March 2022

OfficeLink Updates™

IN THIS ISSUE

Welcome to the latest edition of OfficeLink Updates. As always, we bring you regular updates and relevant news for your office.

The teen mental health crisis

Psych Hub offers access to **best-in-class behavioral health resources** on evidence-based interventions, built with the provider and their patients in mind. This offering is now available to commercial behavioral health providers. **Sign up for suicide prevention courses**. | *PAGE 29*

Attend an Availity® webinar

If you're still calling us to complete your administrative tasks, let us show you how you can work with us electronically instead.

We've designed our webinars with you, our providers, in mind. Spend an hour with us now and barely lift a finger later. Let us show you how to get valuable time back in your day. | *PAGE 20*

90-day notices

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. This change may not be considered a material change in all states. Unless otherwise stated, policy changes apply to both Commercial and Medicare lines of business.

Changes to our National Precertification List (NPL)

Effective July 1, 2022, the following precertification changes apply:

We'll require precertification for additional spinal fusion codes, including the following:

- Additional codes for anterior and posterior arthrodesis
- Exploration of a spinal fusion
- Osteotomy of spine
- Percutaneous lysis of epidural adhesions
- Percutaneous decompression of intervertebral disc
- Reinsertion of spinal fixation device

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.

These changes apply to our commercial and Medicare members.

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

Expanded modality limit to outpatient facility claims

Effective June 1, 2022, we will allow a maximum of four eligible interventions/modalities/therapeutic procedures or one hour of treatment time per date of service to outpatient facility claims.

These changes apply to our commercial and Medicare members.

The material in this article is subject to regulatory review and separate notification in Washington state.

Third-Party Claim and Code Review Program

Beginning June 1, 2022, you may see new claim edits. These are part of our Third-Party Claim and Code Review Program. 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**.*

We are also expanding our claim edits for E&M services to our Medicare line of business with this update. This expansion enhances our prepayment claims editing processes for coding policy rules related to correct coding of E&M of levels of care for our Medicare members. We already apply these rules to our commercial line of business. These edits evaluate the correct coding for level 4 and 5 E&M codes (CPT codes 99204, 99205, 99214, 99215, 99244, 99245, 99204 and 92014) using the American Medical Association (AMA) E&M criteria.

We will review claims billed with the following places of service: office, inpatient hospital, on campus — outpatient hospital, emergency room — hospital, off campus — outpatient hospital, and urgent care facility.

Based on the outcome of the review, we may adjust your payment if the claim detail doesn't support the billed level of service. We will not change the procedure code you bill.

These changes will support our goal of consistency across all lines of business.

You can view any of these edits on our Availity® provider portal.

For coding changes, go to:

- Aetna Payer Space
- Resources
- Expanded Claim Edits

Except for 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 our **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 and bundled services claims, to help confirm coding accuracy.

Note: This is subject to regulatory review and separate notification in Washington state.

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Changes to commercial drug lists begin on July 1

On July 1, 2022, 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 May 1. They'll be on our **Formularies & 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 **1-855-240-0535 (TTY:711)**. Or fax your **authorization request form (PDF)** to **1-877-269-9916**.
- For requests for drugs on the Aetna Specialty Drug List, call **1-866-752-7021** 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 **1-888-267-3277**.

For more information, call the Provider Help Line at **1-800-AETNA RX (1-800-238-6279) (TTY: 711)**.

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Important pharmacy updates

Medicare

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

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

Required changes to our Mid-Level Practitioners policy

This policy update addresses reimbursement for nurse practitioners, physician assistants, certified nurses, midwives and clinical nurse specialists (e.g., nurse practitioners or registered nurses) in Texas Medicare, Commercial and IVL exchange networks.

Who is affected?

Effective July 1, 2022, we will apply our standard policy for mid-level practitioners to those in Texas Medicare, Commercial and IVL exchange networks.

We will pay mid-level practitioners (nurse practitioners, certified nurse midwives, physician assistants and clinical nurse specialists) regardless of contract, employment status or place of service (that is, office or facility) at 85% of the physician market rate, unless otherwise contracted.

This will include our recent expansion of the policy, which now includes audiologists, genetic counselors, massage therapists, nutritionists, respiratory therapists and registered dietitians, allowing reimbursement at 75% of the negotiated fee or recognized charge for covered services.

Note that this expansion applies only to our commercial plans.

Who and what is not affected?

- Mid-level providers with specific rates in their contract
- Certified registered nurse anesthetists and registered nurse first assistants
- Claims billed with an Assistant Surgery modifier
- Covered DME, orthotics, prosthetics, supplies, drugs, laboratory, radiology services and immunizations billed by a mid-level practitioner
- Providers contracted through a third party or vendor

Does this change affect the precertification and concurrent management process?

No. Aetna® will continue to make utilization management decisions and send the appropriate letters and other communications.

Questions?

If you have questions about this policy change, you can contact the Provider Contact Center at **1-888-632-3862 (TTY: 711)**.

Healthcare Common Procedure Coding System (HCPCS) codes added to specific drug contract service groupings*

Individual service codes will be assigned within contract service groupings. Changes to an individual provider's compensation will depend on the presence or absence of specific service groupings within the contract. The changes are outlined below.

All updates will start on June 1, 2022, unless otherwise noted.

Codes	Provider types affected	What's changing
C9254, C9293	Facilities including acute short-term hospitals, free-standing ambulatory surgery centers, skilled nursing facilities, infusion, dialysis, physicians,	Will be added to All Drugs or Drug Agents Without Specific Rates (DEFALLDRUGS); All Drugs, Agents, Inj Drugs (ALLDRUGSWCS); Drugs (DRUGS); All Outpatient Drugs (DRUGCJSQ); and Chemotherapy and All Other Drugs (HCDHPALLWCS) • If the contract contains an All Drugs, Agents, Inj Drugs (ALLDRUGSWCS) rate, it will be

	home health care	applied; if not, then the All Drugs or Drug Agents Without Specific Rates set forth above and herein (DEFALLDRUGS) will be applied. If the contract does not contain All Drugs or Drug Agents Without Specific Rates set forth above and herein (DEFALLDRUGS), the All Other Outpatient rate will be applied. • If the contract contains a Drugs (DRUGS) rate, it will be applied; if not, then the All Drugs or Drug Agents Without Specific Rates set forth above and herein (DEFALLDRUGS) will be applied. If the contract does not contain All Drugs or Drug Agents Without Specific Rates set forth above and herein (DEFALLDRUGS), the All Other Outpatient rate will be applied. • If the contract contains an All Outpatient Drugs (DRUGCJSQ) rate, it will be applied; if not, then the All Drugs or Drug Agents Without Specific Rates set forth above and herein (DEFALLDRUGS) will be applied. If the contract does not contain All Drugs or Drug Agents Without Specific Rates set forth above and herein (DEFALLDRUGS), the All Other Outpatient rate will be applied. • If the contract contains a Chemotherapy and All Other Drugs (HCDHPALLWCS) rate, it will be applied; if not, then the All Drugs or Drug Agents Without Specific Rates set forth above and herein (DEFALLDRUGS) will be applied. If the contract does not contain All Drugs or Drug Agents Without Specific Rates set forth above and herein (DEFALLDRUGS), the All Other Outpatient rate will be applied.

