March 2023

OfficeLink Updates™

IN THIS ISSUE

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

Make your provider profile work for you

Use our new reference guide to update your information on Availity®

Your provider profile is powerful, and when updated on a regular basis, it helps patients and your practice. Use our new **quick reference guide** to make updates in our **Availity provider portal**.| PAGE 15

Drug and alcohol use disorders

Use the SBIRT model to improve patient outcomes

The **National Institute on Drug Abuse** estimates that the cost of alcohol abuse, illicit drug abuse and prescription drug abuse combined exceeds $64 billion. Aetna® will reimburse you when you screen your patients for alcohol and substance use disorders, provide brief intervention, and refer them to treatment.

Go to our **SBIRT** page to learn more. | 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.

Claims edits for home health care during inpatient stays

This article applies to both our commercial and Medicare members.

Beginning June 1, 2023, you may see new claims edits on home health care when the patient is also inpatient. A patient cannot be inpatient and at the same time receive home care.

Currently, we apply edits on home health care claims received after the inpatient charges are paid. We apply our edits when the date of service is after the inpatient admission and prior to the patient's discharge.

Starting June 1, 2023, when we receive inpatient charges after the home health care claim was paid, we will adjust the home health care claim.

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

Claim and Code Review Program (CCRP) update

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

Beginning June 1, 2023, you may see new claims 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 the **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 claims 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.

Changes to commercial drug lists begin on July 1

On July 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 May 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** 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**.

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

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

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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 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

Important reminders

Our office manual keeps you informed

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 Lists**, also known as our formularies.

How to reach us

Contact us by visiting our website, calling 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.

Cultural competency can help your practice

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 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 monitor and track network providers' ability to meet our members' needs, including their cultural, language, racial or ethnic preferences.

Practitioner training on equity, cultural competency, bias, diversity and inclusion

- The U.S. Department of Health and Human Services has 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.
- Take a Johns Hopkins Medicine course on unconscious bias (the Unconscious Bias collection via LinkedIn Learning).
- Our **Racial and Ethnic Equity** page can show you how to reduce health care disparities.

Want to learn more?

Watch Aetna's **cultural competency training video**.

Keep your data updated in NPPES

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 and 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)**.

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.

While only your doctor can diagnose, prescribe or give medical advice, the 24-Hour Nurse Line can provide information on a variety of health topics.

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.

While only your doctor can diagnose, prescribe or give medical advice, the Care Management nurses can provide information on a variety of health topics.

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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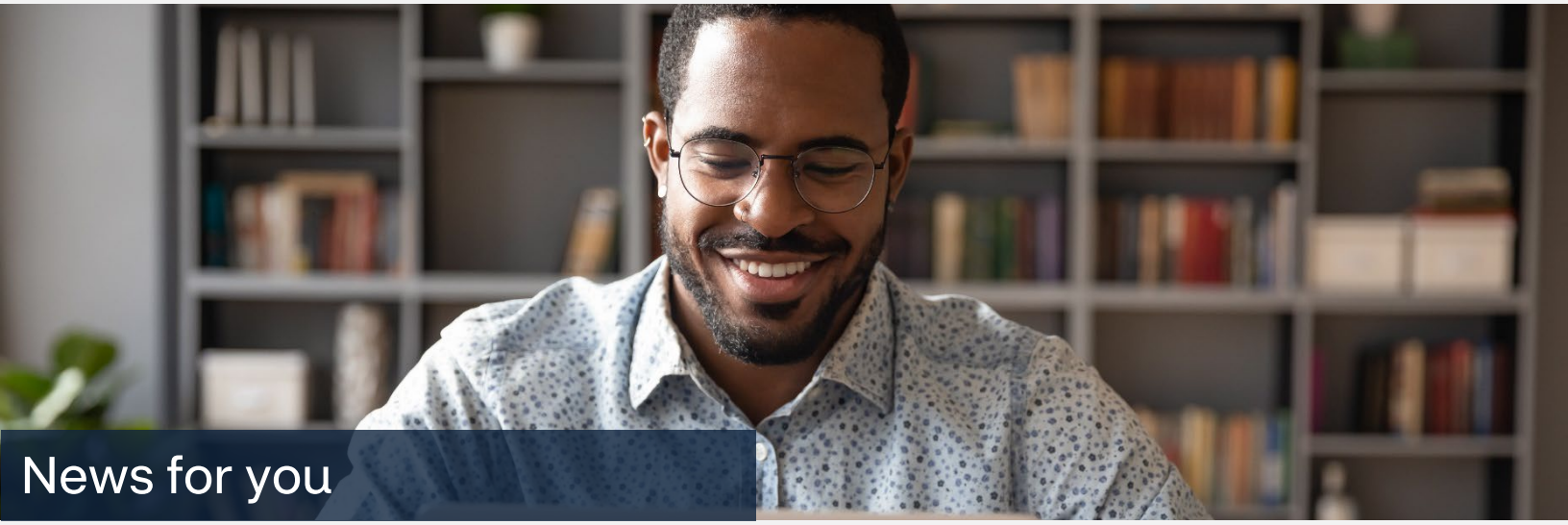

