

Questions?

Visit our **Contact Aetna** page.

Check your Aetna Premier Care Network (APCN) status

Use our provider referral directory to find out if you are participating

Now is a good time to check our **provider referral directory** to see if you’re participating in our APCN/APCN Plus programs for 2024. If you have questions, visit our **Contact Aetna** page.

Notable 2024 changes

- Northern California: market withdrawal of APCN
- Central Valley, California: network expansion
- Council Bluffs, Iowa: new market
- Omaha, Nebraska: new market
- Kansas City, Kansas/Missouri: network name change from I-35 Preferred to KC Care Net Plus
- Winston-Salem, North Carolina: Wake Forest Baptist Aetna Whole Health℠ (AWH) merged with Atrium Health AWH
- Chattanooga, Tennessee: new market
- Connecticut: network expansion

Overview of APCN/APCN Plus

APCN is a performance network for businesses with employees in locations across the country. With this network, employers can offer a single benefits design and simplified communications to all employees, regardless of their location.

APCN Plus includes a combination of performance networks across the country, but also includes Accountable Care Organizations (ACOs) and joint ventures (JVs) in certain areas. Members in these networks will have APCN Plus and the name of the ACO/JV on their ID card.

Tips for spine and total joint surgery precertification requests

To keep your requests from getting delayed, include complete clinical information and refer to the relevant clinical policy bulletins.

Follow the guidance in this article to help make surgery precertification easier.

Scheduling surgery dates

To avoid the significant inconvenience that can result when a surgery is put on hold due to not having final approval, it's best to not schedule a surgery date until receiving approval.

We understand that, in some cases, urgent situations will require immediate surgery.

Precertification forms

Our medical precertification forms specify the clinical information we need to complete precertification reviews. The forms are available on **Aetna.com** and via our **Availity provider portal**.*

What we need to complete a timely spine surgery request review

Exam history

Please submit comprehensive history and physical exam documentation showing that the clinical picture and radiology match the requested surgical level(s).

Radiology reading

Provide a formal radiology reading from the radiologist, within the past year, showing at least one of the following:

- Moderate or greater stenosis (central, lateral recess and/or foraminal)

- Nerve root or spinal cord compression/impingement
- Dynamic cervical spine instability of at least 3 mm or at least 11 degrees on flex/ex films
- Dynamic lumbar spine instability of at least 4 mm or at least 10 degrees or greater on flex/ex films or a static Grade 2 or greater spondylolisthesis
- Deformity parameters
    - Equal to or greater than a 50-degree scoliosis
    - 75-degree thoracic kyphosis
    - Sagittal imbalance with an SVA greater than 5 cm, a pelvic tilt greater than 20 degrees or a LL to PI mismatch greater than or equal to 10 degrees
    - Symptomatic pseudoarthrosis

Physical therapy documentation

We will need physical therapy (PT) documentation for 6 weeks of PT for radiculopathy/stenosis/instability (12 weeks for deformity cases and SI joint fusions) completed within the past year.

Note that:

- The PT must be documented independently by the therapist; that is, the documentation cannot be written just in the surgeon's notes.
- The PT requirement can be waived if you have documentation for any of the following:
    - Serial neurological exams by the surgeon showing numeric graded strength deterioration or 4-/5 strength
    - Myelopathy, cord compression or cauda equina syndrome supported by formal radiologic reading
    - A therapist's contraindication note describing the patient's barriers to completing PT

Fusion and disc arthroplasty documentation

Please submit either of the following, if relevant:

- Specific information related to any implants and/or allografts used, including the brand name and manufacturer name for each implant and/or allograft.
- For members who are undergoing fusion and who have had a smoking history in the past year, please include a nicotine level within 6 weeks prior to the surgery.

Note that fusion surgery for degenerative disk disease with axial back pain alone does not meet Aetna® guidelines for coverage, but if the criteria are met, we can approve lumbar total disc arthroplasty.

More information

Refer to these Clinical Policy Bulletins:

- **Spine surgery**
- **Back pain**
- **Bone and tendon grafts**
- **Intervertebral disc prostheses**

What we need to complete a timely total joint surgery (hip/knee/shoulder) request review

Exam history

Please submit a comprehensive history and physical exam with a diagnosis and treatment plan that corresponds to the surgery request.