*The material in this article is subject to regulatory review and separate notification in Washington state.

Important reminders

Expansion to our Mid-Level Practitioners policy*

In January, we told you that we would expand our current Mid-Level Practitioners policy to include a new reimbursement tier for specific practitioners.

Effective April 1, 2022, our Mid-Level Practitioners policy will now include audiologists, genetic counselors, massage therapists, nutritionists, respiratory therapists and registered dietitians, allowing reimbursement at 75% of the negotiated fee or recognized charge for covered services.

This expansion applies to Commercial business only.

*This is subject to regulatory review and separate notification in Washington state.

Kentucky, New Jersey and Ohio — starting March 1, you must use Anna™ for the SNF concurrent review process

Aetna® has partnered with Post-Acute Analytics (PAA) to automate the concurrent review process by using their Anna™ software platform.

PAA is a business associate that works with health systems, payers and post-acute providers. PAA works with providers and payers that participate in Medicare Advantage (MA) plans and programs to help them understand how members receive care across the care continuum.

What's changing

Starting March 1, 2022, all skilled nursing facilities (SNFs) in Kentucky, New Jersey and Ohio that admit Aetna Medicare Advantage members who reside in and receive care in those states will be required to work with PAA and use Anna to:

- Notify Aetna of a member's arrival in the facility (admission verification notification)
- Conduct concurrent review processes, including providing clinical documentation to receive authorization of additional days beyond the initial approved days

The precertification and concurrent management process

Aetna will continue to make utilization management decisions and send the appropriate letters and other communications.

PAA will provide clinical programming services for identified SNF partners, with the oversight of their Chief Clinical Officer and Senior Medical Officer. One of these services is a root cause analysis, which PAA does to ensure that members receive appropriate care and services. The goal is to prevent unnecessary readmissions and to make sure members get the right follow-up care.

How to start using Anna

PAA will contact you soon to walk you through how to set up and use this exciting tool. It will reduce manual processes, decrease administrative burden and streamline communication with Aetna utilization managers. This can lead to better clinical outcomes and make working with Aetna easier.

Aetna and PAA may integrate your electronic medical records (EMR) system with Anna. You will not be charged any fees from Aetna or PAA. The integration is important for high-volume providers, since it will make working with Aetna simpler.

One of PAA's Post-Acute Care (PAC) engagement managers will contact you to schedule a meeting and answer questions. If you prefer to contact PAA directly, you can:

- Send a message to **Provider Relations**
- Call Tammy Starr at **1-469-312-1030**

Sending "continued stay" documentation

Use the **Anna portal** to send "continued stay" documentation (preferred method). If you aren't able to use the portal, you can send a fax to **1-469-533-4908**. Note that you should continue to send pre-certification documents via Availity®.*

How to reach us

If you have questions about this change, you can email **PAAQuestions@Aetna.com**.

If you have questions about the Aetna utilization review process, you can contact your facility's assigned utilization review nurse or Provider Relations at **1-800-624-0756 (TTY: 711)**.

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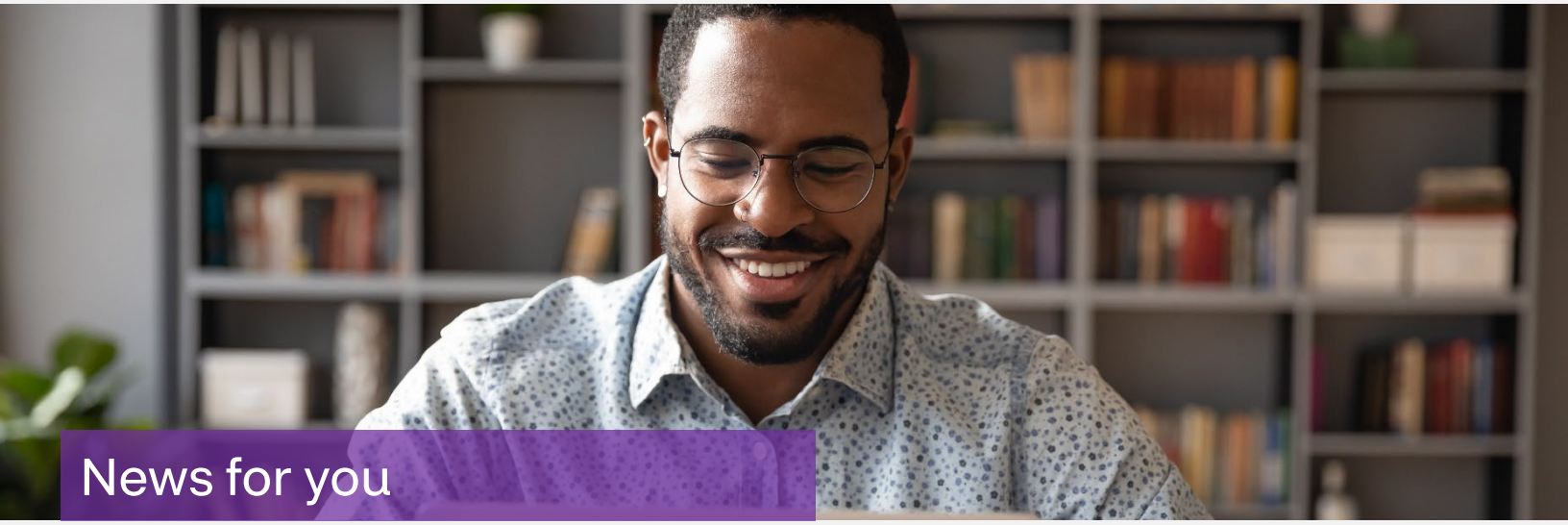
Updated COVID-19 provider FAQs

Our **updated COVID-19 provider FAQs** are available on **Aetna.com**.

Medicare Advantage billing

This is a reminder to bill us the same way you bill traditional Medicare.



News for you

Affirmative statement for financial incentives

How we make coverage determinations and utilization management (UM) decisions

We use evidence-based clinical guidelines from nationally recognized authorities to make UM decisions.

- We review requests for coverage to see if members are eligible for certain benefits under their plan.
- The member, member's representative or a provider acting on the member's behalf may appeal this decision if we deny a coverage request.

How we help members access services

Our UM staff helps members access services covered by their benefits plans.

- We don't pay or reward practitioners or individuals for denying coverage or care.
- We base our decisions entirely on appropriateness of care and service and the existence of coverage.
- Our review staff focuses on the risks of underutilization and overutilization of services.

Questions?

Visit us online to view a copy of your **provider manual (PDF)**.

Million Hearts® 2022

Million Hearts 2022 is a national initiative co-led by the Centers for Disease Control and Prevention (CDC) and the **Centers for Medicare & Medicaid Services (CMS)**. The initiative's goal is to prevent a million heart attacks and strokes by the end of 2022.

How does Million Hearts 2022 improve health outcomes?

Million Hearts 2022 seeks strong and specific commitments to improve heart health for all. It focuses on a small set of priorities that can reduce heart disease, stroke and related conditions.

What does Million Hearts 2022 do?

The CDC's **Division for Heart Disease and Stroke Prevention** offers support. It works with CMS, sets priorities, and leads communications, partnership development, research, and evaluation efforts.