News for you

New onboarding webinar for providers and their staff

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 claims 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 at **NewProviderTraining@Aetna.com** with any questions that you may have. We look forward to seeing you in an upcoming session.

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 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)**.

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)**.

Female infertility procedure prior authorization (PA) requests now include associated drugs

We're simplifying the process for female infertility procedure PA requests requiring associated drugs. Previously, you had to request one PA for the female infertility therapy procedure requiring infertility drugs and a separate PA for the drugs. With the change, you no longer need to request a separate PA for the drugs.

Now, just submit a PA request. If we approve it, your approval covers the procedure and the preferred drugs on the member's formulary. Then, simply send a prescription for the preferred drug to the member's pharmacy. We'll handle the rest.

These changes apply only to fully insured plans.

We hope that eliminating the second PA saves you time. We encourage you to submit your initial PA request using **our Availity provider portal** or your preferred electronic vendor or clearinghouse.* Submitting your requests electronically will save you even more time.

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Sickle cell disease and who should get tested

What is sickle cell trait and disease?

Sickle cell disease (SCD) causes red blood cells (RBC), which are normally round and squishy, to become C-shaped (sickle shaped), stiff and sticky. Stiff and sticky RBC don't move as easily through the blood vessels, and this can cause organ damage and episodes of severe pain.

People who are carriers of sickle cell disease are considered to have sickle cell trait.[1] Although people who have sickle cell trait usually don't have any symptoms, they might, in rare circumstances, experience pain or other problems. These problems are likely to occur whenever they experience a change in oxygen levels, such as being located at a high altitude, performing extreme exercise, scuba diving, or suffering from dehydration.

Who does sickle cell trait and disease affect?

While anyone can have SCD, people who have ancestors from Africa, Central and South America, India and the Middle East are most likely to be at risk.[2] In the United States, 1 in 13 African Americans have sickle cell trait and 1 in 365 have sickle cell disease.[2]

Who should be considered for sickle cell trait screening?

All newborns in the United States are screened for multiple inherited conditions, including sickle cell trait. Sickle cell trait testing is also routinely offered to individuals who are planning a family or who are pregnant. The National Collegiate Athletic Association recommends that college athletes get screened, since those with sickle cell trait may need to take extra precautions against overheating and dehydration during training.[3] If sickle cell trait is suspected of being a complicating factor for certain health conditions, like kidney disease, testing may be recommended.[4]

Where can people get tested?

Our preferred labs, Quest Diagnostics®, Labcorp™ , and BioReference®, provide sickle cell trait testing. Members can obtain a lab order through their doctor. MinuteClinic® locations can provide testing upon request as part of a sports physical for student athletes. The test uses a small blood sample and tests for different factors that can cause sickling diseases.

[1]The Centers for Disease Control and Prevention. **What is sickle cell trait?** December 14, 2020. Accessed on December 7, 2022.

[2]The Centers for Disease Control and Prevention. **Data and statistics on sickle cell disease**. May 2, 2022. Accessed on December 7, 2022.

[3]National Collegiate Athletic Association, Sport Science Institute. **Sickle cell trait**. Accessed on December 7, 2022.

[4]The Centers for Disease Control and Prevention. **Steps to better kidney health for those with sickle cell disease**. September 15, 2021. Accessed on December 7, 2022.

Your provider profile is powerful — make essential updates today

When patients search for you, they first need to know whether you are in network, where you practice and how to contact you. Many also want to know if you offer virtual visits.