Radiology reading

Provide a radiology reading that shows the following:

- For primary total joint surgery: at least moderate osteoarthritis of the involved joint
- For reverse total shoulder arthroplasty: a massive rotator cuff tear with or without osteoarthritis
- For revision surgery: failure of the primary joint arthroplasty

Physical therapy

For primary total joint surgery, provide a physical therapist's note documenting at least 6 weeks (12 weeks if patient is under age 50 or has a BMI over 40) of physical therapy (PT) in the past year.

- The PT must be documented independently by the therapist; that is, the documentation cannot be written just in the surgeon's notes.
- The PT requirement can be waived if you have documentation for the following:
    - For total hip surgery: bone-on-bone arthritis in the weight-bearing portion of the joint; progressive flexion contracture; or avascular necrosis with collapse of the femoral head
    - For total knee surgery: bone-on-bone arthritis in the weight-bearing portion of the joint (medial and/or lateral but not patello-femoral); severe angular deformity; avascular necrosis with collapse of tibial or femoral condyle; or progressive flexion contracture
    - For total shoulder surgery: glenoid bone loss with anterior or posterior subluxation (not superior or proximal humeral migration) or with avascular necrosis of the humeral head with collapse

- A therapist's contraindication note describing the patient's barriers to completing PT

More information

Refer to these Clinical Policy Bulletins:

- **Hip arthroplasty**
- **Knee arthroplasty**
- **Shoulder arthroplasty**
- **Joint resurfacing**

*Availity is available only to providers in the U.S. and its territories.

Now available: Use our new virtual assistant to check authorization status

By calling the phone numbers you already use, you can get more details about your authorization requests for commercial patients.

We're excited to let you know about our new virtual assistant, which you can use to check authorization status for commercial patients. Now you can get more robust status details on your authorization requests using the virtual assistant than you were getting in the past. We'll tell you when your request is approved, pending, canceled or denied — with reasons, when applicable.

It's easy to use. Follow these two simple steps:

1. Call any telephone number you already use for Provider Services (the Provider Contact Center) or Precertification.
2. Once you validate your information, say "precert," then "precert status." Then speak or use your telephone's keypad to enter the reference number when prompted to get the status.

You can even check authorization status for multiple members in the same call. The best part is that you can check status at your convenience. There's no need to wait on hold to speak to a representative. You can save time and quickly get back to your day.

More features coming soon

Later this year, we'll add the ability to check:

- Authorization status on Medicare patients
- Whether we require authorization on a specific service

We're working on these enhancements, and we'll let you know when they're ready. Stay tuned to this space.

Now you can send electronic claims attachments using a new secure solution

Get paid faster and save money by submitting claim attachments electronically.

We're ready to receive your electronic claim attachments using the X12N 275 transaction. Right now, we're working with four vendors: **Change Healthcare**, **Waystar**, **PNT Data** and **SSI**. If you submit claims through any of these vendors, contact them to find out how to send supporting documents to us online.

Not sure if your claims go through one of these vendors?

Ask your vendor if they use one of these companies. If not, check out **our vendor list** and look for "Claim Attachments" in the "Transactions Available" column. Check back periodically because we update the list every time a new vendor is ready.

Why send claim attachments electronically?

You can:

- Get paid faster
- Track the attachments
- Get protection for personal health information (PHI)
- Save on mailing, printing and labor costs related to paper mail

Are you interested in digital prior authorizations (PAs)?

If you're interested in getting PA notices online, reach out to your vendor. We'll let you know when digital PAs become available.

It's important to keep your demographic information up to date

Giving us your race, ethnicity and language information is voluntary, but keeping your information current helps our members connect with you to get care. Update your information via Availity® using our how-to guide.

How we use demographic details

We share demographic details in our online provider directory. Patients can refer to them when searching for care. Our customer service representatives might provide these demographic details if a plan member requests them.

Giving us your race, ethnicity and language information is voluntary. You can request that this information be removed from your profile at any time.

It's easy to update

The provider data management (PDM) tool on Availity® allows you to update information about your business and providers. Keeping your information current and accurate helps our members connect with you for care.

