March 2024

OfficeLink Updates™

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

HIGHLIGHTS IN THIS ISSUE

Improvements to our clinical questionnaires

These questionnaires support your prior authorization requests. Now, the questions are easier to understand, we don't collect as much information and our approval criteria match our clinical policies.

Caring for out-of-state DSNP members

DSNP members living near a state border may choose to receive services from a provider located outside of their residential state.

Register with Medicaid in bordering states to receive payment. The process varies by state.

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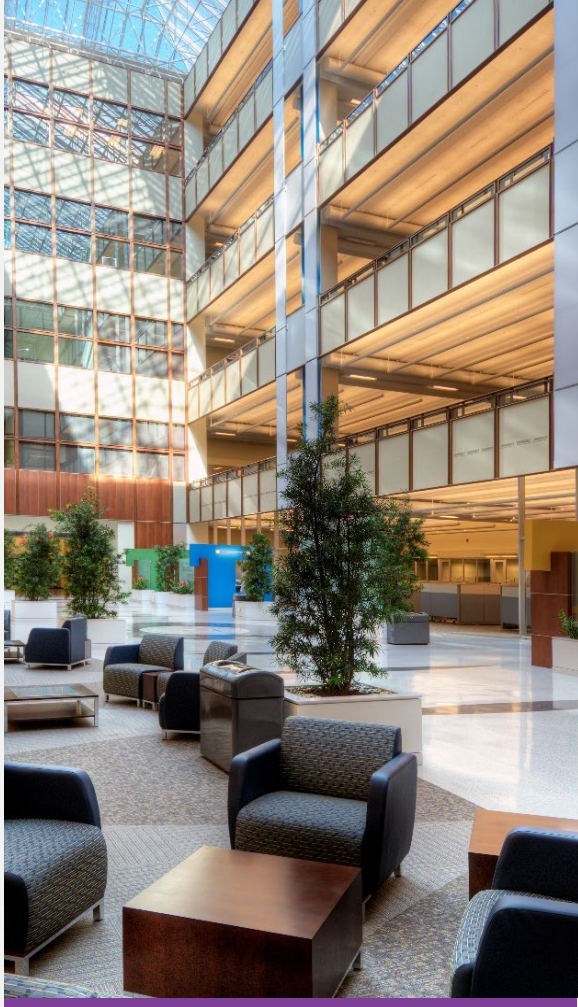

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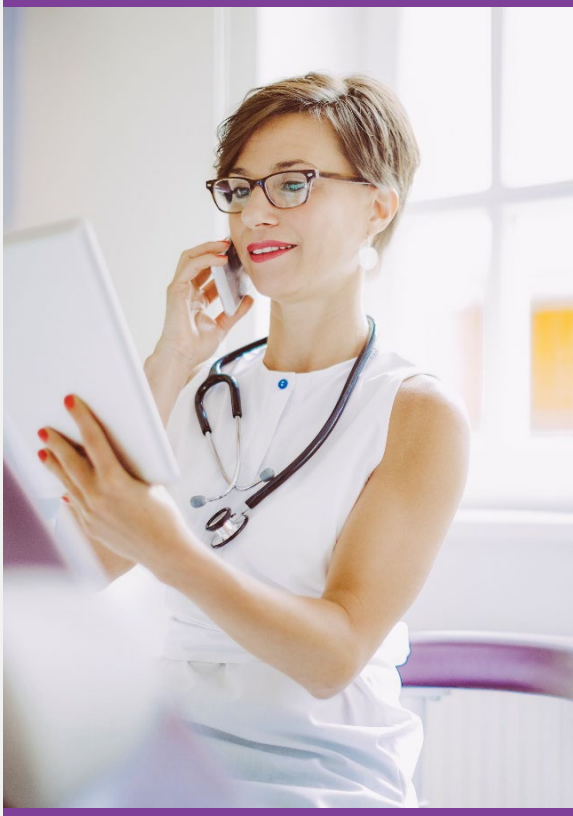

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Other topics

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[Aetna® complies with the Two Midnight Benchmark]

90-day notices and related reminders

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

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

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

Oral nutrition — modifier BO

This update applies to our commercial and Medicare members.

Aetna® does not cover banked breast milk, food supplements, specialized infant formulas, and vitamins and/or minerals taken orally billed with modifier BO.

Radiation therapy payment policy — 77295

This update applies to our commercial and Medicare members.

Aetna® allows one radiation therapy session per treatment course for all tumor types.

Claim and Code Review Program (CCRP) update

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

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

Beginning June 1, 2024, you may see new claim edits. These are part of our CCRP. These edits support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. You can view these edits on our **provider portal on Availity**.*

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 **provider portal on Availity**. 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.

Note to Texas providers: Changes described in this article will be implemented for fully insured plans written in the state of Texas in accordance with regulatory requirements. Changes for all other plans will be as outlined in this article.

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

We will no longer pay for HCPC code S0260

This update applies to both our commercial and Medicare members.

Beginning June 1, 2024, we will no longer pay for code S0260: History and physical (outpatient or office) related to surgical procedure (list separately in addition to code for appropriate evaluation and management service). Code S0260 is not eligible for separate reimbursement.

If you bill for this code, we will deny it, since reimbursement has already been received through the single global surgery allowance and/or the related E/M service (if eligible for separate reimbursement in addition to the global surgery package).

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

Note to Texas providers: Changes described in this article will be implemented for fully insured plans written in the state of Texas in accordance with regulatory requirements. Changes for all other plans will be as outlined in this article.

Service code updates

These updates take effect on September 1, 2024.

We are assigning or reassigning individual service codes within contract service groups. Changes to your compensation depends on the presence of specific service groupings in your contract. You will find the changes below.

Unless noted, all updates take effect on September 1, 2024.

Codes	Provider types affected	What's changing
92920, 92924, 92986, 92987, 92990, 92997, 0238T, 0338T, 0339T, C9783	Facilities, including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 7 (AEG7) Code will remain assigned to Ambulatory Surgery: Default Rate. • If the contract contains an Ambulatory Surgery — Aetna Enhanced Grouper: Category 7 rate, it will be applied. If not, then the Ambulatory Surgery: Default Rate will be applied.
92920, 92924, 92986, 92987, 92990, 92997, 0238T, 0338T, 0339T, C9783	Facilities, including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Coventry Enhanced Grouper: Category 7 • If contract contains an Ambulatory Surgery — Coventry Enhanced Grouper: Category 7 rate, it will be applied; if not, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.
0644T	Facilities, including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 7 (AEG7) and to Cardiac Catheterization — AEG 7 procedures Code will be removed from Cardiac Catheterization — Default Surgery procedures Code will remain assigned to Cardiac Catheterization and Ambulatory Surgery: Default Rate.