What can you do?

Urge your patients to **explore heart disease and stroke risk, consequences and tips for prevention**.

The Chronic Condition Improvement Program (CCIP)

Every year, our National Quality Management Department implements the CCIP. We do this in accordance with Centers for Medicare & Medicaid Services (CMS) requirements.

The CCIP is a clinical effort designed to improve your patients' quality of life.

What does the CCIP do?

The CCIP promotes effective management of enrollees' chronic diseases over a three-year period. The program goals are to:

- Slow disease progression
- Prevent complications
- Inhibit development of comorbidities
- Reduce preventable emergency room (ER) encounters
- Decrease inpatient stays
- Improve the health of a specific group of enrollees with chronic conditions

How does the CCIP improve health outcomes?

The quality improvement model we use is based on the Plan-Do-Study-Act (PDSA) quality improvement model. In accordance with the Centers for Medicare & Medicaid Services (CMS) CCIP Resource Document, PDSA is cyclical in nature and includes planning, implementing, studying a change and acting on the result of that change. Care management and case management incorporate the PDSA model and are CCIP interventions.

What you can do

Urge your patients to take part in the program so we can help manage their chronic diseases.

Resources

Learn more about our **care management and case management initiatives**. Also refer to **your provider manual (PDF)**.

Our office manual keeps you informed

Our **Office Manual for Health Care Professionals (PDF)** is available on our website. The Aetna® office manual also 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 to get a paper copy of the manual.

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 Lists**, also known as our formularies

How to reach us

Our medical directors are available 24 hours a day for specific utilization management issues. Contact us by visiting our website, calling the Provider Contact Center at **1-800-624-0756 (TTY: 711)** or calling patient management and precertification staff using the Member Services number on the member's ID card.

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.

What is cultural competency?

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 standards to ensure that members' cultural and language needs are met. In addition, each year, we measure our members' perspectives via a health plan survey. The responses help us to monitor and track network providers' ability to meet our members' needs, including their cultural, language, racial or ethnic preferences.

Want to learn more?

Please **watch this cultural competency video**.

Other resources

- **Racial and ethnic equity: helping to reduce health care disparities**
- The **U.S. Department of Health and Human Services' Think Cultural Health** page

Improving the patient experience: tips for your practice

Each year, Aetna® sends a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to gather feedback from members about their overall health care experience, including their experience with their personal doctor.

It's important that members have positive experiences with their providers. Better outcomes lead to healthier, happier patients.

Tips for how to improve the patient experience

Encourage open communication

Tips	Benefits
Use receptive body language (for example, sit down, lean in and maintain face-to-face engagement)	Shows patients you acknowledge that their time is important
Maintain eye contact with the patient and avoid interrupting while the patient is speaking	Shows patients that they are being heard
Use simple, easy-to-understand words, and avoid using medical terminology and abbreviations	Facilitates adherence and better health outcomes

Offer flexible access to care

Tips	Benefits
Consider offering evening and/or weekend appointments	Better access to care
See patients within 15 minutes of the appointment or arrival time	Patients feel that you spent sufficient time with them
Call patients 24 to 48 hours before their appointments to confirm and remind them about items they will need to bring	Reduces no-shows
Explain after-hours access to the physician on call, Aetna's after-hours nurse line and when to seek urgent versus emergency care	Reduces ER visits

Keep the patient informed

Tips	Benefits
Consider providing a preventive health care visit at the same time that you see a member for a sick visit	Addresses patient needs and improves health outcomes
Review the member's chart for any consults or specialist treatment prior to seeing the patient to help facilitate coordination of care	Shows patients you acknowledge that their time is important Addresses coordination of care
Review all treatment options with member and/or parents/guardians and allow their input, questions and collaboration	Patients feel sufficient time was spent with them Facilitates adherence and better health outcomes
Provide handouts, brochures, diagrams and other materials to help members understand diagnostic tests, medications, and prevention	Reduces patient anxiety Facilitates adherence and better health outcomes

Additional resources for office staff and patients

The 24-Hour Nurse Line

Our 24-Hour Nurse Line gives members ready access to registered nurses who can answer their questions on a variety of health topics, which can prevent an unneeded trip to the emergency room. Aetna members can reach these nurses 24 hours a day, 7 days a week, via a toll-free phone number. Refer members to their health plan's customer service department for additional information.

Aetna care management

The Aetna One® care management program is transforming the health care experience using predictive analytics, personal outreach and local access. We engage members in a more proactive and connected way. Our care management model takes a holistic approach to physical and emotional well-being. Refer members to their health plan's customer service department for additional information.

Our provider portal

Our **Availity provider portal** helps you spend less time on administration so you can focus more on patient care.* You get a one-stop portal to quickly perform the key functions you do

every day. If you're already registered with Availity® for another payer, you're all set. You can use your existing log-in credentials to get started with Aetna.

You can:

- Submit or check claims
- Submit or check prior authorizations
- Check patient benefits and eligibility
- Upload medical records and supporting documentation
- File disputes and appeals
- Update your information, including race and ethnicity

Cultural competency webinar

Good health — and a good doctor–patient relationship — begins with understanding patients' cultural, ethnic, racial and linguistic needs. Watch this short **cultural competency video** to learn more about cultural competency and the important roles that you and your office staff members play.

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Introducing preferred labs for noninvasive prenatal testing (NIPT)

Aetna® has taken steps to lower out-of-pocket costs by adding network labs that are now preferred for NIPT. Simplify your referral process while helping your patients save up to $90 on out-of-pocket costs compared to other labs.*

In-network labs include:

- **Labcorp (1-877-821-7266)**
- **Quest Diagnostics (1-866-697-8378)**

For additional in-network labs, go to **Aetna.com**. All of these labs are included in the new Aetna preferred NIPT network. Help your patients save money while using an experienced lab.

*Based on 2020 Aetna claims data and new contracted rates. There may be some local hospitals in our lab network that are cost effective. Please contact your local representative or the Provider Contact Center at **1-800-624-0756 (TTY: 711)**.

Try a new and improved online prior authorization system powered by Novologix®

Why use Novologix?

You'll get:

- An efficient intake process through a web-based application
- A self-service experience and access to real-time status updates
- Instant approvals for many of your submissions

When to use Novologix

This new program is available for Commercial and Medicare members when requesting a medication on our **National Precertification List (NPL)**.

Where to find the Novologix tool

You can find the Novologix tool on Availity®.

- Availity* users: Have your administrator enable your access.
- To learn how to navigate from Availity to Novologix and how to submit a prior authorization request electronically, register for the **webinar**.

How to get help

For help using Novologix, call **1-866-378-3791** or **send an email to Novologix**. For help registering for or using Novologix on Availity, call **1-800-AVAILITY (1-800-282-4548)**.

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Submitting additional diagnosis codes for encounters (supplemental file feeds)

Sending encounter data for all services rendered is a crucial step in accurately reporting data to the Centers for Medicare & Medicaid Services (CMS). You can submit supplemental diagnosis codes for risk adjustment purposes through an Alternative Submission Method (ASM).

Reasons to submit a supplemental file include but are not limited to the following:

- There are more than 12 diagnosis codes identified for a single professional claim form.
- You have an EMR system that truncates diagnosis codes for claim submission.
- You use a clearinghouse that only submits a certain number of codes per claim.