Making updates in the PDM tool allows you to share information with Aetna® and other payers, reducing phone calls to your office. Some other benefits include:

- Staying listed in provider directories
- Avoiding potential claims payment delays

Updating your information is easy. Simply log in to our **Availity provider portal.*** Navigate to My Providers and then to Provider Data Management. Update the languages you speak and your race. That's it!

Update your profile in minutes

Follow the steps shown in our **quick reference guide**, which you can use for making updates in our **Availity provider portal**.* The guide will help you update essential information like:

- Email addresses
- Telehealth status
- Appointment phone number
- Mailing address
- NPI number

More information

If you need further help, you can go to the **Learn about Provider Data Management** page. You'll find short demos about how to enter, update, validate and attest to demographic data in the Availity PDM application.

If you need to add a new provider to your practice, use **Aetna.com**.

*Availity® is available only to providers in the U.S. and its territories.

Good impressions start with accurate provider profile information — update yours today

It's easy to update by using our quick reference guide. Help patients and other providers find you.

Keeping your provider profile up to date with current, complete information helps you make a good impression by:

- Letting patients easily find and contact you when searching for the care they need
- Helping other providers refer patients to you
- Allowing Aetna® to better keep in touch with you about important updates

Update your provider profile in minutes

Follow the steps shown in our new **PDM quick reference guide (PDF)**, which you can use for making essential updates to your profile in our **Availity provider portal**.* The guide will help you update:

- Email addresses
- Telehealth status
- Appointment phone number
- Mailing address
- NPI number

Not able to use Availity®? No problem.

If you're unable to use Availity, check out the **additional ways you can update your provider profile**.

If you are a delegated, custom, NAP, rental, dental or EyeMed provider, please submit your change request to your contracted group's administrator.

*Availity® is available only to providers in the U.S. and its territories.

Update your profile with your virtual care information

Make sure that your profile includes your virtual care details.

Since the height of the pandemic, virtual care has evolved into a major modality for both patients and providers. In 2022, about 685,000 of our network providers conducted over 15 million virtual visits. Our members have voiced their desire to continue to use virtual care to manage their health.

Our directories now display virtual care information

If you are a network provider who offers virtual visits, keep your virtual care information updated. This will help our members get care the way they feel is right for them.

How to update

There are two ways:

- Log in to our **Availity provider portal** and navigate to the Provider Data Management (PDM) tool. Follow the steps shown in our new **PDM quick reference guide (PDF)** to make updating your profile easy.
- If you're unable to use Availity® to update your profile, check out the **additional ways you can update your provider profile**.

Member access to care

We gather and monitor data to make sure members have required access to care. Make sure you know about any state requirements that supersede ours.

We measure member access to care every year. We do this in many ways. For example, we review:

- Member satisfaction survey results
- Complaint data
- Phone surveys we conduct (the phone surveys include a random sampling of primary care and specialty care providers)

Access standards include appointment availability time frames for routine care, urgent matters and after-hours care. State requirements supersede these access standards and can be found in the Office Manual Supplement (all states).

Read more about the **access standards we measure**.

Thank you for taking part in these phone surveys. We do all this to comply with the National Committee for Quality Assurance (NCQA) accreditation standards and with various state regulations.

Medical clinical practice and preventive services guidelines

We refer to the sources in this article, among others, to build our guidelines.

Clinical practice guidelines from nationally recognized sources promote the use of evidence-based treatment methods. This helps provide the right care at the right time. We make these guidelines available to you to help improve health care.

These guidelines are for informational purposes only. They are not meant to direct individual treatment decisions. All patient care decisions are the sole responsibility of providers.

Clinical practice guidelines

American Diabetes Association (ADA): Standards of Care in Diabetes
American College of Cardiology guidelines
Centers for Disease Control and Prevention opioid prescribing resources

Preventive services guidelines

U.S. Preventive Services Task Force (USPSTF) recommendations
Centers for Disease Control and Prevention immunization schedules
Health Resources & Services Administration (HRSA) women's preventive services guidelines

When these sources lack sufficient evidence to recommend for or against a service or when they present conflicting evidence, we may adopt recommendations from other nationally recognized sources.

Make a difference in health equity and improve patient outcomes

Use validated depression screenings to improve your patients' overall health.