		• If the contract contains a Cardiac Catheterization rate, it will be applied. If the contract does not contain a Cardiac Catheterization rate but contains an Ambulatory Surgery — Aetna Enhanced Grouper: Category 7 rate, it will be applied. If not, then the Ambulatory Surgery: Default Rate will be applied.
0644T	Facilities, including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Coventry Enhanced Grouper: Category 7 • If contract contains an Ambulatory Surgery — Coventry Enhanced Grouper: Category 7 rate, it will be applied; if not, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.
C9600	Facilities, including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 7 (AEG7) Code will remain assigned to Percutaneous Transluminal Coronary Angioplasty and Ambulatory Surgery: Default Rate. • If the contract contains a Percutaneous Transluminal Coronary Angioplasty rate, it will be applied. If the contract does not contain a Percutaneous Transluminal Coronary Angioplasty rate but contains an Ambulatory Surgery — Aetna Enhanced Grouper: Category 7 rate, it will be applied. If not, then the Ambulatory Surgery: Default Rate will be applied.
C9600	Facilities, including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Coventry Enhanced Grouper: Category 7 • If contract contains an Ambulatory Surgery — Coventry Enhanced Grouper: Category

		7 rate, it will be applied; if not, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.
92928, 92933, 92937, 92943, 0645T	Facilities, including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 8 (AEG8) Code will remain assigned to Ambulatory Surgery: Default Rate. • If the contract contains an Ambulatory Surgery — Aetna Enhanced Grouper: Category 8 rate, it will be applied. If not, then the Ambulatory Surgery: Default Rate will be applied.
92928, 92933, 92937, 92943, 0645T	Facilities, including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Coventry Enhanced Grouper: Category 8 • If contract contains an Ambulatory Surgery — Coventry Enhanced Grouper: Category 8 rate, it will be applied; if not, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.
C9602, C9604, C9607	Facilities, including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 8 (AEG8) Code will remain assigned to Percutaneous Transluminal Coronary Angioplasty and Ambulatory Surgery: Default Rate. • If the contract contains a Percutaneous Transluminal Coronary Angioplasty rate, it will be applied. If the contract does not contain a Percutaneous Transluminal Coronary Angioplasty rate but contains an Ambulatory Surgery — Aetna Enhanced Grouper: Category 8 rate, it will be applied.

		If not, then the Ambulatory Surgery: Default Rate will be applied.
C9602, C9604, C9607	Facilities, including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Coventry Enhanced Grouper: Category 8 • If contract contains an Ambulatory Surgery — Coventry Enhanced Grouper: Category 8 rate, it will be applied; if not, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.
92921, 92925, 92929, 92934, 92938, 92944, C9601	Facilities, including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 1 (AEG1) Code will remain assigned to Ambulatory Surgery: Default Rate. • If the contract contains an Ambulatory Surgery — Aetna Enhanced Grouper: Category 1 rate, it will be applied. If not, then the Ambulatory Surgery: Default Rate will be applied.

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

Changes to commercial drug lists begin on July 1

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

On July 1, 2024, 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, 2024. 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 **provider portal on Availity**.*
- For requests for non-specialty drugs, call **1-800-294-5979 (TTY: 711)**. Or fax your **authorization request form (PDF)** to **1-888-836-0730**.
- For requests for drugs on the Aetna Specialty Drug List, call **1-866-814-5506 (TTY: 711)** or go to our **Forms for Health Care Professionals** page and scroll down to the Specialty Pharmacy Precertification (Commercial) drop-down menu. If the specific form you need is not there, scroll to the end of the list and use the generic Specialty Medication Precertification request form. Once you fill out the relevant form, fax it to **1-866-249-6155**.

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

More information

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

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

Important pharmacy updates

Read the updates for Medicare, Medicare Part B step therapy and commercial.

Medicare

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

Student Health

Visit **Aetna Student Health** to view the most current Aetna Student Health plan formularies (drug lists). Follow these steps:

1. Select your college or university and click "View your school."
2. Select the "Members" link at the top of the page.
3. Click the "Prescriptions" link under Resources for Members.
4. Scroll down to the Aetna Pharmacy Documents section.

Aetna federal employee plans

Visit our **Aetna Federal Plans** website to view the most current formularies (drug lists).

Changes to our National Precertification List (NPL)

This update applies to our commercial and Medicare members.

Effective July 1, 2024, we'll require precertification for the following procedures:

- Osteotomy posterolateral approach, thoracic
- Osteotomy anterior approach
- Knee meniscectomy — requires precertification for Medicare Advantage members only

In a February letter, we informed some Florida providers that, effective May 12, 2024, we'll require precertification for the following services (applicable only to Florida Dual-Eligible Special Needs Plans):

- Psychosocial rehabilitation services (H2017)
- Therapeutic behavioral services (H2019)
- Mental health clubhouse services (H2030)
- Targeted case management (T1017)

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**.**

If you need precertification for a specialty drug for a commercial or Medicare member, submit your request through Novologix®, also available on Availity®.

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

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Alaska: Alaska's Aetna® Market Fee Schedule (AMFS) is changing for certain vaccines

Reimbursement for certain vaccines is changing on June 1, 2024, to match the Alaska Vaccine Assessment Program AVAP rates.

Effective June 1, 2024, we will update Alaska's AMFS to match the rates for vaccines included in the AVAP.

What this means for you

If your practice receives vaccines through AVAP, there will be no impact to you.

If your practice purchases and bills for vaccines included under AVAP, your payment rate will be no greater than the vaccine formulary pricing under the statewide immunization program.

Information about AVAP

Read more about AVAP. To locate the current formulary pricing, go to the For Providers tab.

State-specific updates

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

Aetna® Medicare offers chiropractic care through WholeHealth Living®, a Tivity Health Company

Find out whether you participate in the DSNP plans.

This article applies to Alabama, Arkansas, Louisiana and Mississippi.

The American College of Physicians, the Centers for Disease Control and Prevention (CDC) and other leading medical entities recommend chiropractic care as a nonpharmacologic, first-line therapy for musculoskeletal pain.[1,2]

All DSNP plans in Alabama, Arkansas, Louisiana and Mississippi offer a supplemental chiropractic benefit through WholeHealth Living®, a Tivity Health Company. This benefit does not require any referrals and includes twelve in-network annual visits with a $0 copay.

Services included with this benefit:

- One physical examination or re-examination per calendar year
- One spinal X-ray procedure per calendar year
- One chiropractic manipulation/adjustment of joints such as shoulders, elbows, knees and ankles (not the spine) per visit*
- One of the following therapeutic procedures or manual therapies per visit:
    - Electrical stimulation
    - Ultrasound
    - Therapeutic exercise
    - Manual therapy (such as mobilization or manipulation, manual lymphatic drainage and manual traction)

New for 2024

In addition to chiropractic services offered for HMO DSNP plans, chiropractic services are now also offered on PPO DSNP plans for all states listed above. In addition, PPO DSNP plan members have an "out-of-network" benefit, which means they can see a practitioner outside the WholeHealth network. Members who decide to see an out-of-network practitioner will be subject to a member cost share.

You can find out whether you participate in the DSNP plans by visiting **Aetna Medicare Solutions** and choosing "find a doctor or hospital" under the Members tab.