ASM files do not require proof-of-service documentation and do not require Primary Source Verification (PSV) audits, unlike a HEDIS® supplemental file feed.

Aetna® encourages submission of this supplemental data to make up for the limitations on the number of diagnoses that can be submitted through the claims process.

If you have questions or to initiate the ASM setup process, please **send an email to Risk Adjustment**. In the subject line, type "ATTN: ASM."

Aetna Smart Compare™ designation program overview and updates

What is Aetna Smart Compare?

The Aetna Smart Compare designation program helps members find high-quality, effective providers. The program assigns up to two designations per physician practice: one for effectiveness and one for clinical quality. We use industry standard methodologies and provide members with personalized recommendations that they can easily access through our secure member portals.

These designations do not impact practice network status or reimbursement. Members will not receive different benefits based on Aetna Smart Compare.

Designation notification

We publish designations for the following Commercial membership specialties:

- Primary care physicians (PCPs)
- Obstetricians (new in 2022)
- Gynecologists (new in 2022)
- Orthopedics who treat hip and knee

For the specialties outlined above, practices received a letter in November 2021. We exclude physicians who see few or no Aetna® members. Physician designations will not display for Maryland and New York until sometime in 2022.

Questions?

Visit the **Aetna Smart Compare designation program** page for more details and helpful guides.

Send us an email message if you have questions or feedback about the program.

You're invited to attend a live Aetna® webinar

It's a new year and the perfect time to start something new. Like changing how you do business with us. If you're still calling us to complete your administrative tasks, let us show you how you can work with us electronically instead.

We've designed our webinars with you, our providers, in mind. Spend an hour with us now and barely lift a finger later. Let us show you how to get valuable time back in your day.

These webinars showcase the electronic transactions and tools available on our **provider portal on Availity**.* We offer three of them:

- "Working with Aetna® on Availity": perfect for those who'd like a general overview
- "Authorizations on Availity": perfect for those who submit authorization requests
- "Claim management on Availity": perfect for those who work in revenue cycle management

Get tips and tricks from our trainers. Ask your questions and get answers on the spot. **Get the schedule and register for any (or all) of our webinars**.

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Our progress on implementing an electronic solution for receiving supporting documentation

In our December issue, we told you that we're **creating a new secure solution for receiving supporting documentation electronically**. We continue to work with the following four clearinghouses to deliver documentation to us:

- Availity® (the clearinghouse, not the provider portal)
- Change Healthcare
- PNT Data
- Waystar

Each one of the clearinghouses is making progress on helping us deliver the solution to you this year. You can start **working with a clearinghouse** now, if you want. In the meantime, you can continue to upload supporting documentation for claim and authorization requests through our **provider portal on Availity**.*

We'll continue to give you updates on our progress.

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

Add and change modifiers on authorization requests you initiate on our provider portal, Availity®

We've made changes to our authorization transaction on our **provider portal on Availity**. We'll accept the following modifiers: bilateral, left or right.

Here's how to add or change modifiers:

- Initiate your "Authorization (Precertification) Add" request on Availity.*
- In step 2 (inputting service and diagnosis information), check the "Show optional fields" box. Select the appropriate modifier from the drop-down list for each procedure code in your authorization request.

You can even change the modifier for a submitted request. Just complete an Authorization Inquiry transaction and edit the request.

We'll show you what to do! Register for our **Authorizations on Availity** live webinar.

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Pennsylvania providers — Aetna® Medicare payment card for the Keystone market

How does the card work?

Starting January 1, we load the card every quarter with $100. Members can use the card to pay for in-network copayments when visiting a primary care physician (PCP) office, a specialist office, and offices that perform certain other types of services.

If your office accepts Mastercard®, the member can swipe the card as a debit card (with or without a PIN) to pay the copayment amount. The member can pay the full amount in this way. Or, if your office allows the use of more than one payment method, the member can

opt to pay a portion of the amount with the card and use a different payment method for the rest of the amount.

What if the member forgets to bring their card or does not have enough money on the card?

The member should pay the copayment in some other way and then request a manual reimbursement. Or, if the member knows their card balance, your office can do a split payment, whereby the member can pay a portion of the amount with the card and use a different payment method for the rest of the amount.

What if the card doesn't work or is declined?

- Make sure the member is using the card only for a copayment.
- The card hasn't been activated. The member can activate their card by calling the number on their activation sticker. That number is **1-877-261-9951 (TTY: 711)**. The member should call that number to activate the card and then try to pay again.
- The expense might not be considered eligible under their plan. The member should refer to their Explanation of Coverage (EOC) document.
- The member might not be in an eligible plan. Eligible plans are Keystone market plans H3959-001, H3959-002, H3959-010, H3959-011, H3959-037, H3959-041, H3959-047, H3959-051, H3959-053, H5521-261 and H5522-018.

Behavioral health updates

Follow-up care after emergency department (ED) visits

A visit to the emergency department should always be followed by a visit to a patient's behavioral health provider. Talk with your patients about the importance of a timely follow-up visit. Best practice is a visit within 7 days, and no later than 30 days after an ED visit.

Assess

A timely follow-up visit allows you to assess the reasons why the patient needed emergency care, the outcome of the emergency visit and changes to the treatment plan. If possible, obtain a copy of the discharge orders.

Educate

Take time to educate your patients on where they can obtain routine and urgent care. Every Aetna® plan has a member portal that provides members with information on behavioral health topics and benefits. When your patients know where to go, you may be able to prevent future emergency visits.

Support

You can offer follow-up visits in person or through telehealth. Depending on your patients' care needs and benefits, telemedicine can be an easy and convenient alternative. Their Aetna plan may also offer behavioral health support programs to supplement their care. Steer members to their plan's member portal for details.

Coverage determinations and Utilization Management criteria

Our Utilization Management (UM) staff helps members access the services their benefits plans cover. The staff uses evidence-based clinical guidelines from nationally recognized authorities to guide its decisions, and it bases its decisions on the appropriateness of care, the appropriateness of service and the existence of coverage. In addition, the staff focuses on the risks of both underutilization and overutilization of services.

The UM staff reviews requests for coverage to see if members are eligible for certain benefits under their plan. Aetna® doesn't pay or reward practitioners for denying coverage or care.

Appeals

If we deny a coverage request, here's who can appeal the decision:

- The member
- A provider acting on the member's behalf
- Someone else, with the member's permission, acting on the member's behalf

Hard copies

Need hard copies of a specific clinical practice guideline or criteria for a specific determination? We're here to help. Call our Provider Contact Center at **1-888-632-3862 (TTY: 711)**.

Clinical criteria resources

To save you time, we've gathered some clinical criteria resources for you. Remember, individual states may mandate the use of other criteria and guidelines.

- **Aetna clinical policy bulletins**
- **Aetna coverage determination guidelines**
- **Texas Standards for Reasonable Cost Control and Utilization Review** for **New York Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)**

Behavioral health clinical practice guidelines

Clinical practice guidelines from nationally recognized sources promote consistent application of evidence-based treatment methods. This helps provide the right care at the right time. For this reason, we make them available to you to help improve health care.