Race, ethnicity, and geography all contribute to health outcomes. Screening for depression is important and can help improve your patients' overall health.

We know you are busy, and we are here to help. We want to support you by providing access to validated depression screening tools and to resources for follow-up.

Aetna®, a CVS Health® company, is committed to increased depression screening and follow-up in primary care to improve access to care across diverse communities. Our campaign will provide you with information and resources for all your patients.

What's next?

- Watch these pages for notification of a publicly accessible and culturally relevant resource website.
- Take advantage of our upcoming trainings and tools, also in development, to support culturally relevant depression screening and follow-up in your practice.

Help improve communication between treating providers

Use our forms to make it easier to communicate with other practitioners.

Based on the results of a recent survey, we know that primary care physicians (PCPs) are concerned about how they don't get regular reports about their patients' ongoing evaluation and care from other treating providers.*

This breakdown in communication can pose a threat to quality patient care. We understand that coordinating care with many physicians, facilities and behavioral health care professionals can be a challenge.

Use our tools to share information

Comprehensive patient care includes communicating with your patients' other treating health care professionals. To promote collaboration and comprehensive care, it's critical that PCPs and specialists talk openly with each other.

You can use **our tools** to help. Here are a few to get you started:

- **Dilated Retinal Eye Examination Report Form (PDF)**
- **Physician Communication Form (PDF)**
- **Physician Communication Post-Fragility Fracture Care Form (PDF)**
- **Specialist Consultation Report (PDF)**

Thank you for your efforts to improve how you communicate with other providers.

*Each year we survey primary care practices contracted for all Aetna® products. The surveys assess the practices' attitudes and perceptions on key interactions with us. We use the Center for the Studies of Services, a third-party vendor, to administer the surveys. It performs the surveys at market levels accredited by the National Committee for Quality Assurance (NCQA).

Use Aetna® preferred labs for breast cancer gene and prenatal testing

You can get automatic approvals in some cases.

Breast cancer gene testing

We've simplified your patients' access to breast cancer gene 1 (BRCA1) and breast cancer gene 2 (BRCA2) testing with Quest Diagnostics®. When you use Quest for services covered in our **Clinical Policy Bulletin #0227**, you'll get automatic approvals for your commercial members.

Other Aetna national BRCA network labs:

- Labcorp
- BioReference Health, LLC/Genpath
- Ambry Genetics
- Baylor Miraca Genetics Laboratories, LLC
- Myriad Genetics, Inc.
- Medical Diagnostics Laboratories, LLC
- Invitae

Noninvasive prenatal testing (NIPT)

We've negotiated lower out-of-pocket NIPT rates with four preferred labs. That means you can now enjoy the convenience of working with labs you may have used before, help your patients save money and simplify your referral process.

Aetna's national NIPT network:

- Quest Diagnostics
- Labcorp
- BioReference Health, LLC/GenPath
- Invitae

Participating providers

For a complete list of our in-network participating providers, please use our provider search at **Aetna.com**.

Help improve the health care transition for adolescents and young adults

Use the resources listed in this article to give your young patients the help they need.

We know that adolescents and young adults are a vulnerable population with evolving health conditions, high rates of behavioral health risks, and low use of health care services. Health care clinicians play a crucial role in supporting the transition from pediatric to adult health care. For optimal health outcomes, transitioning adolescents need supportive primary care providers and specialists.

We're here to help

To support our youth and help facilitate an effective transition, we provide resources you can use when you talk with your patients:

- The health plan's website to learn more about available plan benefits and special programs
- The Aetna Health℠ app, so you can keep a safe and handy health record online
- The Health Risk Assessment, which helps provide personalized health results that can be shared with clinicians confidentially
- Access to Aetna® nurses, who can help navigate the health care system and find needed resources
- Access to behavioral health counselors to help arrange mental health or substance use disorder care and connections to community resources
- Access to telehealth services, which offer flexible ways to get care

How to document sepsis

Best documentation practices include being specific about the type of sepsis and test results.

Sepsis is a life-threatening medical emergency caused by the body's overwhelming immune response to an infection and, as such, is seldom coded in the provider office setting.