More information

For more information on the benefit, you can call **1-800-624-0756 (TTY: 711)**.

*In addition to this supplemental chiropractic benefit, Aetna has contracted with WholeHealth Living to administer core chiropractic benefits for the 2024 program year.

[1]Qaseem A, Wilt TJ, McLean RM, et al. **Noninvasive treatments for acute, subacute, and chronic low back pain: a clinical practice guideline**. American College of Physicians. February 14, 2017. Accessed on December 13, 2023.

[2]Dowell D, Ragan KR, Jones CM, et al. **CDC clinical practice guideline for prescribing opioids for pain — United States, 2022**. Centers for Disease Control and Prevention (CDC). November 4, 2022; 71(3): 1–95. Accessed on December 13, 2023.

Alaska: Alaska's Aetna® Market Fee Schedule (AMFS) is changing for certain vaccines

Reimbursement for certain vaccines is changing on June 1, 2024, to match the Alaska Vaccine Assessment Program AVAP rates.

Effective June 1, 2024, we will update Alaska's AMFS to match the rates for vaccines included in the AVAP.

What this means for you

If your practice receives vaccines through AVAP, there will be no impact to you.

If your practice purchases and bills for vaccines included under AVAP, your payment rate will be no greater than the vaccine formulary pricing under the statewide immunization program.

Information about AVAP

Read more about AVAP. To locate the current formulary pricing, go to the For Providers tab.

California: Our paper claims addresses

For paper claims submissions, please use the industry standard claim form and mail it to the addresses below.

Aetna® medical claims

Aetna
P.O. Box 14079
Lexington KY 40512-4079

Aetna Dental® claims

Aetna Dental
P.O. Box 14094
Lexington, KY 40512-4094

To assist us in processing and paying claims efficiently, accurately, and timely, the health plan highly encourages practitioners and providers to submit claims electronically when possible.

If you have any questions about our claims submission process, refer to our **Contact Aetna** page. Use the non-Medicare plans phone number.

Florida: Hillsborough County Public Schools Custom Plan (Tampa)

Please charge these members a $15 copay for pediatrician visits.

The Hillsborough County Public Schools became an Aetna® customer on January 1. Its customized plan has about 21,000 members in the Tampa area.

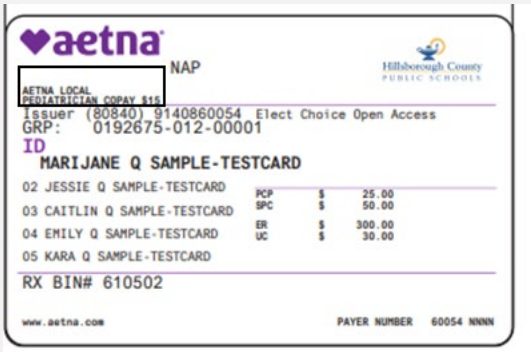
The plan offers a custom $25 copay for PCP visits and a $15 copay for pediatrician visits.

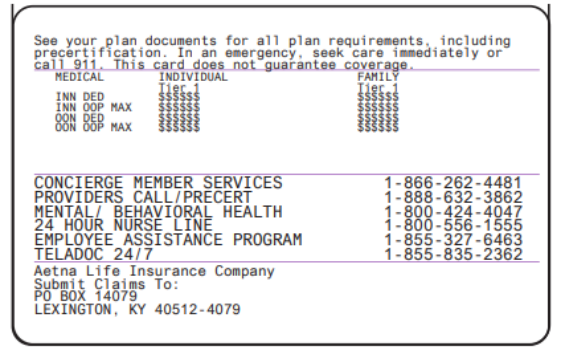
The problem

An eligibility and benefits inquiry response will only display the $25 PCP copay. The $15 pediatrician copay will not display.

What to do

Until we can work the $15 pediatrician copay into the eligibility response, please take note of the group name, which you can find on the patient's ID card or within the eligibility response details. We also added the pediatrician copay amount to member ID cards in the upper-left corner (see the first image below).





If Hillsborough County Public Schools is shown on the card, pediatric facilities should charge the member a $15 copay.

A must-pass medical records audit to come in April 2024

Prepare your office in case it is randomly chosen.

Note: This article applies to Florida and Pennsylvania.

In April 2024, the National Committee for Quality Assurance (NCQA) will audit medical records to comply with Florida and Pennsylvania state regulatory requirements.

Your contract with Aetna® requires you to participate in quality improvement activities, which include supplying copies of medical records. If you are chosen for the audit, you should send all the following information for the time frame of April 1, 2023, through March 31, 2024.

- Face sheet (demographics)
- Problem lists
- Lists of allergies and adverse reactions
- Past medical history, including diagnosis
- Progress or visit notes
- Treatment plan
- Consult letters and/or discharge summaries
- Lab and X-ray reports

Please fax or email records within 14 days of the request. If your practice normally uses a copy service to send medical records, we ask that you do not use it for this request so that we are sure to get the records in time.

Illinois: Coverage for cleft lip and cleft palate

A new Illinois law, which went into effect on January 1, 2024, requires health plans to cover medically necessary care and treatment of cleft lip and cleft palate for children under age 19. Cost share applicable to cleft lip and cleft palate care and treatment may be the same as that imposed on other types of surgical benefits covered under the plan.

This law applies only to fully insured plan sponsors and the State Employees Group Insurance Program.

More details

For the full language of the statute, see **coverage for cleft lip and cleft palate**.

Questions

If you need assistance with processing your claim, please contact the Aetna Oral Surgery Unit at **1-800-531-7895 (TTY: 711)**.

New Jersey: Take a brief survey to understand how to best help your Aetna® Assure Premier Plus dual-eligible members

The Aetna Assure Premier Plus plan

Dual-eligible members of the Aetna Assure Premier Plus (HMO DSNP) plan are in a special type of Medicare Advantage Plan — one that provides both Medicare and Medicaid health benefits. If your practice provides Medicare-covered services, you are already able to see our members.

About the special needs survey

Aetna Assure Premier Plus (HMO DSNP) members have unique conditions that require providers to be attentive to their special needs. The survey is meant to help you gauge your current patients' special needs and your experience in treating them. It will also help you understand your practice's ability to handle new special needs members and how accessible and available you are to them.

How to take the survey

Simply complete the **Special Needs Provider Survey form (PDF)** and return it to your provider liaison or to Aetna Assure Premier Plus's **provider mailbox**. If you need assistance completing the survey or if you have any questions about our membership or the plan, please feel free to call Aetna Assure Premier Plus's provider services line at **1-844-362-0934 (TTY: 711)**.

North Carolina: Find the latest North Carolina (NC) State Health Plan information

Aetna® will be the new third-party administrator for the NC State Health Plan beginning January 1, 2025.

Explore our new NC State Health Plan site

We've launched a new site to help you **find the latest updates and information** for the NC State Health Plan transition to Aetna. We'll regularly update this site as we approach open enrollment this fall, so bookmark this link and keep checking back for more information.