These guidelines are for informational purposes only. They aren't meant to direct individual treatment decisions. And they don't dictate or control your clinical judgement about the right treatment of a patient in any given case. All patient care and related 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 in Children and Adolescents
- American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Major Depressive Disorder (PDF)
- APA Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder (PDF)
- APA Practice Guideline for the Treatment of Patients with Substance Use Disorders (PDF)
- Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain

More resources

- SAMHSA Treatment Improvement Protocol (TIP) Series
  - TIP 45: Detoxification and Substance Abuse Treatment
  - TIP 63: Medications for Opioid Use Disorder
- ASAM Criteria
- National Institute on Alcohol Abuse and Alcoholism (NIAAA)
- National Institute on Drug Abuse (NIDA)

Refer patients to our Complex Case Management program

Our Complex Case Management program is a joint process including Aetna®, the member, the caregiver and the providers.

We conduct a thorough screening of the member's physical and emotional health, including assessing the member's current condition, the presence of co-existing mental health and substance use disorder issues, and treatment history. We provide patients who have complex conditions with extra help understanding their health care needs and benefits. We also help them access community services and other resources available to them.

Our goal is to produce better health outcomes while managing health care costs. We welcome referrals to the program from many sources. These include:

- Primary care physicians
- Specialists

- Facility discharge planners
- Family members
- Internal departments
- The member's employer
- Organization programs
- Vendors or delegates

You can submit a referral through the toll-free phone number on the member's ID card.

Depression screening for pregnant and postpartum women

The Aetna Maternity Program assists pregnant and postpartum members by identifying depression and getting them behavioral health support. Our Aetna Maternity Program nurses provide educational and emotional support and case management to eligible members, helping them reach their goal of a healthy, full-term delivery.

Program elements

- The clinical case management process focuses on members holistically. This includes behavioral health and comorbidity assessment, case formulation, care planning, and focused follow-ups.
- The Aetna Maternity Program nurses, who have high-risk obstetrical experience, help members follow their providers' plan of care. They also refer members with positive depression or general behavioral health screens to Behavioral Health Condition Management if members have the benefit and meet the program criteria.
- A behavioral health specialist is part of the Aetna Maternity Program team. This specialist helps enhance effective engagement and helps identify members with behavioral health concerns.
- Aetna Maternity Program nurses reach out to members who have experienced a loss in their pregnancy, if appropriate. They offer condolences and behavioral health resources.

How to contact us

- Members and providers can call **1-800-272-3531 (TTY: 771)** to verify eligibility or register for the program. Members can enroll in the Aetna Maternity Program with a representative at this number.
- Members can also enroll through **Aetna.com** by logging in to their member website online and searching under the "Stay Healthy" section.

Depression in primary care

An estimated 21 million adults in the United States (8.4%) had at least one major depressive episode in 2020.[1] Of those adults, 14.8 million had severe impairment connected to their depression.[1]

In 2020, 33.5% of adults struggling with mental illness said that they didn't know where to go for help.[1]

The **U.S. Preventive Services Task Force** issued a statement in 2016. It recommended that depression screenings in adults be implemented in primary care settings and that there be adequate systems in place for diagnosis and referral. Primary care physicians can serve as the entry point to the health care system for many patients. These physicians play a critical role in recognizing and treating symptoms of depression.

The **Aetna Depression in Primary Care Program** is designed to support the screening for and treatment of depression at the primary care level.

Program benefits

- Access to a tool to screen for depression as well as monitored response to treatment
- Reimbursement for depression screening and follow-up monitoring
- **Patient health questionnaire (PHQ-9)** — specifically developed for use in primary care
- Quick and easy self-administration
- Specific for depression
- Materials available in English and Spanish
- PHQ-9 reimbursement — submit claim with the following billing combination: CPT® code 96127 (brief emotional/behavioral assessment) or G0444 (annual screening for depression) in conjunction with diagnosis code Z13.13 (screening for depression)

To get started, you simply need to:

- Be a participating provider
- Use the **PHQ-9** tool to screen and monitor your patients
- Submit your claims using the combination coding

Learn more about the Depression in Primary Care Program.

[1]Substance Abuse and Mental Health Services Administration (SAMHSA). **Key substance use and mental health indicators in the United States: results from the 2020 national survey on drug use and health (PDF)**. October 2021. Accessed January 7, 2022.

Opioid overdose risk screening program

Our behavioral health clinicians screen members to identify patients at risk for an opioid overdose. Any patient receiving a diagnosis of opioid dependence may be at risk.

Learn more about the opioid epidemic.

How you can help

Consider naloxone for patients at risk for an opioid overdose. Naloxone reverses the effects of an opioid overdose. Giving naloxone kits to laypeople reduces overdose deaths, and is safe and cost effective. You can also tell patients and their families and support networks about the signs of overdose and about how to administer medication.

Coverage of naloxone varies by individual plan. Call the number on the member's ID card for more information on coverage. We waive copays for the naloxone rescue medication Narcan® for fully insured commercial members.

Resources for you and your patients

- **Aetna opioid FAQ**
- **The U.S. Department of Health and Human Services: Naloxone: the opioid reversal drug that saves lives (PDF)**
- **SAMHSA: Opioid Overdose Prevention Toolkit**
- **Seeking Treatment for Opioid Use Disorder (Aetna video)**
- **CVS/Aetna: Our opioid response**

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Aetna® will reimburse you when you screen your patients for alcohol and substance use, provide brief intervention, and refer them to treatment. SBIRT is an evidence-based practice designed to support health care professionals. Overall, the practice aims to improve both the quality of care for patients with alcohol and substance use disorder conditions, as well as outcomes for patients, families and communities.

Screen and refer your patients

Use of the SBIRT model is encouraged by the Institute of Medicine recommendation that calls for community-based screening for health risk behaviors, including alcohol and substance use. Our participating practitioners who treat patients with Aetna medical benefits can provide this service and be reimbursed. Go to **Aetna.com** to learn more.

Get started today

The SBIRT app is now available as a free download through the **Apple App Store** or **Google Play**.*

The app provides questions to screen patients for alcohol, drug and tobacco use. A screening tool is provided to further evaluate the specific substance use. The app also provides steps to complete a brief intervention and/or referral to treatment for the patient, based on motivational interviewing.

*The App Store® is a trademark of Apple Inc., registered in the U.S. and other countries. Google Play and the Google Play logo are trademarks of Google LLC.

Working together to solve the teen mental health crisis

We're dedicated to working with you to resolve the teen mental health crisis. We're here with resources you need to best support your young patients.

Partnering with Psych Hub

Our behavioral health providers can have a meaningful impact on our members. That's why we're partnering with **Psych Hub**, the world's largest online platform for mental health education. Psych Hub offers access to **best-in-class behavioral health resources** on evidence-based interventions, built with the provider and their patients in mind.

What you'll receive

You'll get free access to a series of courses you can take to earn an **eLearning certification in suicide prevention (video)**, developed by leading experts at Columbia University, the University of Pennsylvania and Harvard University.

Course titles and descriptions

"CBT Adaptations for Adolescents"

Learners will build on their knowledge of CBT Foundations and acquire the skills to summarize developmental factors related to adolescents, create strategies to help young clients engage and stay motivated to continue therapy, and develop a rapport with adolescent clients' parents or guardians and include them in treatment as appropriate.