Your provider profile is powerful, and when updated on a regular basis, it helps patients and your practice. Here's how:

You'll create a good impression

Trust begins with a good first impression. And keeping your provider information current is a great place to start. Remember the following:

- Current and complete information helps patients find you to get the care they need.
- Patients could feel better about the care they'll receive from you if they get complete initial information.

You'll have an office that runs more smoothly

An accurate profile helps us comply with rules and regulations, and some of those involve communicating essential information to you. And when you have that information, you can respond better to the needs of your office and therefore to your patients.

Plus, accurate provider information can help other providers refer their patients to you.

Update your profile in minutes

Follow the steps shown in our new **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

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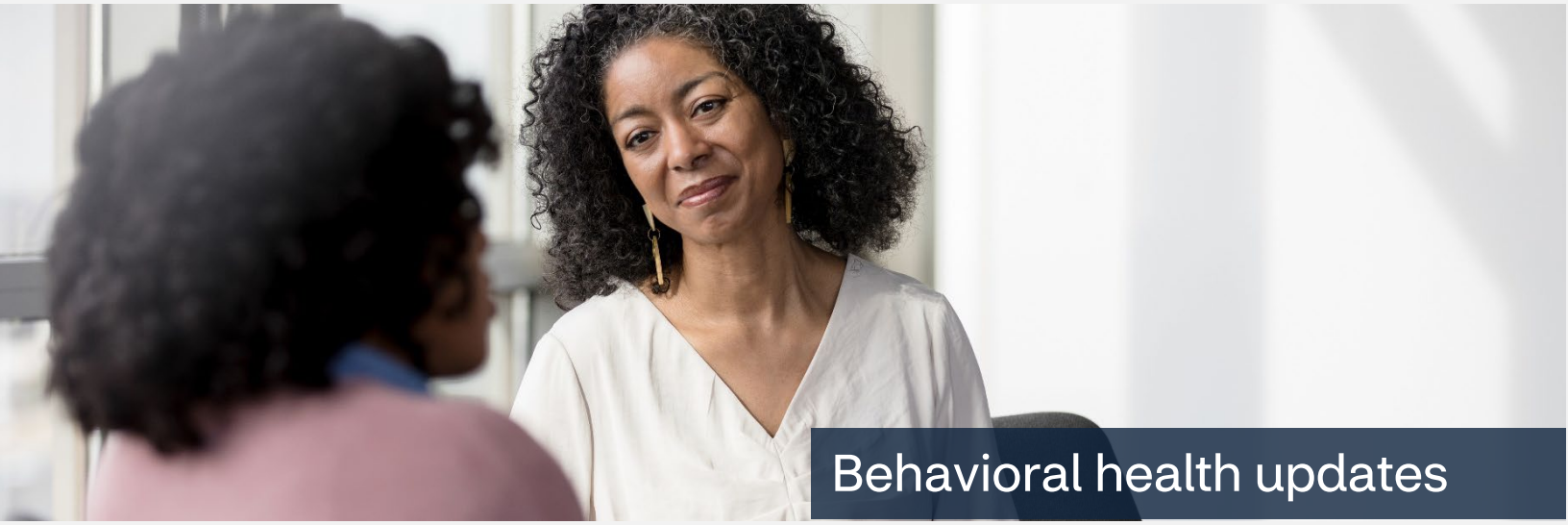

Behavioral health updates

Behavioral health supervisory billing

Aetna® recognizes that high consumer demand for behavioral health services affects its behavioral health network. As part of our effort to support our providers and improve member access to care, Aetna allows supervisory billing for behavioral health care provided by qualified license-eligible behavioral health clinicians.

Note that we will allow supervisory billing only for in-network behavioral health clinicians, supervisors, groups and facilities.

What is a qualified license-eligible clinician?

Qualified license-eligible clinicians:

- Have completed all educational requirements for their target license type
- Are actively completing their clinical practice hours required for independent licensure
- Are actively receiving clinical supervision from a qualified supervisor at a frequency and duration commensurate with their caseload

Example: A clinician graduates with a master's degree in counseling psychology. She has completed all required educational credit hours to sit for her state licensure exam as a Licensed Independent Social Worker (LICSW). She is required to work a minimum number of clinical hours and receive regular clinical supervision prior to taking the exam. She is eligible for supervisory billing if she receives regular supervision from a qualified clinical supervisor.

What is a qualified clinical supervisor?