Join the Clear Pricing Project (CPP)

Join the CPP by May 31, 2024. If you're a current CPP provider, you will need to re-enroll in the CPP with Aetna. Visit the **NC State Health Plan** site for more information.

Texas: News for Aetna Medicare Dual Complete Plan (HMO DSNP)

Effective January 1, 2024, several plan changes help both members and providers.

In-network deductible

Aetna members in Texas have no co-pays and no co-insurance. What's new in 2024 is that you will no longer see the in-network deductible reduced from your claims reimbursement. Normally, this scenario will apply to a member's initial visit or annual wellness exam.

Co-insurance reimbursement

In 2024, specialists are reimbursed at 100% of their contracted rate with the elimination of both the in-network deductible and specialty co-insurance.

Statewide reciprocity

Aetna implemented statewide reciprocity for the HMO DSNP plan. Members can now see any in-network provider within the state of Texas.

Member cost share

As always, members will continue to benefit from no cost sharing (for example, co-pays, deductibles and/or co-insurance).

News for you

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

New provider onboarding webinar for providers and their staff

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

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

We'll show you how to:

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

Register today

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

Questions?

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

Our office manual keeps you informed

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

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

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

What's in the manual

The manual contains information on the following:

- Policies and procedures
- Patient management and acute care
- Our complex case management program and how to refer members
- Additional health management programs, including disease management, the Aetna Maternity Program, Healthy Lifestyle Coaching and others
- Member rights and responsibilities
- How we make utilization management decisions, which are based on coverage and appropriateness of care, and include our policy against financial compensation for denials of coverage
- Medical Record Criteria, which is a detailed list of elements we require to be documented in a patient's medical record and is available in the **Office Manual for Health Care Professionals (PDF)**
- The most up-to-date **Aetna Medicare Preferred Drug Lists**, **Commercial (non-Medicare) Preferred Drug Lists** and **Consumer Business Preferred Drug List**, also known as our formularies

How to reach us

Contact us by visiting our **Contact Aetna** page, calling the Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** and selecting the "precertification" phone prompt, or calling patient management and precertification staff using the Member Services number on the member's ID card. The Medicare phone number is **1-800-624-0756, TTY: 711**. 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

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

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

Our commitment

We're committed to meeting the National Committee for Quality Assurance (NCQA) standards to ensure that we meet members' cultural, ethnic, racial and language needs.

Culture, race and ethnicity

To demonstrate our commitment to meeting all NCQA standards and ensuring that member access to care is available and satisfactory, each year we ask members about in-network providers' ability to meet their needs. We do this through the Consumer Assessment of Healthcare Providers and Systems (CAHPS). We use the responses to monitor, track and improve members' experiences.

Language

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

Your Aetna® patients can access interpreter services by calling the number on the back of their ID card. There is no charge for this interpretation service.

Practitioner training on cultural competency, diversity, humility and inclusion:

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

Want to learn more?

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

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 incorporates the PDSA model into the 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 initiatives** and refer to your **provider manual (PDF)**.

Preventive care definition and coverage

Preventive care defined

Preventive care is defined as health care services, including diabetes screening, designed for prevention and early detection of illness in asymptomatic people with average risk. Services generally include routine physical examinations, tests and immunizations.

Coverage: Aetna® commercial products

The member's benefits plan and Schedule of Benefits governs our coverage of routine preventive visits. We cover grade A and B preventive services as recommended by the **U.S. Preventive Services Task Force (USPSTF)**.

Coverage: Aetna Medicare products

Our commercial plan coverage guidance and preventive care codes do not apply to Aetna Medicare plans. Refer to the **Medicare Preventive Services Quick Reference Guide** for coverage guidance and a preventive care code list that applies to members enrolled in Aetna Medicare plans. Some Aetna Medicare plans may cover additional preventive services beyond those mandated by the Centers for Medicare & Medicaid Services (CMS). Refer to the member's plan documents for details.

Remember, when determining whether a service is covered for a particular member, you must review the member's specific plan documents. If there is any difference between coverage guidance and the member's benefits plan, the member's plan will govern.

Labs

Refer your patients to one of our three preferred national labs — Quest Diagnostics®, Labcorp or BioReference® — when they need a lab test.

University of Utah Health Plans is a new Aetna Signature Administrators® (ASA) payer partner

Find out how to check eligibility and claims status, verify benefits and submit claims.

On January 1, 2024, members of the University of Utah Health Plans started using the ASA preferred provider organization program and medical network outside the state of Utah.

How to check eligibility and get additional support

To check eligibility and claims status, verify benefits or initiate an inpatient authorization, call the University of Utah Health Plans dedicated customer service numbers. You'll find them on the member's ID card.

- University of Utah Health Plans commercial: **1-833-981-0213**
- University of Utah Health Plans individual: **1-833-981-0214**
- Mountain Health Co-Op: **1-855-447-2900**

For inpatient notifications, you may also fax your request to **1-801-213-2132**.

How to send claims

Our payer partners handle all claims processing and claims questions. Contact the University of Utah Health Plans customer service phone numbers to obtain the payer ID based on your clearinghouse.

Or send paper claims to:

P.O. Box 45180
Salt Lake City, UT 84145-0180

If an ASA member uses a transplant facility in our Institutes of Excellence™ program, the facility will use the Special Case Customer Service Unit for submitting claims.

Please note that neither Aetna® nor ASA can verify eligibility or process claims.

More information

To learn more, see our **ASA flyer (PDF)**.

Presbyterian Health Plan is a new Aetna Signature Administrators® (ASA) payer partner

Find out how to check eligibility, verify benefits and submit claims.

On December 1, 2023, Presbyterian Health Plan members started using the ASA preferred provider organization program and medical network outside New Mexico.

How to check eligibility and get additional support

To check eligibility or verify benefits, call the Presbyterian Health Plan dedicated phone number at **1-505-923-5757** or **1-888-923-5757**. You'll also find the phone number on the member's ID card.

You can also log in to the **myPres provider portal** to view claims and benefits information. First-time log-in will require you to register to get a user ID and password.

How to send claims

Our payer partners handle all claims processing and claims questions. Send claims electronically to Presbyterian Health Plan based on your clearinghouse.

Clearinghouse	Payer ID number
Availity®	PREHP
Nthrive	Z0003
Change Healthcare	05003
ClaimMD	PRESB

Or send paper claims to:

P.O. Box 27489
Albuquerque, NM 87125-7489

If an ASA member uses a transplant facility in our Institutes of Excellence™ network, the facility will use the Special Case Customer Service Unit for submitting claims.

Please note that neither Aetna® nor ASA can verify eligibility or process claims.

More information

To learn more, see our **ASA flyer (PDF)**.

Check your Aetna Premier Care Network (APCN) status for 2025

Use our provider referral directory to find out if you participate.

Now is a good time to check our **provider referral directory** to see if you're participating in our APCN/APCN Plus) programs for 2025. If you have questions, visit our **Contact Aetna** page.