Sepsis types

- Severe sepsis is sepsis with failure of one or more organ systems.
- In septic shock, there is a critical reduction in tissue perfusion and, despite intravascular volume replacement, the person remains hemodynamically unstable.
- Systemic inflammatory response syndrome (SIRS) is a condition where there is inflammation throughout the body that can lead to multiple organ failure and shock. Sepsis, trauma or pancreatitis can cause SIRS. Criteria for diagnosing SIRS are:
    - Temperature greater than 100.4 or less than 96.8

- Heart rate greater than 90
- Respiratory rate greater than 20
- White blood cell count greater than 12,000 or less than 4,000

A person must meet two or more of the criteria to be diagnosed with SIRS.

Remember, no infection, no sepsis. Also, an infection that does not meet SIRS criteria is not sepsis.

Documentation

Best practice is to write out the condition in full followed by the abbreviation in parentheses the first time it is used. Subsequently, within the same note, you can use the abbreviation only.

Physical exam notes should include any current associated findings and diagnostic testing results, including:

- Sepsis: The presence of (suspected or confirmed) infection with two or more of the SIRS criteria. Do not code sepsis unless these criteria are met. If the visit is for a follow up of previous sepsis, document the current infection being treated (C-Diff, pneumonia, UTI, etc.).
- Severe sepsis: Acute organ dysfunction or tissue hypoperfusion secondary to sepsis
- Septic shock: Severe sepsis plus hypotension (systolic blood pressure less than 90) not reversed with fluid resuscitation, plus Mean Arterial Pressure (MAP) less than 65 or persistent lactic acidosis greater than or equal to 4

Assessment/Impression

- The term “sepsis” without any further description is classified as sepsis, unspecified.
- If known, state the infectious agent (E. coli, fungal, viral, etc.) so that it can be correctly classified.
- Document the etiology (pneumonia, UTI, decubitus ulcer, infected surgical site, etc.).
- When applicable, document any consequences of sepsis.

Treatment plan

The treatment plan should be as specific as possible and include items such as:

- Blood tests and other laboratory tests
- Imaging tests
- Medications, including antibiotics, IV fluids and vasopressors
- Supportive care (oxygen, dialysis, etc.)
- Referrals/Consultations

We submitted the 2023 HEDIS® medical record collection project results

We submitted our 2022 data. Thank you for providing medical records in support of this effort.

Annually, we collect HEDIS (Healthcare Effectiveness Data and Information Set)* data from claims, encounters, administrative data and medical records. We support a consumer-obsessed culture — one that enhances member health and quality of life, expands provider relationships to support an enhanced patient experience, and closes data and care gaps.

We submitted our 2022 data in accordance with National Committee for Quality Assurance (NCQA) reporting requirements.

We want to thank staff members who provided medical records in support of our HEDIS efforts.

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Behavioral health

Stay informed about behavioral health coverage updates so you can deliver the best possible treatment to your patients.

Behavioral health clinical practice guidelines

These sources could help you improve the care you deliver to your patients

Clinical practice guidelines from nationally recognized sources promote the use of evidence-based treatment methods. This helps provide the right care at the right time. We make them available to you to help improve health care.

These guidelines are for informational purposes only. They are not meant to direct individual treatment decisions. All patient care decisions are the sole responsibility of providers.

Adopted guidelines

American Academy of Pediatrics (AAP)
Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in children and adolescents (2019)

American Society of Addiction Medicine (ASAM)
Clinical Practice Guideline on Alcohol Withdrawal Management (2020)

American Society of Addiction Medicine (ASAM)
National Practice Guideline for the Treatment of Opioid Use Disorder (2020)

American Psychiatric Association (APA)
Practice Guideline for the Treatment of Patients with Schizophrenia, Third Edition (2021)

Veterans Affairs/Department of Defense
Clinical Practice Guideline for the Management of Major Depressive Disorder (MDD) (2022)

Additional resources

American Academy of Child & Adolescent Psychiatry (AACAP)

American Society of Addiction Medicine (ASAM)

Substance Abuse and Mental Health Services Administration (SAMHSA)

U.S. Preventive Services Task Force (USPSTF) Recommendations

Aetna adopts the U.S. Preventive Services Task Force recommendations, Grade A & B, for healthy children and adults with normal risk. Where there is lack of sufficient evidence to recommend for or against a service, or where there is conflicting interpretation of evidence, we may adopt recommendations from other nationally recognized sources.