“DBT Foundations”

Learners will find out how to identify the stage of treatment the client is currently in, understand the client’s Life Worth Living goals, target an initial focus of treatment, and collaboratively define the highest priority goal of treatment.

“DBT Skills — for Clinicians”

These four modules cover the four main guiding practices and skills of DBT for providers to learn and reinforce implementation specifically with adolescent clients.

The courses include:

- Expert instruction and role play
- Scenario-based activities
- Engaging animated videos
- Resources and homework for your patients

You can earn national Continuing Education (CE) credits and Continuing Medical Education (CME) credits for these courses.

When you can start

This offering is now available to commercial behavioral health providers. **Sign up for suicide prevention courses**.

Pharmacy

Changes to commercial drug lists begin on July 1

On July 1, 2022, 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 May 1. They'll be on our **Formularies & 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 **1-855-240-0535 (TTY: 711)**. Or fax your **authorization request form (PDF)** to **1-877-269-9916**.
- For requests for drugs on the Aetna Specialty Drug List, call **1-866-752-7021** 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 **1-888-267-3277**.

For more information, call the Provider Help Line at **1-800-AETNA RX (1-800-238-6279) (TTY: 711)**.

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

Important pharmacy updates

Medicare

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

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

Medicare

Alaska — State of Alaska Alaskacare Retiree plans now cover preventive care

The State of Alaska Alaskacare retiree plans now cover ACA-compliant preventive services, effective January 1, 2022. The State of Alaska retiree plans have been exempt from the ACA and have historically not covered preventive care until now.

Network arrangement and claims management

The State of Alaska wants to ensure that providers and members are aware of the additional benefits coverage and encourage members to use their preventive benefits.

What you need to know

- This change became effective January 1, 2022, and you should call **1-888-632-3862 (TTY: 711)** if you have any questions.
- This change is for the retiree Alaskacare plans only.

Submit Home Health Care (HHC) Notice of Admissions (NOA) instead of a Request for Anticipated Payment (RAP)

Effective January 1, 2022, Medicare requires the submission of a one-time NOA instead of a RAP.

How to submit NOA

You should submit NOA using Type of Bill (TOB) 32A. Then, use TOB 329 for Periods of Care (POC) following submission of the NOA.

We allow the NOA to be sent with the generic code 1AA11. When submitting the generic code 1AA11 to notify the start of care, you must send the correct Health Insurance Prospective Payment System (HIPPS) for the final bill.

As always, Medicare Advantage providers should bill us just as they would bill Traditional Medicare.

The National Uniform Billing Committee (NUBC) has redefined TOB 329 to represent an original claim, rather than an adjustment, for all claims with "from" dates on or after January 1, 2022.

Need help?

Refer to the **Replacing Home Health Requests for Anticipated Payment document (PDF)** for further instructions.

You may also refer to the Centers for Medicare & Medicaid Services **companion guide (PDF)**, which outlines the billing requirements for an Electronic Data Interchange (EDI) NOA.

Kentucky, New Jersey and Ohio — starting March 1, you must use Anna™ for the SNF concurrent review process

Aetna® has partnered with Post-Acute Analytics (PAA) to automate the concurrent review process by using their Anna™ software platform.

PAA is a business associate that works with health systems, payers and post-acute providers. PAA works with providers and payers that participate in Medicare Advantage (MA) plans and programs to help them understand how members receive care across the care continuum.

What's changing

Starting March 1, 2022, all skilled nursing facilities (SNFs) in Kentucky, New Jersey and Ohio that admit Aetna Medicare Advantage members who reside in and receive care in those states will be required to work with PAA and use Anna to:

- Notify Aetna of a member's arrival in the facility (admission verification notification)
- Conduct concurrent review processes, including providing clinical documentation to receive authorization of additional days beyond the initial approved days

The precertification and concurrent management process

Aetna will continue to make utilization management decisions and send the appropriate letters and other communications.

PAA will provide clinical programming services for identified SNF partners, with the oversight of their Chief Clinical Officer and Senior Medical Officer. One of these services is a root cause analysis, which PAA does to ensure that members receive appropriate care and services. The goal is to prevent unnecessary readmissions and to make sure members get the right follow-up care.

How to start using Anna

PAA will contact you soon to walk you through how to set up and use this exciting tool. It will reduce manual processes, decrease administrative burden and streamline communication with Aetna utilization managers. This can lead to better clinical outcomes and make working with Aetna easier.

Aetna and PAA may integrate your electronic medical records (EMR) system with Anna. You will not be charged any fees from Aetna or PAA. The integration is important for high-volume providers, since it will make working with Aetna simpler.

One of PAA's Post-Acute Care (PAC) engagement managers will contact you to schedule a meeting and answer questions. If you prefer to contact PAA directly, you can:

- Send a message to **Provider Relations**
- Call Tammy Starr at **1-469-312-1030**

Sending "continued stay" documentation

Use the **Anna portal** to send "continued stay" documentation (preferred method). If you aren't able to use the portal, you can send a fax to **1-469-533-4908**. Note that you should continue to send pre-certification documents via Availity®.*

How to reach us

If you have questions about this change, you can email **PAAQuestions@Aetna.com**.

If you have questions about the Aetna utilization review process, you can contact your facility's assigned utilization review nurse or Provider Relations at **1-800-624-0756 (TTY: 711)**.

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

Avoid a network status change — complete your required Medicare compliance training to comply with CMS requirements by December 31, 2022

Participating providers in our Medicare Advantage (MA) plans, Medicare-Medicaid Plans (MMPs) and/or Dual Eligible Special Needs Plans (DSNPs) must 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.

If you are participating in the DSNP plan, you must complete the annual Model of Care (MOC) training and attestation (when released) by December 31, 2022. The delegated provider/entity is required to attest based on contracted plan(s).

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

In the summer of 2022, we will post training materials on our **Medicare page**.

Our training materials include:

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

Where to get more information

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

Aetna® HEDIS® data collection is underway

You'll be hearing from us soon. Either someone from our staff or from our contracted representatives (Ciox Health) will contact your office to collect medical record information on behalf of our members.

We appreciate your understanding and cooperation as we complete this required quality reporting with minimal disruption to your practice.

Why is this necessary?

Healthcare Effectiveness Data and Information Set (HEDIS) data collection is a nationwide, joint effort among employers, health plans and physicians. The goal is to monitor and

compare health plan performance as the National Committee for Quality Assurance (NCQA) specifies.

We are required to send health care quality data to the Centers for Medicare & Medicaid Services (CMS) for our Aetna Medicare Advantage and Coventry Medicare Advantage organizations. We collect most of the data from claims and encounters. We also gather data on services provided and member health status from medical records.

What we may need from you

When we reach out to you, we'll ask that you give us timely access to our members' medical records. Our contracted representatives will work with you and give you options for sending medical records.

Meeting HIPAA guidelines

Our contracted representatives, like Ciox Health, serve us in a role that the Health Insurance Portability and Accountability Act (HIPAA) defines and covers. As HIPAA defines, Aetna is a "Covered Entity," and our representative's role is as a "Business Associate" of a "Covered Entity."

Giving medical record information to us or our contracted representatives meets HIPAA regulations.