Notable 2025 APCN changes

- Utah: addition of High Performance Network

Notable 2025 APCN Plus changes

- Atlanta, GA: addition of the Emory Aetna Whole Health℠ Open Access Aetna Select to APCN Plus concentric
- Arizona: Banner|Aetna joint venture is adding Gila County
- Oregon: addition of Legacy Health Partners Aetna Whole Health℠ to APCN Plus concentric and multi-tier

- Dallas, TX: addition of Texas Health Aetna Whole Health℠ APCN Plus concentric and multi-tier
- Utah: addition of the Aetna Whole Health℠ Connected Utah to APCN Plus concentric
- NC Aetna Whole Health℠ networks: removal of the concentric style offering; multi-tier arrangements will remain

Overview of APCN/APCN Plus

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

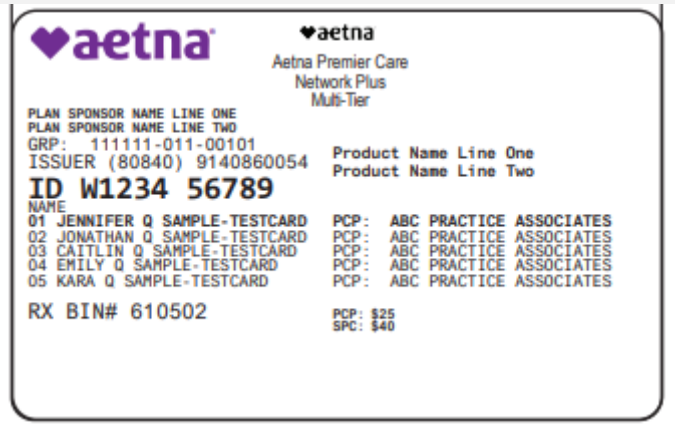
APCN Plus concentric and multi-tier includes a combination of performance networks across the country, but also includes Accountable Care Organizations (ACOs) and joint ventures (JVs) in certain areas. Members in these networks will have APCN Plus and the name of the ACO/JV on their ID card for identification.

The Aetna Premier Care Network Plus program is now multi-tiered

Starting January 1, 2024, some of your patients might be in our new Aetna Premier Care Network Plus Multi-Tier program. This program is a new national performance network offering. Multi-tiered programs sort doctors and facilities into tiers based on their performance and ability to save money. The highest performing and most efficient doctors and facilities are in Tier 1.

How to identify patients who in the multi-tier program

The member ID card will say “Aetna Premier Care Network Plus Multi-Tier.”



Find out whether you participate and what tier you are in

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

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

Tier 1 participation

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

Tier 2 participation

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

Out of network

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

Questions?

Call the Provider Service Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)**.

Affirmative statement for financial incentives

Here's how we make coverage decisions and help members access eligible services.

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)**.

Participating physicians may ask for a hard copy of the criteria we used to make a determination. Go to our **Contact Aetna** page. Call the "non-Medicare plans" number listed under the "By phone" tab.

Check out the improvements to our clinical questionnaires

We've made improvements to our clinical questionnaires based on your feedback — like writing questions and answers in plain language and reducing the number of questions you need to answer.

Benefits of completing clinical questionnaires

We developed clinical questionnaires to collect clinical information to support your prior authorization requests. **For eligible procedure types**, we may invite you to complete a clinical questionnaire right on our provider portal on Availity®.* From your pended request, just click the "Take me to clinical questionnaire" button to get started. Answer the questions and get a decision right away. If you get an approval, you're done. You don't need to do anything else like send us medical records or fax additional forms. And that saves you valuable time.

How we're improving clinical questionnaires

Here are some of the changes we've made:**

- We rewrote questions and answers to make them easier to understand.
- We reduced the amount of information we collect.

- We made our approval criteria match our clinical policies.

Your feedback is valuable

We made changes to our clinical questionnaires based on your feedback. At the end of every clinical questionnaire, you can choose to complete a survey about your experience. We read every response and have recently updated our survey questions to allow you to be more candid. You can now share your contact information with us if you'd like us to speak with you. We strive to make our clinical questionnaires a valuable time-saving tool, so sharing your opinion on how we can meet your needs is invaluable.

Coming soon: live webinars on how to complete clinical questionnaires

Based on your feedback, we understand that sometimes you may need help completing our clinical questionnaires. We're designing live webinars for each procedure group to help you complete the questionnaires. We'll send email communications soon and include an announcement in a future newsletter issue.

Need help with completing authorization requests on Availity? Go to our **Educational Webinars** page and look for the "Authorizations on Availity" webinar to get the schedule and to register.

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

** The listed changes may not apply to all clinical questionnaires.

Medical clinical criteria

Find out how we make coverage decisions and where to go for more information.

How we determine coverage

Our licensed clinical staff use evidence-based clinical guidelines from nationally recognized authorities along with the terms of a member's benefits plan to guide utilization management (UM) decisions. When the initial clinical reviewer cannot approve a request, a medical director, pharmacist, dentist, or oral and maxillofacial surgeon reviews coverage requests and applies the appropriate clinical criteria or guidelines.

Our clinical staff use the following criteria as guides in making coverage determinations, which are based on information about the specific member's clinical condition.

- **Guidelines for coverage determination**
- **Milliman Care Guidelines (MCGs)** (Seattle, WA: MCG Health, LLC)
- **Aetna Clinical Policy Bulletins (CPBs)**

- **Centers for Medicare & Medicaid Services (CMS)**
    - National Coverage Determinations (NCDs) (under Coverage, then Medicare Coverage Database)
    - Local Coverages Determinations (LCDs) (under Coverage, then Coverage Determination Process)
    - Medicare Benefit Policy Manual (under Regulations & Guidance, then Manuals)
- **National Comprehensive Cancer Network (NCCN) guidelines**

We may use other recognized criteria or applicable state and federal guidelines, if needed. Note that the tools above do not replace the professional judgment exercised by properly trained, licensed and experienced clinicians and professionals who evaluate the provision of services in accordance with accepted standards of care.

We are here to help

Visit our **Contact Aetna** page to request hard copies of specific criteria, if needed.

Medical clinical practice and preventive services guidelines

We base our guidelines on the sources in this article, among other sources.

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

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

Clinical practice guidelines

- **American Diabetes Association (ADA): standards of care in diabetes (2023)**
- **American College of Cardiology guidelines**
- **Centers for Disease Control and Prevention opioid prescribing guideline (2022)**

Preventive service guidelines

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

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

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 **provider portal on Availity** 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.

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

Process change for diagnosis-related group (DRG) reconsiderations

The process change applies to Medicare and commercial products and affects only pre-pay DRG reviews.

If you requested a reconsideration between November 1, 2023, and December 31, 2023, we will honor it. We will not honor reconsiderations after December 31, 2023. After December 31, 2023, DRG disputes will need to go through the appeals process.

Behavioral health

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

Behavioral health clinical practice guidelines

These sources could help you improve patient care.