Medical record documentation standards

Aetna® standards related to treatment documentation apply to behavioral health providers and can be found in the Behavioral Health Provider Manual.

We want to ensure that member care is appropriately documented. We also must show compliance with state treatment documentation regulations. For those reasons, we maintain specific standards regarding treatment documentation. In some cases, we are required to audit treatment records.

It is important that you understand and apply these standards.

Find medical record documentation standards in the provider manual

For detailed information, please see the **Behavioral Health Provider Manual (PDF)**. You can find information related to our documentation standards in the Quality Programs section. Appendix A lists the specific criteria we use when auditing treatment records.

Thank you for your efforts to maintain detailed, comprehensive and organized treatment records.

Behavioral health clinical criteria

Read about how we determine coverage and where to go for more information.

How we determine coverage

Aetna® medical directors make all coverage denial decisions based on behavioral health clinical criteria. Only Aetna medical directors, psychologists, board-certified behavior analysts — doctoral (BCBA-D) and pharmacists make denial decisions for reasons related to medical necessity. (Licensed pharmacists and psychologists review coverage requests as permitted by state regulations.)

Where state law mandates, utilization review coverage denials are made, as applicable, by a physician or pharmacist licensed to practice in that state.

Behavioral health staff members use evidence-based clinical guidelines from nationally recognized authorities to guide utilization management decisions involving precertification, inpatient review, discharge planning and retrospective review. Staff members use the following criteria as guides in making coverage determinations, which are based on information about the specific member's clinical condition.

More information about our behavioral health clinical criteria

- **Aetna's clinical policy bulletins**
- **Guidelines for coverage determination**
- **Centers for Medicare & Medicaid Services (CMS)**
    - National Coverage Determinations (in the blue box at the top of the page)
    - Local Coverage Determinations (under Coverage Process)
    - Medicare Benefit Policy Manual (under Related Instructions)
- **The American Society of Addiction Medicine (ASAM) Criteria** textbook, third edition
- **Applied Behavior Analysis (ABA) Medical Necessity Guide**
- Substance abuse care in New York state: **Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)**
- **LOCUS and CALOCUS-CASII**

States may also mandate the use of other criteria or guidelines.

Hard copies

Do you need hard copies of a specific criteria for a specific determination? We are here to help. Visit our **Contact Aetna** page.

Suicide prevention training and support for primary care practices

Contracted providers can enroll in two Aetna®-sponsored programs to get CME credits.

Suicide and suicide behavior is a major public health crisis and a leading cause of death among people from 10 to 14 years of age and from 25 to 34 years of age in the United States.[1,2] We are committed to reducing member suicide attempts by 20% by 2025.

We understand the important role primary care practices play in our members' well-being and want to offer two free suicide prevention trainings for our Aetna® contracted providers.

The Extension for Community Healthcare Outcomes (ECHO) model for pediatric practices

The **American Academy of Pediatrics (AAP)**, in partnership with the **American Foundation for Suicide Prevention (AFSP)**, is recruiting pediatric health professionals to join an eight-month ECHO learning collaborative for youth suicide prevention designed from the **Blueprint for Youth Suicide Prevention**.

This Aetna-sponsored program is free to participating pediatric practices and offers complimentary Continuing Medical Education (CME) credit. The eight-month program is delivered virtually via monthly one-hour Zoom sessions with the opportunity to opt in to an additional 6 one-hour quality improvement sessions.

Curriculum topics:

- Addressing suicide prevention in pediatric practice
- Screening for youth suicide risk in practice
- Conducting a Brief Suicide Safety Assessment (BSSA)
- Providing appropriate care for youth at risk
- Brief interventions that can make a difference
- Resources and support
- Addressing common implementation barriers
- Preparing your practice for a suicide prevention protocol

SafeSide Prevention's InPlace® Learning for primary care physicians

This program focuses on training primary care physicians in depression recognition and treatment for adults 18 years of age and older. It uses three major components:

- Three one-hour video-guided workshops
- Monthly office hours to share experiences and build your professional network
- Updates and refreshers to stay current with advances in Zero Suicide care

Groups of 2 to 25 meet in person or via videoconference to work through workshop modules together. Meetings are scheduled at your team's convenience. Aetna covers the cost, and you get three hours of CME credit.