Qualified clinical supervisors are independently licensed behavioral health providers actively credentialed and contracted with Aetna individually and/or under a contracted behavioral health group or facility.

Example: A supervisor at a Community Mental Health Center (CMHC) provides regular clinical supervision for master's level, license-eligible employees.

How to manage claims

Providers may submit claims for services delivered by license-eligible clinicians by listing the licensed supervisor as the rendering clinician. The services rendered must be covered under the member's benefits plan and an individual, group or facility contract with Aetna.

Prior authorization is not required for routine outpatient services such as psychotherapy and medication management.

Questions?

If you have questions, please call the Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)**.

Refer patients to our Complex Case Management (CCM) program

Program description

Our CCM program is a collaborative process that includes the Aetna® clinician, the member, the caregiver and providers.

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

We encourage this collaboration between the behavioral health and medical providers to improve patient outcomes.

How members get connected

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 in primary care

Approximately 8.4% of U.S adults aged 18 or older reported symptoms of depression in 2020, and 6% of adults had a major depressive episode with severe impairment.[1] These numbers increased because of the COVID-19 pandemic.

Throughout 2021, the Centers for Disease Control and Prevention (CDC) conducted an online **Household Pulse Survey**. The results showed the national prevalence of Depressive Symptoms ranging between 20.2% and 31.1%. **An earlier study** found that only about 4% of adults were screened for depression in primary care settings.

The role of primary care physicians

Primary care physicians serve as the entry point to the health care system for many patients and play a critical role in recognizing and treating symptoms of depression. According to a 2019 article in the New England Journal of Medicine, "An estimated 60% of mental health care delivery occurs in the primary care setting, and 79% of antidepressant prescriptions are written by providers who are not mental health care providers."[2] Research indicates that screening for and treating significant depression among primary care patients may improve the quality of medical care and decrease the burden of physical illnesses.

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

This program provides access to the **patient health questionnaire (PHQ-9)** tool, specifically developed for use in primary care, to screen for depression and monitor the response to treatment. The tool is a short, self-administered screener that is available in both English and Spanish. Reimbursement is available for providers who submit claims using the following billing codes in conjunction with the diagnosis code Z13.13 (screening for depression):

- CPT® code 96127 (brief emotional/behavioral assessment)
- G0444 (annual screening for depression)

How to get started

To get started, you simply need to:

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

Learn more about the **Depression in Primary Care program**.

[1]National Institute of Mental Health. **Major depression**. January 2022. Accessed on December 12, 2022.

[2]Park LT, Zarate CA Jr. **Depression in the primary care setting**. New England Journal of Medicine. February 7, 2019; 380 (6): 559–568. Accessed on December 12, 2022.

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 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.
- Our 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 they 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.
- Our 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 also enroll through **Aetna.com** by logging in to their member website and searching under the "Stay Healthy" section.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

In 2020, more than 28 million people (10.2%) aged 12 or older had an alcohol use disorder, and an estimated 18.4 million people aged 12 or older had at least one illicit drug use disorder in the past year.[1] At least 1 in 10 children live in a home with a parent who has a drinking problem, and at least 1 in 35 live in a home with a parent with an illicit drug use disorder.[2]

The **National Institute on Drug Abuse** estimates that the cost of alcohol abuse, illicit drug abuse and prescription drug abuse combined exceeds $64 billion.

Our knowledge about evidence-based therapies to treat people with substance use disorder conditions continues to increase. Clinical trials show that brief interventions can promote significant, lasting reductions in drinking levels for individuals who are at risk but not alcohol dependent. Because many patients will not self-identify or have not yet developed detectable problems associated with substance use, screening can help identify patients needing intervention.

Aetna® will reimburse you when you screen your patients for alcohol and substance use disorders, provide brief intervention, and refer them to treatment. SBIRT is an evidence-based practice designed to support health care professionals. The goal is 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

The Institute of Medicine encourages use of the SBIRT model. It recommends 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 our **SBIRT** page to learn more.

Get started today

Resources for the SBIRT program are available online at the **Substance Abuse and Mental Health Services Administration** website.

This site provides background for the program, links to scholarly articles and research, and coding information.

[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 on December 12, 2022.

[2]Lipari RN and Van Horn SL. **Children living with parents who have a substance use disorder**. The CBHSQ Report. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. August 24, 2017. Accessed on December 12, 2022.