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

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

Adopted guidelines

American Academy of Pediatrics (AAP)
Clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder (ADHD) in children and adolescents (2019)

American Society of Addiction Medicine (ASAM)
Clinical practice guideline on alcohol withdrawal management (2020) (PDF)

American Psychiatric Association (APA)
Practice guideline for the pharmacological treatment of patients with alcohol use disorder (2018) (PDF)

American Society of Addiction Medicine (ASAM)
National practice guideline for the treatment of opioid use disorder (2020) (PDF)

American Society of Addiction Medicine (ASAM)
Clinical considerations: buprenorphine treatment of opioid use disorder for individuals using high-potency synthetic opioids (2023)

VA/Department of Defense
Clinical practice guideline for the management of major depressive disorder (MDD) (2022) (PDF)

American Academy of Child & Adolescent Psychiatry (AACAP)
Clinical practice guideline for the assessment and treatment of children and adolescents with major and persistent depressive disorders (2023) (PDF)

American Psychiatric Association (APA)
Practice guideline for the treatment of patients with schizophrenia, third edition (2021)

American Psychiatric Association (APA)
Practice guideline for the treatment of patients with eating disorders, fourth edition (2023)

Preventive services guidelines

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

Refer patients to our Complex Case Management (CCM) program

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.

Improved outcomes

Members who participate in at least 60 days of CCM have been shown to have significantly reduced behavioral health symptoms. Assessments completed upon enrollment and case closure for these members show an average of 25% to 35% reduction in symptoms of depression and anxiety. Re-admission rates are also lower for members participating in CCM compared to members who have not.[1]

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 in two ways:

- Call: **1-800-424-4660 (TTY: 711)**
- Email: **AetnaBehavioralHealthReferrals@aetna.com**

[1]Aetna®. Annual analysis of the effectiveness of complex case management, 2022. The analysis was based on pre- and post-scores of the PHQ-9 and GAD-7 assessment tools.

We want to help you improve patient outcomes

Let us know how you'd like to find out about clinical practice guidelines and quality improvement activities (QIAs).

Quality improvement activities

We use a variety of clinical measures to assess and monitor member outcomes. These include Healthcare Effectiveness Data and Information Set (HEDIS®) data collection as well as internal program metrics. We strive to align our clinical practice guidelines with our identified opportunities for improvement. Clinical issues that we are currently working on include:

- Consistent follow-up with prescribers for children taking ADHD medications
- Initiation of and engagement in treatment for patients with substance use disorders
- Improving rates of medication assisted treatment (MAT) and reducing overdose rates for members with opioid use disorders
- Decreasing rates of intentional self-harm
- Improving medication adherence for depression

Partnering with providers

We need to understand how to best communicate with you about identified clinical practice guidelines and QIAs. Please **email us** to share your communication preferences (email, newsletters, website, etc.) for these initiatives.

Please do not use the mailbox to ask about claims, billing, etc. We will direct inquiries about those topics to provider services.

Depression in primary care

Our program can help you screen and treat depression at the primary care level. Find out how to get started.

Approximately 8.4% of U.S. adults who are 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

Reimbursement is available for providers who submit claims using a combination of one of the following diagnostic codes in conjunction with one of the following billing codes:

Diagnostic codes

- Z13.31 (encounter for screening for depression) or
- Z13.32 (encounter for screening for maternal depression) or
- Z13.29 (encounter for screening examination for other mental health and behavioral disorders)

Billing codes

- 96127 (brief emotional/behavioral assessment) or
- 96160 (patient-focused health risk assessment) or
- 96161 (caregiver-focused health risk assessment) or
- G0444 (annual screening for depression)

How to get started

To get started, you simply need to:

- Be a participating provider
- Use a validated 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 8, 2023.

[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 8, 2023.

Maternal mental health screening

Aetna® recognizes the importance of maternal mental health and requires all licensed health care practitioners who provide prenatal or postpartum care to screen or offer to screen mothers.

Mental health concerns include not only depression but also conditions like anxiety disorders and postpartum psychosis. These conditions are often missed or mistaken as normal within pregnancy and post-partum periods. Careful screening can identify those with mental health conditions and improve the outcome for at least two patients, if not the whole family.

We reimburse for screening

Submit your claim with the following billing combination: CPT® codes 96127 or G0444 (brief emotional/behavioral assessment) in conjunction with diagnosis code Z13.31 (screening for depression).*

Screening tools

You can use the following screening tools:

- **Patient Health Questionnaire-9 (PHQ-9) (PDF)**
- **Edinburgh Postnatal Depression Scale (PDF)**

Scoring references are included, and we've also made recommendations below. The final determination for referral to treatment resources belongs to the screening/treating professional.

Prenatal screening with the PHQ-9

- Any score under 4 requires no immediate action.
- For a score of 5 to 14, we recommend referring the member to a behavioral health (BH) counselor via the customer service number on the member's ID card (ask for behavioral health customer service).
- For a score of 15 or over, refer directly to BH Condition Management Services by calling **1-800-424-4660 (TTY: 711)**.

Postnatal screening with the Edinburgh Scale

- Any score from 7 to 13 warrants a referral to BH Customer Services. BH Customer Services can make referrals to BH providers.
- Any score of 14 or above suggests a referral directly to BH Condition Management Services by calling **1-800-424-4660 (TTY: 711)**.
- A score of 1 or higher on question #10 (self-harm) should be referred to BH Condition Management Services immediately for follow-up.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

The Institute of Medicine encourages you to use the SBIRT model, and we will reimburse you if you do.

In 2021, more than 14 million people (about 1 in 19) who are 18 or older had an alcohol use disorder, and 1 in 10 children lived in a home with a parent who had a drinking problem.[1] **The 2021 National Survey on Drug Use and Health** estimated that 46.3 million people who are 12 or older had an illicit drug use disorder, notably highest in the 18- to 25-year-old population (25.6%, or 8.6 million people), followed by adults over 26 (35.5 million people, or 16.1%), and then adolescents from age 12 to 17 (8.5%, or 2.2 million people).[2]

The U.S. Department of Health and Human Services estimates that the annual economic impact of substance misuse is about $249 billion for alcohol misuse and $193 billion for illicit drug use.[3]

The importance of brief intervention

Our knowledge of evidence-based therapies to treat people with substance use disorders 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 developed detectable problems associated with substance use, screening can help identify patients needing intervention.

What is SBIRT?

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.

The Institute of Medicine encourages using SBIRT. It recommends community-based screening for health risk behaviors, including alcohol and substance use.

Screening and reimbursement

When participating practitioners treat patients with Aetna® medical benefits and provide this service, they can be reimbursed. Go to our **SBIRT** page to learn more.

More information

You can get SBIRT resources from **Substance Abuse and Mental Health Services Administration (SAMHSA)**, which provides background for the program, links to scholarly articles and research, and coding information.

[1]National Institute on Alcohol Abuse and Alcoholism (NIAAA). **Alcohol's effects on health**. September 2023. Accessed on December 11, 2023.

[2]Substance Abuse and Mental Health Services Administration (SAMHSA). **2021 national survey on drug use and health (NSDUH)**. See table 5.1A and 5.1B. Accessed on December 11, 2023.