We appreciate your help in our data collection efforts.

Required changes to our Mid-Level Practitioners policy

This policy update addresses reimbursement for nurse practitioners, physician assistants, certified nurse, midwives and clinical nurse specialists (e.g., nurse practitioners or registered nurses) in Texas Medicare, Commercial and IVL exchange networks.

Who is affected?

Effective July 1, 2022, we will apply our standard policy for mid-level practitioners to those in Texas Medicare, Commercial and IVL exchange networks.

We will pay mid-level practitioners (nurse practitioners, certified nurse midwives, physician assistants and clinical nurse specialists) regardless of contract, employment status or place of service (that is, office or facility) at 85% of the physician market rate, unless otherwise contracted.

This will include our recent expansion of the policy, which now includes audiologists, genetic counselors, massage therapists, nutritionists, respiratory therapists and registered

dietitians, allowing reimbursement at 75% of the negotiated fee or recognized charge for covered services.

Note that expansion applies only to our commercial plans.

Who and what is not affected?

- Mid-level providers with specific rates in their contract
- Certified registered nurse anesthetists and registered nurse first assistants
- Claims billed with an Assistant Surgery modifier
- Covered DME, orthotics, prosthetics, supplies, drugs, laboratory, radiology services and immunizations billed by a mid-level practitioner
- Providers contracted through a third party or vendor

Does this change affect the precertification and concurrent management process?

No. Aetna® will continue to make utilization management decisions and send the appropriate letters and other communications.

Questions?

If you have questions about this policy change, you can contact the Provider Contact Center at **1-888-632-3862 (TTY: 711)**.

A friendly reminder: You can't balance bill Medicare beneficiaries who have extra benefits

Some dual-eligible Medicare beneficiaries have extra benefits. You can't charge these members for cost sharing.

State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. But federal law allows states to limit provider reimbursement for Medicare cost sharing under certain conditions.

Dual-eligible individuals may qualify for Medicaid programs that pay Medicare Part A and B premiums, deductibles, coinsurance and copays to the extent that the state Medicaid plan provides.

These programs include:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)

- Qualified Disabled and Working Individuals (QDWI)
- Qualifying Individual (QI)

What happens if you don't comply?

Medicare providers must accept the Medicare and Medicaid payment (if any) in full for services given to a beneficiary who has full Medicaid benefits or who is part of one of the Medicare Savings Programs listed above. Failure to follow these billing rules may result in sanctions from the Centers for Medicare & Medicaid Services (CMS). Also, your provider agreement stipulates that you must follow these billing rules.

Helpful tips

- All Original Medicare and Medicare Advantage providers — not just those that accept Medicaid — must follow the balance-billing rules.
- Providers can't balance bill these members when they cross state lines for care. This rule applies no matter which state provides the benefit.

Where to go for more information

- **Medicare-Medicaid general information**
- **Additional Dual Eligible Special Needs Plans (DSNPs) resources**

Check out our newly designed Dual Eligible Special Needs Plans (DSNPs) provider website

Aetna® is committed to supporting you with the **information, tools and resources you need** during your day-to-day operations.

What's new?

Here's what you'll find:

- A state-by-state DSNP provider FAQ for all providers that service Aetna DSNPs.
- A glossary to assist you with locating answers to specific questions
- Helpful tools and resources, including information on how to access Medicaid information, member eligibility, ID cards and patient benefits

We also understand the challenges that DSNP providers face when it comes to billing. Refer to **this provider page** for help in understanding the billing and cost-sharing process.

Updated COVID-19 provider FAQs

Our **updated COVID-19 provider FAQs** are available on **Aetna.com**.

Medicare Advantage — billing

This is a reminder to bill us the same way you bill traditional Medicare.

Check out our updated Medicare page

We've updated our job aids

Take a few minutes to review the new materials posted on our **Medicare provider page**:

- **2022 — How to verify Medicare member eligibility (PDF)**
- **2022 individual Medicare service area expansion counties (PDF)**
- **Aetna Medicare Advantage Quick Reference Guide (PDF)**

More information

Here are a few highlights:

- **2022 Medicare Advantage Quality Incentive Program (PDF)**
- **Annual Medicare Compliance Program requirements**
- **Aetna Medicare disputes and appeals overview**

Advance Beneficiary Notice of Noncoverage (ABN) documents and the organization determination (OD) notice of denial

ABN documents

Providers should be aware that an ABN document is not a valid denial notice for a Medicare Advantage member. The Original Medicare program uses ABN documents — sometimes called "waivers." But you can't use them for patients in Aetna® Medicare Advantage plans, since the Centers for Medicare & Medicaid Services (CMS) prohibits them.

What Aetna Medicare Advantage plans cover

Providers in the Medicare program should know which services Original Medicare covers and those it does not.

Aetna Medicare Advantage plans must cover everything Original Medicare does. In some cases, they may provide coverage that is more generous. Or benefits that go beyond what's covered by Original Medicare. We urge you to call to verify coverage or for answers to other questions you might have.

Organization determination (OD) notice of denial

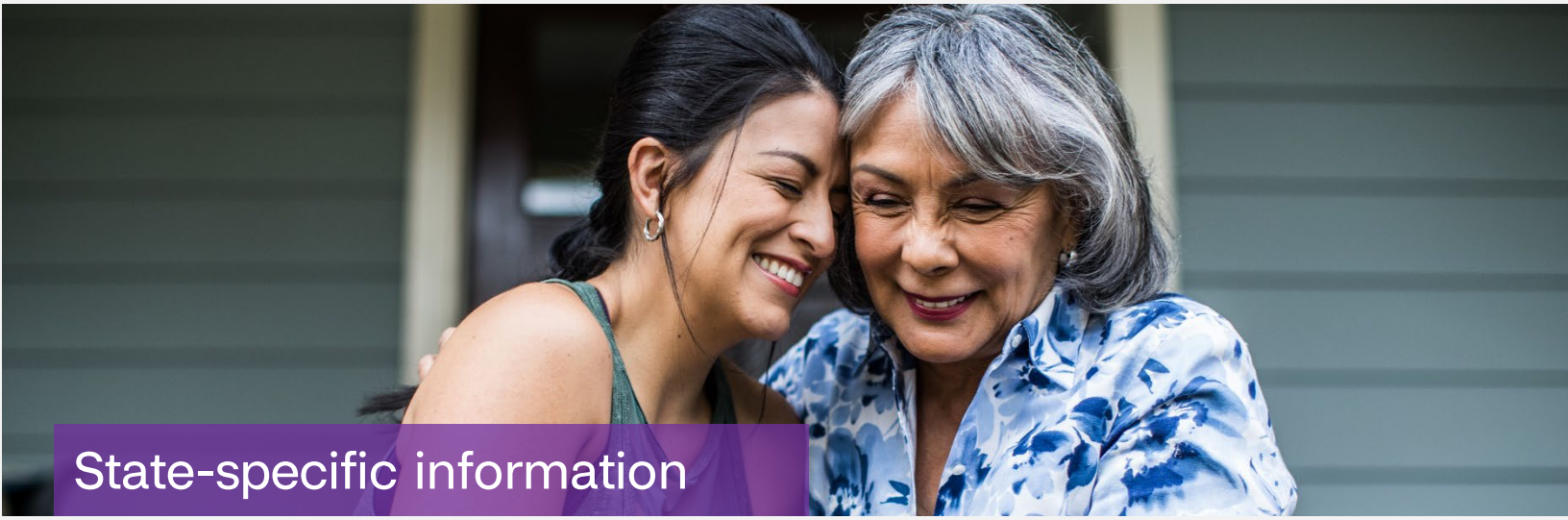
Providers in a Medicare Advantage plan can't charge a Medicare Advantage member for a service not covered under their plan unless that member gets a preservice OD notice of denial from us before getting such services. If the member does not have a preservice OD notice of denial from us, you must hold the member harmless for the noncovered services. You can't charge them any amount beyond the normal copayments, coinsurance and deductibles.