Interested in applying to ECHO or learning more?

Please contact **Aimee Prange** or **Sara Miscannon**.

[1]Centers for Disease Control and Prevention. **Suicide prevention**. March 13, 2023. Accessed on March 20, 2023.
[2]Mental Health.gov. **Suicidal behavior**. December 5, 2022. Accessed on March 20, 2023.

Make a difference in health equity and improve patient outcomes

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Race, ethnicity, and geography all contribute to health outcomes. Screening for depression is important and can help improve your patients' overall health.

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Aetna®, a CVS Health® company, is committed to increased depression screening and follow-up in primary care to improve access to care across diverse communities. Our campaign will provide you with information and resources for all your patients.

What's next?

- Watch these pages for notification of a publicly accessible and culturally relevant resource website.
- Take advantage of our upcoming trainings and tools, also in development, to support culturally relevant depression screening and follow-up in your practice.

Follow-up care for ADHD

ADHD follow-up care has declined during the past year. We encourage you to work with parents, care providers and schools for better outcomes.

Providing education and partnering with parents and service providers is important for managing attention-deficit/hyperactivity disorder (ADHD). The **American Academy of Pediatrics** and the **American Academy of Child & Adolescent Psychiatry** provide recommendations.

Medication follow-ups

The most recent **clinical practice guideline** from the American Academy of Pediatrics recommends that physicians who prescribe medication for ADHD:

- Schedule a follow-up visit with the patient 30 days after the initial prescription to assess side effects and improvements
- Schedule monthly visits, if needed, until a good routine is in place, then every three months for the first year
- Recognize that ADHD is a chronic condition and therefore requires ongoing treatment
- Collaborate with other medical providers and the school personnel for behavior therapy

Partner with patients for improved outcomes

We have seen a decline in follow-up care for ADHD over the past year and want to make sure that patients understand the importance of keeping those appointments. Treatment plans often include medication, behavior therapy and classroom interventions. Using a mix of these may increase understanding of the importance of follow-up care and medication adherence. It may also promote calmer relationships with family members, better study habits and more independence in children.

Collaboration between the prescribing physician, therapist and the school is important for success. There are also **several apps** that may help.

Support for patients and parents

You may want to encourage your patients (and their parents) to use the following resources:

- **Support groups**
- **The CHADD parent training program**
- Pharmacy medication alerts and reminders

- Counseling
- The local school district

Medicare

Get Medicare-related information, reminders and guidelines.

Complete your required Medicare compliance training by December 31, 2023

Participating providers in our Medicare networks need to take CMS training.

Participating providers in our Medicare networks are required to meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related (FDR) entities as outlined in the FDR program guide.

- DSNP and/or FIDE providers must complete the annual Model of Care (MOC) training and attestation by December 31, 2023.
- Delegated providers/entities are required to attest based on contracted networks.

Aetna Medicare Advantage (MA) plans include HMOs, PPOs, and DSNPs

To learn more about our MA plans, including DSNP plans, view our **Medicare Advantage quick reference guide (PDF)**.

How to complete your Medicare compliance FDR or FDR/DSNP attestation

Training materials and attestations are posted on our **Medicare page**.

Our training materials include:

- **Medicare compliance FDR program guide (PDF)**
- **DSNP Model of Care (MOC) guide (PDF)**
- **FDR frequently asked questions document (PDF)**

Where to get more information

If you have questions, please review all supporting materials published on our **Medicare page** or review the quarterly **First Tier, Downstream and Related (FDR) entities compliance newsletters**.

COVID-19 Public Health Emergency (PHE) transition

Read on to find out about COVID-19 policy changes.

The U.S. Department of Health and Human Services announced in February 2023 that the COVID-19 PHE "emergency phase" would expire on May 11, 2023. This decision was based on COVID-19 trends.

Read about our **COVID-19 policy changes**. Scroll down the page to view "COVID-19 resources and support."

Your City of New York Aetna Medicare Advantage (MA) patients have a new plan for 2023

Most of these patients will transition to an Aetna Medicare℠ Plan (PPO). Know how to identify these patients and assist them with important details about their plan.