[3]U.S. Department of Health and Human Services. **Addiction and substance misuse reports and publications**. August 31, 2023. Accessed on January 3, 2024.

Care coordination contributes to better patient outcomes

We expect our behavioral health providers to work with medical providers, and this collaboration is both reimbursed and audited.

Many of your patients receive care from other behavioral health providers, primary care providers and medical specialists. The Collaborative Care Model is an evidence-based practice that leads to better patient outcomes. And using it is reimbursable.

Care coordination improves patient interactions

Coordination works in the following ways:

- It eliminates the feeling of disjointed care by making patients feel that they are working with a team focused on their care.
- It smooths out the referral process by helping patients schedule appointments and telling them what to expect from a referral.
- It improves the quality of medical and behavioral health care by sharing relevant diagnosis and treatment information between providers to allow for necessary adjustments to treatment plans.

See the **American Psychiatric Association** for more information on the importance of the Collaborative Care Model and how it works.

HIPAA guidelines

Note the following **HIPAA guidelines (PDF)** related to sharing behavioral health information:

- Physicians may disclose Protected Health Information (PHI) (whether orally, on paper, by fax or electronically) for treatment, payment and health care operations without consent or authorization.
- HIPAA treats mental health information the same as other information.
- Health care providers may share any PHI contained in the medical record for treatment, case management and coordination of care. Mental health information in the medical record is subject to the same HIPAA standards as other PHI* and may include:
    - Medication prescription and monitoring
    - Counseling session start and stop times
    - The modalities and frequencies of treatment offered
    - Results of clinical tests
    - Summaries of diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date

Please request that patients sign release of information forms for all providers involved in their care. This will help ensure prompt communication between providers when it is necessary.

We expect collaborative care and reimburse for it

We evaluate our behavioral health providers on care collaboration. We do this via our annual Behavioral Health Practitioner Experience Survey and treatment record audits. Please see the Coordination of Care section (page 49) of the current **Aetna Provider Manual** for more information.

The CPT® codes for collaboration include 99484, 99492, 99493 and 99494.**

*Covered entities must get patient authorization to disclose separately maintained psychotherapy session notes.

Documentation and coding for autism spectrum disorder (ASD)

Autism spectrum disorder (ASD) is a developmental disorder that can affect communication and behavior. It can be diagnosed at any age but is said to be a “developmental disorder” because symptoms tend to appear between the ages of 2 and 3. Because there is a wide variation in the type and severity of symptoms, it is known as a “spectrum” disorder.

Although ASD is a lifelong disorder, treatments and services can alleviate symptoms and improve the ability to function. The American Academy of Pediatrics (AAP) recommends that all children be screened for ASD.

Documentation tips

- Avoid the use of abbreviations.
- Physical exams should include any current associated findings and diagnostic testing results.
- Medical history should include the diagnosis of ASD to the highest specificity.
- Document a specific and concise treatment plan so that it includes referrals, consultations, therapies, medications, sensory processing, assistive technology and diet.

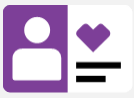
Codes for ASD

- F84.0 — ASD
- F84.2 — Rett syndrome
- F84.3 — Other childhood disintegrative disorder
- F84.5 — Asperger syndrome
- F84.8 — Other pervasive developmental disorders

- F84.9 — Pervasive developmental disorder, unspecified

Coming in 2024: V28 education

The key focus of our nurse educators is to ensure that providers know how to accurately code and submit documentation. Email **Risk Adjustment** for additional information and to schedule education.



Medicare

Get Medicare-related information, reminders and guidelines.

A friendly reminder: You can't balance bill most dual-eligible beneficiaries

Most dual-eligible beneficiaries are cost-share protected, which means you must accept the Medicare and Medicaid (if applicable) payments as payment in full.

Dual-eligible individuals who qualify for Medicare Part A and B cost-share protection (payment of Medicare premiums, deductibles, coinsurance and copays) cannot be billed for Medicare A & B cost share.

The chart below includes the categories of dual-eligible beneficiaries.

Full Medicaid benefits (yes/no)

- Yes — beneficiary has full Medicaid benefits
- No — beneficiary has no Medicaid benefits plan and no Medicare cost-share protection
- Conditional — beneficiary's Medicare Part B cost share is paid by Medicaid only when service is covered by both Medicare and Medicaid, and provider accepts Medicaid

Dual-eligible category	Full Medicaid benefits	Medicaid pays Medicare cost share
QMB	No	Yes
QMB+	Yes	Yes
SLMB	No	No
SLMB+	Yes	Conditional*
QI	No	No

QDWI	No	No
FBDE	Yes	Conditional*

*If Medicaid covers service, and provider accepts Medicaid.

Medicare providers must accept the Medicare and Medicaid payment (if any) in full for services given to a beneficiary that is cost-share protected under these Medicare Savings Programs. Failure to follow these billing rules is a violation of applicable law and a breach of your provider agreement. In addition, providers who fail to comply may be subject to sanctions.

More information

- **Medicare-Medicaid general information**
- **Beneficiaries Dually Eligible for Medicare & Medicaid (PDF)**

Complete your required Medicare compliance training by October 31, 2024

This year we are requiring all participating providers to sign an attestation.

We require participating providers in our Medicare Advantage (MA) networks to meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related entities (FDRs) as outlined in the FDR program guide.

This year we are requiring all participating providers to sign an attestation:

- **MA/MMP-only providers** are required to complete their annual FDR compliance training and attestation.
- **SNP and/or FIDE providers** are required to complete their annual FDR compliance and Model of Care (MOC) training and attestation.
- **Delegated providers/entities** are required to attest based on their contracted plans.

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

2024 direct provider notification

This summer, we will send you a training and attestation notice. We will send it to the compliance email(s) identified in your 2023 attestation. If we do not have your email address or if the email message bounces, you will receive a postcard in the fall reminding you to complete your attestation (and MOC training, if applicable) by October 31, 2024.

Our training materials

We post training materials and attestations on our **Medicare page**.

- **FDR Medicare compliance guide (PDF)**
- **SNPs Model of Care (MOC) provider training (PDF)**
- **Provider and delegate frequently asked questions document (PDF)**

Where to get more information

If you have questions, please see the above links or review the quarterly **First Tier, Downstream and Related Entities (FDR) compliance newsletters**.

News for Aetna Medicare Dual Complete Plan (HMO DSNP)

Effective January 1, 2024, several plan changes help both members and providers.

This article applies to Texas.

In-network deductible

Aetna members in Texas have no co-pays and no co-insurance. What's new in 2024 is that you will no longer see the in-network deductible reduced from your claims reimbursement. Normally, this scenario will apply to a member's initial visit or annual wellness exam.

Co-insurance reimbursement

In 2024, specialists are reimbursed at 100% of their contracted rate with the elimination of both the in-network deductible and specialty co-insurance.

Statewide reciprocity

Aetna implemented statewide reciprocity for the HMO DSNP plan. Members can now see any in-network provider within the state of Texas.