But if a service is never covered under Original Medicare or is a clear exclusion in the plan documents, a preservice OD isn't needed. You may hold the member financially liable for such noncovered services. Note that services or supplies that are not medically necessary or are not covered in the clinical criteria are not "clear exclusions." In such cases, the member isn't likely to know if a service is medically necessary.

You or the member can initiate an OD notice of denial. This will help determine if the member has coverage for a service before they receive care. This will also help everyone know the status of benefits before setting up a lab or diagnostic test.

You'll be able to hold an Aetna Medicare member financially responsible for a noncovered service only if:

- A service or supply is never covered under Original Medicare
- The member has a preservice OD notice of denial from Aetna and decides to proceed with the service knowing they will have to pay the full cost



State-specific information

Alaska — State of Alaska Alaskacare Retiree plans now cover preventive care

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Network arrangement and claims management

The State of Alaska wants to ensure that providers and members are aware of the additional benefits coverage and encourage members to use their preventive benefits.

What you need to know

- This change became effective on January 1, 2022, and you should call **1-888-632-3862 (TTY: 711)** if you have any questions.
- This change is for the retiree Alaskacare plans only.

Colorado providers — notice of material change to contract

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

Kentucky, New Jersey and Ohio — starting March 1, you must use Anna™ for the SNF concurrent review process

Aetna® has partnered with Post-Acute Analytics (PAA) to automate the concurrent review process by using their Anna™ software platform.

PAA is a business associate that works with health systems, payers and post-acute providers. PAA works with providers and payers that participate in Medicare Advantage (MA) plans and programs to help them understand how members receive care across the care continuum.

What's changing

Starting March 1, 2022, all skilled nursing facilities (SNFs) in Kentucky, New Jersey and Ohio that admit Aetna Medicare Advantage members who reside in and receive care in those states will be required to work with PAA and use Anna to:

- Notify Aetna of a member's arrival in the facility (admission verification notification)
- Conduct concurrent review processes, including providing clinical documentation to receive authorization of additional days beyond the initial approved days

The precertification and concurrent management process

Aetna will continue to make utilization management decisions and send the appropriate letters and other communications.

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One of PAA's Post-Acute Care (PAC) engagement managers will contact you to schedule a meeting and answer questions. If you prefer to contact PAA directly, you can:

- Send a message to **Provider Relations**
- Call Tammy Starr at **1-469-312-1030**

Sending "continued stay" documentation

Use the **Anna portal** to send "continued stay" documentation (preferred method). If you aren't able to use the portal, you can send a fax to **1-469-533-4908**. Note that you should continue to send pre-certification documents via Availity®.*

How to reach us

If you have questions about this change, you can email **PAAQuestions@Aetna.com**.

If you have questions about the Aetna utilization review process, you can contact your facility's assigned utilization review nurse or Provider Relations at **1-800-624-0756 (TTY: 711)**.

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

Pennsylvania — Pennsylvania Employees Benefit Trust Fund's (PEBTF) durable medical equipment (DME) benefit changed effective January 1, 2022

PEBTF's durable medical equipment (DME) coverage transitioned from DMEnsions to Aetna®. As of January 1, 2022, Aetna provides DME coverage for medically necessary items for PEBTF members enrolled in an Aetna medical plan.

What this change means for you

For all Aetna PEBTF members, submit all DME claims to Aetna for review and payment in accordance with our DME policy for any claims incurred January 1, 2022, and after.

Questions?

If you have any questions, just call us at **1-888-632-3862 (TTY: 711)**.

Pennsylvania — Aetna® Medicare payment card for the Keystone market

How does the card work?

Starting January 1, we load the card every quarter with $100. Members can use the card to pay for in-network copayments when visiting a primary care physician (PCP) office, a specialist office, and offices that perform certain other types of services.

If your office accepts Mastercard®, the member can swipe the card as a debit card (with or without a PIN) to pay the copayment amount. The member can pay the full amount in this way. Or, if your office allows the use of more than one payment method, the member can opt to pay a portion of the amount with the card and use a different payment method for the rest of the amount.

What if the member forgets to bring their card or does not have enough money on the card?

The member should pay the copayment in some other way and then request a manual reimbursement. Or, if the member knows their card balance, your office can do a split payment, whereby the member can pay a portion of the amount with the card and use a different payment method for the rest of the amount.

What if the card doesn't work or is declined?

- Make sure the member is using the card only for a copayment.
- The card hasn't been activated. The member can activate their card by calling the number on their activation sticker. That number is **1-877-261-9951 (TTY: 711)**. The member should call that number to activate the card and then try to pay again.
- The expense might not be considered eligible under their plan. The member should refer to their Explanation of Coverage (EOC) document.
- The member might not be in an eligible plan. Eligible plans are Keystone market plans H3959-001, H3959-002, H3959-010, H3959-011, H3959-037, H3959-041, H3959-047, H3959-051, H3959-053, H5521-261 and H5522-018.

Texas: Required changes to our Mid-Level Practitioners policy

This policy update addresses reimbursement for nurse practitioners, physician assistants, certified nurse, midwives and clinical nurse specialists (e.g., nurse practitioners or registered nurses) in Texas Medicare, Commercial and IVL exchange networks.

Who is affected?

Effective July 1, 2022, we will apply our standard policy for mid-level practitioners to those in Texas Medicare, Commercial and IVL exchange networks.

We will pay mid-level practitioners (nurse practitioners, certified nurse midwives, physician assistants and clinical nurse specialists) regardless of contract, employment status or place of service (that is, office or facility) at 85% of the physician market rate, unless otherwise contracted.

This will include our recent expansion of the policy, which now includes audiologists, genetic counselors, massage therapists, nutritionists, respiratory therapists and registered dietitians, allowing reimbursement at 75% of the negotiated fee or recognized charge for covered services.

Note that expansion applies only to our commercial plans.

Who and what is not affected?

- Mid-level providers with specific rates in their contract
- Certified registered nurse anesthetists and registered nurse first assistants
- Claims billed with an Assistant Surgery modifier
- Covered DME, orthotics, prosthetics, supplies, drugs, laboratory, radiology services and immunizations billed by a mid-level practitioner
- Providers contracted through a third party or vendor

Does this change affect the precertification and concurrent management process?

No. Aetna® will continue to make utilization management decisions and send the appropriate letters and other communications.

Questions?

If you have questions about this policy change, you can contact the Provider Contact Center at **1-888-632-3862 (TTY: 711)**.

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