How we use Healthcare Effectiveness Data and Information Set (HEDIS®) to improve patient outcomes

Clinical data that we monitor

Aetna® monitors internal data and compares it against National Committee for Quality Assurance (NCQA) benchmarks to evaluate how our organization and provider networks are working together to improve member outcomes. We monitor the measures that focus on:

- Screening (depression, alcohol use or other substance use)
- Medication management (ADHD, depression, schizophrenia, psychosis)
- Treatment (alcohol or other substance use)
- Follow-up care for mental health or substance use disorders (after hospitalization or ED visits)

Ongoing quality improvement

We continually work to improve our services and member outcomes, and we often use HEDIS data to help measure the effectiveness of our interventions. Interventions may include:

- Member and/or provider communication or education campaigns
- New partnerships or pilot programs to improve access to resources and treatment
- Updating member and provider websites for accuracy and improved usability

Ways you can help support our efforts

We would like to partner with our behavioral health provider network to improve member outcomes. We ask that you please:

- Use the Clinical Practice Guidelines and Preventive Service Guidelines we have adopted
- Keep your contact information up to date so that we can share information
- Encourage members to use the programs and services Aetna offers when it is clinically appropriate to do so

Pharmacy

Changes to commercial drug lists begin on July 1

On July 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 May 1. They'll be on our **Formularies and Pharmacy Clinical Policy Bulletins** page.

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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

Ohio: You'll have a simplified claims process for supplemental chiropractic benefits in 2023

We are ending our relationship with the ASH Group for administration of supplemental chiropractic benefits in Ohio. This change becomes effective on December 31, 2022.

All claims with dates of services on or before December 31, 2022, should go to ASH for review and processing. For services you provide on January 1, 2023, and after, send claims to Aetna®. You can submit claims up to 120 days after the date of service.

Supplemental Medicare benefits participation

In addition to having the standard Medicare benefits, our Medicare Premier HMO members have supplemental chiropractic benefits. These include unlimited chiropractic visits for things like:

- Evaluation and management
- X-ray exams
- Chiropractic manipulative therapy
- Modalities and therapeutic procedures
- Rehabilitation for musculoskeletal conditions of the spine and extremities

We pay you for these services as described in your Aetna® Medicare Provider Agreement.

Questions?

If you have questions about claims and participation with ASH for 2022 dates of service, call ASH at **1-888-511-2743**.

If you have questions about claims, benefits and participation with Aetna, go to our **Availity provider portal**.* Or call us at **1-888-632-3862** **(TTY: 711)**.

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

The truncation report and the importance of accurate coding

What is the truncation report?

Our Medicare Revenue Integrity compliance team runs a yearly truncation report. This report shows the number of attributed members associated with a designated provider, and it stratifies the total number of diagnoses (expressed as a percentage) that have been reported on a claim. Categories are 1-4 diagnoses, 5-8 diagnoses, 9-12 diagnoses, and 13-31 diagnoses.

Coding information and tips

- It is very important to code all diagnoses that are reflected in the documentation to paint a clear and accurate picture of what is going on with the member.
- All dates of service stand alone.
- Section 21 of the 1500 Claim Form is the section where the ICD 10 codes are collected for Risk Adjustment. This section should contain all active conditions present for the date of service. There is a limit of 12.
- If there are more than 12 diagnosis codes, you can submit a secondary claim form using CPT® code 99499.

More information

In this rapidly changing environment, our nurse educator plays an important role by working to ensure that providers have access to the most updated information.

For additional information, contact us at **RiskAdjustment@aetna.com**.

Complete your required Medicare compliance training by December 31, 2023

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 (when released in the summer) 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 will be released in the summer of 2023 and will be 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 **FDR compliance newsletters**.

Aetna® HEDIS® data collection is underway

We'll be reaching out soon. Either someone from our staff or from our contracted representative (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 activity 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 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 provide options for sending medical records.

Meeting HIPAA guidelines

Our contracted representative, Ciox Health, serves as our Business Associate as defined under the Health Insurance Portability and Accountability Act (HIPAA).

Giving medical record information to a Covered Entity and to a Covered Entity's legally contracted Business Associate meets HIPAA regulations.

We appreciate your assistance in our medical record collection efforts.

Keep your data updated in NPPES

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 and 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)**.

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 us to verify coverage or for answers to other questions you might have.

Organization determination (OD) notice of denial

Providers in Medicare Advantage plans 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.