Your office currently sees patients who are enrolled in the City of New York Aetna MA PPO plan. Starting September 1, 2023, most retirees enrolled in the current City of New York health plans will automatically transition to an Aetna Medicare℠ Plan (PPO), also known as the Aetna Medicare Advantage PPO plan. This is a type of Medicare Advantage plan. We'll help you help these retirees during their transition.

Reminders about the Aetna Medicare Advantage PPO plan

- Members enrolled in this plan do not need referrals.
- Precertification is required for some services.
- "Medicare PPO" appears in the upper-right corner of the ID card.
- This plan provides all the benefits of Traditional Medicare and more, such as unlimited hospitalization and coverage for certain preventive services.

Aetna Medicare Advantage PPO plan highlights

You can help your City of New York patients better understand their Aetna Medicare Advantage PPO plan. Here's a summary of key benefits:

	Your patients' responsibility for network and out-of-network providers
Annual medical deductible	$0 deductible for 2023 $150 calendar-year deductible beginning in 2024
Annual out-of-pocket maximum This includes any deductible, copayment, or coinsurance	$1,500

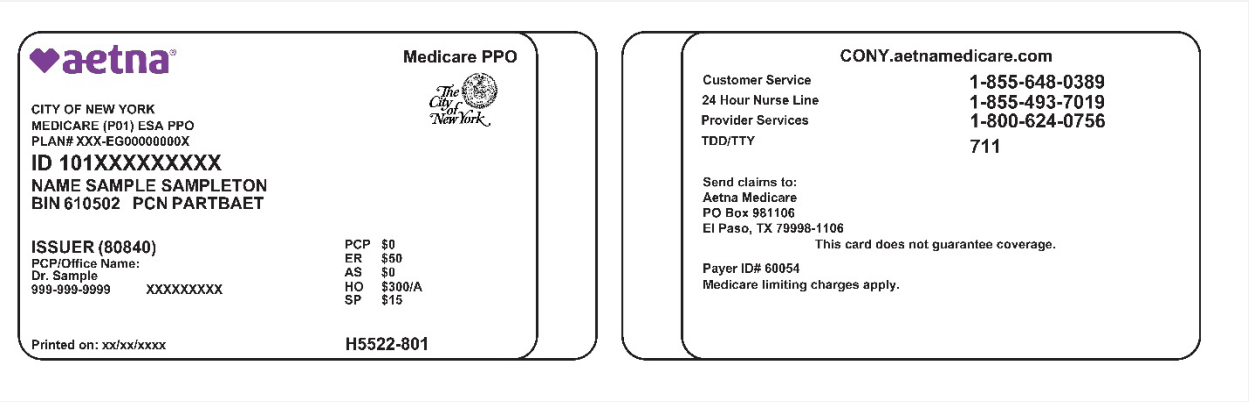
Primary care physician visits	$0
Physician specialist visits	$15
Urgent care	$15
Emergency care	$50 (waived if admitted)
Diagnostic procedures (X-rays, MRIs, lab services)	$15

Prior authorizations

Only the following services and items will be subject to prior authorization under the Aetna Medicare Advantage PPO plan for City of New York retirees:

- Acute hospital inpatient, long-term acute care, acute physical rehabilitation, skilled nursing facility, and home care services.
- Services or items that are not covered by Medicare
- Services that could be considered experimental and investigational in nature
- Services that are cosmetic in nature (for example, breast augmentation, removal of excessive skin/tummy tuck or eyelid surgery)
- Specialty medications, some of which are Part B medications
- Select drugs, therapies, procedures, services and technologies covered by Medicare

Aetna Medicare Advantage PPO plan ID card example



More information

If you have questions about your patient's medical plan, just visit our **Contact Aetna** page.

Keep your data updated in NPPES

Accurate provider directories help Medicare patients identify and locate providers and make health plan choices.

Use the National Plan and Provider Enumeration System (NPPES) to correct your data and improve provider directory accuracy.

CMS suggests updating NPPES

The Centers for Medicare & Medicaid Services (CMS) suggests using the NPPES to review, update and attest to your NPPES data. We join with CMS to remind providers to keep their data up to date.

Accurate provider directories help Medicare beneficiaries identify and locate providers and make health plan choices.

For more information, refer to this **frequently asked questions document (PDF)**.

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