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.

Insulin and vaccine cost-sharing for 2023

The changes below are included in the 2023 Inflation Reduction Act.

Insulin cost-sharing

Starting January 1, 2023, people enrolled in a Medicare Prescription Drug Plan (Medicare Part D Plan) will not pay more than $35 for a month's supply of each type of insulin that they take. The insulin must be covered by their Medicare Part D Plan and dispensed at a pharmacy or through a mail-order pharmacy. Medicare Part D deductibles will not apply to the covered insulin product.

Starting July 1, 2023, people enrolled in the Medicare Advantage Plan who take insulin through a traditional pump will not pay more than $35 for a month's supply of covered insulin, and the deductible will not apply to the insulin. This rule will apply to people using pumps covered through the durable medical equipment (DME) benefit under Part B vaccine cost-sharing.

The beneficiaries of the Medicare Advantage Plan (effective July 1, 2023) and the Medicare Prescription Drug Plan (effective January 1, 2023) will not pay more than $35 for a month's supply of covered insulin regardless of whether they have met their deductible.

Vaccine cost-sharing

Starting January 1, 2023, adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), including the shingles vaccine, will be available to people with Medicare Part D at no extra cost to them.

For more information

- View the **Medicare-changes timeline (PDF)**.
- See the CMS **frequently asked questions document (PDF)** about reduced drug prices and enhanced Medicare benefits under the Inflation Reduction Act.

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 Plan (DSNP) resources**

Medicare Advantage — billing

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

Hospitals: By April 27, you need to revise several beneficiary notices

By April 27, hospitals must add the following changes to three notices:

- Centers for Medicare & Medicaid Services (CMS) revised standardized nondiscrimination language
- Updated Office of Management and Budget (OMB) approval numbers
- Updated expiration dates

These changes are provided below and need to be made to the three forms listed in the next section. Note that nothing else has changed.

Which forms need to be changed

The following forms require the updates. The revised expiration dates and OMB approval numbers are shown here:

- **Important Message from Medicare (CMS-10065)** (exp. 12/31/2025) OMB approval 0938-1019
- **Detailed Notice of Discharge (CMS-10066)** (exp. 12/31/2025) OMB approval 0938-1019
- **Medicare Outpatient Observation Notice (CMS-10611)** (exp. 11/30/2025) OMB approval 0938-1308

Revised standardized nondiscrimination disclaimer language

By April 27, hospitals must add the following revised nondiscrimination disclaimer to the above three forms:

> You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **Medicare.gov/about-us/accessibility-nondiscrimination-notice** or call **1-800-MEDICARE (1-800-633-4227)** for more information. TTY users can call **1-877-486-2048**.

More information

Visit the **Beneficiary Notices Initiative** page for the new forms and instructions, including Spanish versions of the notices.

State-specific information

Reminder: State of Alaska AlaskaCare Retiree plans now cover preventive care

The State of Alaska AlaskaCare retiree plans now cover ACA-compliant preventive services. This coverage became effective on January 1, 2022. State of Alaska retiree plans are exempt from the ACA (Affordable Care Act) and did not cover preventive care until 2022.

This change applies only to AlaskaCare retiree plans.

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

If you have any questions about benefits, coverage or claims, call our Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)**.

Colorado reminder: The Cofinity network was discontinued on December 31, 2022

The Cofinity network was discontinued on December 31, 2022. As of January 1, 2023, Aetna® membership will continue under the Aetna brand, and any third-party access will migrate to the First Health network brand.

What this means for you

You currently have an Aetna agreement that covers both the Aetna and First Health lines of business, or you have a stand-alone First Health agreement. Therefore, there will be no workflow, reimbursement or system changes associated with this contract change, and you will continue to follow the current claims submission processes.

If you have any questions, please send a message to **CofinityQuestions@aetna.com**.

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.

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Pennsylvania and West Virginia: The Aetna® Medicare Payment Card for the Keystone market

What is the Aetna Medicare Payment Card?

The Aetna Medicare Payment Card is a preloaded debit card that Aetna Medicare members received on or before January 1, 2023. The purpose of this card is to make it easier for members to pay for medical services or, for certain plans, medical services and over-the-counter (OTC) expenses. On the first day of every quarter, PayFlex® will load funds onto the card.

For plans that offer coverage for medical services only, members can use their card to pay for copays, and coinsurance for plan-covered services such as:

- Physician visits
- Physical, speech and occupational therapy visits
- Diagnostic procedures, labs, X-rays and tests
- Telehealth-related services

For plans that offer coverage for both medical and OTC expenses, members can use their card for the medical services listed above and for purchasing over-the-counter items through Over-the-Counter Health Solutions (OTCHS) via mail order or in person at any CVS Health® retail stores.

How does the Aetna Medicare Payment Card work?

If your office accepts Mastercard, the member can swipe the card with or without using a PIN to pay for their medical services up to the quarterly amount that is on the card.

If your office allows the use of more than one payment method, the member can opt to pay a portion of their bill using the card and the rest of their bill using another form of payment.

If your office does not accept Mastercard or if the member forgets their card, they can request a manual reimbursement. When a member requests reimbursement, they must provide itemized statements that include their name, the provider's name, the date of service, a description of the service and the payment amount.

What Aetna Medicare Advantra plans include the Aetna Medicare Payment Card in 2023?

Effective January 1, 2023, there are sixteen Advantra plans that include the Aetna Medicare Payment Card. The plans are provided below. Plans marked with an asterisk provide additional coverage for over-the-counter items.

Plan number	Plan name
H1608-027	Aetna Medicare Advantra Gold (PPO)
H1692-002	Aetna Medicare Advantra Silver (HMO-POS)
H3931-004*	Aetna Medicare Premier Plus (HMO-POS)
H3931-064*	Aetna Medicare Premier (HMO-POS)
H3959-001	Aetna Medicare Advantra Gold (HMO)
H3959-002	Aetna Medicare Advantra Gold (HMO)
H3959-010	Aetna Medicare Advantra Silver (HMO-POS)
H3959-011	Aetna Medicare Advantra Silver (HMO-POS)
H3959-037	Aetna Medicare Advantra Gold (HMO-POS)
H3959-041	Aetna Medicare Advantra Eagle (HMO)
H3959-047	Aetna Medicare Advantra Butler Prime (HMO)
H3959-049	Aetna Medicare Advantra Excela Prime (HMO-POS)
H3959-051	Aetna Medicare Beaver Valley Prime (HMO)
H3959-053*	Aetna Medicare Advantra Philly Prime (HMO)
H5521-261	Aetna Medicare Value (PPO)
H5522-022	Aetna Medicare Silver Back (PPO)

What would cause a card to be declined?

- The member did not activate their card. The phone number to activate their card is **1-877-261-9951 (TTY: 711)**.
- The expense might not be considered eligible under the plan.
- There is not enough money on the card to cover the expense.

Texas: Aetna® to enter the individual exchange market in additional counties

We're expanding! As previously shared, we re-entered the ACA exchanges in Texas on January 1, 2022. On January 1, 2023, we expanded further into new Texas markets.

Welcome our new members by checking your participation status

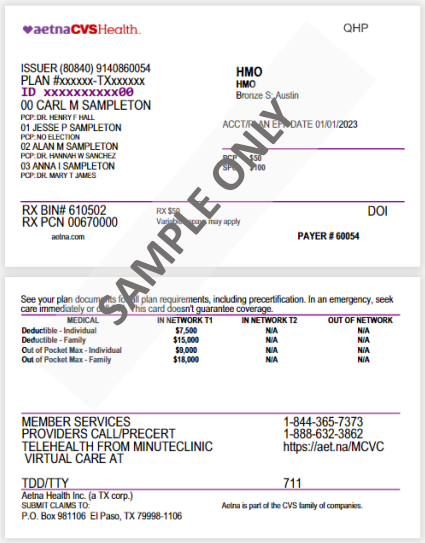
If you practice in Austin, El Paso, Houston, San Antonio, Dallas or Corpus Christi, check out the **Aetna CVS Health provider directory** to check your status.

Plan basics

- Primary care physician (PCP) and referrals are required.
- Members must use in-network providers to receive benefits.
- Coverage outside the service area is for emergencies only.

Know what to look for

Here is a sample of our ID card. Look for “QHP” (qualified health plan).



Questions?

If you have questions, please **refer to our FAQs** or call **1-888-MD AETNA (1-888-632-3862) (TTY: 711)**.

Health plans are offered or underwritten or administered by Aetna Health Inc. (Texas) (Aetna). Aetna® is part of the CVS Health® family of companies.

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