Member cost share

As always, members will continue to benefit from no cost sharing (for example, co-pays, deductibles and/or co-insurance).

Aetna® Medicare offers chiropractic care through WholeHealth Living®, a Tivity Health Company

Find out whether you participate in the DSNP plans.

This article applies to Alabama, Arkansas, Louisiana and Mississippi.

The American College of Physicians, the Centers for Disease Control and Prevention (CDC) and other leading medical entities recommend chiropractic care as a nonpharmacologic, first-line therapy for musculoskeletal pain.[1,2]

All DSNP plans in Alabama, Arkansas, Louisiana and Mississippi offer a supplemental chiropractic benefit through WholeHealth Living®, a Tivity Health Company. This benefit does not require any referrals and includes twelve in-network annual visits with a $0 copay.

Services included with this benefit:

- One physical examination or re-examination per calendar year
- One spinal X-ray procedure per calendar year
- One chiropractic manipulation/adjustment of joints such as shoulders, elbows, knees and ankles (not the spine) per visit*
- One of the following therapeutic procedures or manual therapies per visit:
    - Electrical stimulation
    - Ultrasound
    - Therapeutic exercise
    - Manual therapy (such as mobilization or manipulation, manual lymphatic drainage and manual traction)

New for 2024

In addition to chiropractic services offered for HMO DSNP plans, chiropractic services are now also offered on PPO DSNP plans for all states listed above. In addition, PPO DSNP plan members have an “out-of-network” benefit, which means they can see a practitioner outside the WholeHealth network. Members who decide to see an out-of-network practitioner will be subject to a member cost share.

You can find out whether you participate in the DSNP plans by visiting **Aetna Medicare Solutions** and choosing “find a doctor or hospital” under the Members tab.

More information

For more information on the benefit, you can call **1-800-624-0756 (TTY: 711)**.

*In addition to this supplemental chiropractic benefit, Aetna has contracted with

WholeHealth Living to administer core chiropractic benefits for the 2024 program year.

[1]Qaseem A, Wilt TJ, McLean RM, et al. **Noninvasive treatments for acute, subacute, and chronic low back pain: a clinical practice guideline**. American College of Physicians. February 14, 2017. Accessed on December 13, 2023.

[2]Dowell D, Ragan KR, Jones CM, et al. **CDC clinical practice guideline for prescribing opioids for pain — United States, 2022**. Centers for Disease Control and Prevention (CDC). November 4, 2022; 71(3): 1–95. Accessed on December 13, 2023.

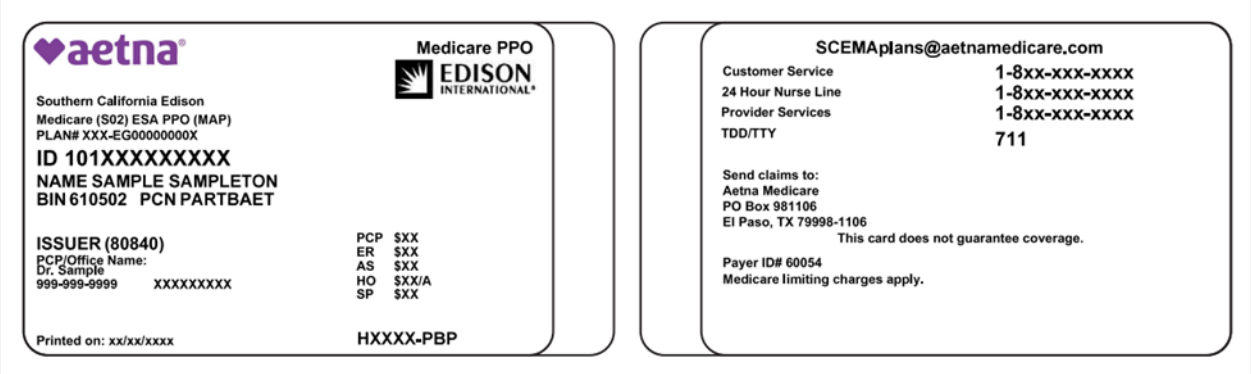
Your Southern California Edison Medicare patients may have a new plan in 2024

Find out how to identify these patients and which Aetna® programs support them.

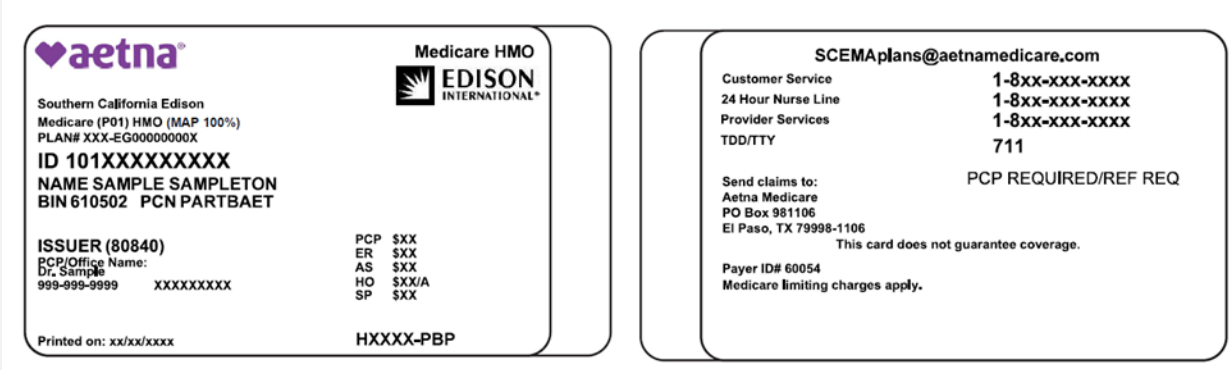
Starting January 1, 2024, many retirees enrolled in the Southern California Edison-sponsored coverage will transition to an Aetna Medicare[SM] Plan (PPO) with ESA or the Aetna Medicare[SM] Plan (HMO) coverage. Both of these plans are Medicare Advantage (MA) plans.
ID card

Here's what the patient ID cards look like:

PPO



HMO



Plan information

If you have questions about the specific benefits, review the information on our **provider portal on Availity** or visit our **Contact Aetna** page. Use the "Medicare medical and dental plans" phone number under the "By phone" tab. We're available Monday–Friday, 8 AM–5 PM local time.

It's easy to work with us

Providers who aren't part of our network can see Southern California Edison Aetna Medicare Advantage PPO ESA plan patients and get reimbursed just as they do with Medicare. That's because this plan allows members to use doctors and hospitals in or out of the Aetna Medicare network, as long as the doctor or hospital is:

- Eligible to receive payment under Medicare
- Willing to bill and accept payment from us

Payment details

- We pay you 100% of the Medicare-allowable rates (after the member cost share and Aetna payments are applied).
- Your patients won't pay more to see an out-of-network provider.
- Collect the copayment, coinsurance and/or deductible for covered services as shown on your patient's ID card.
- If you're not in our Aetna Medicare network, we pay you the Medicare-allowable rates for clean claims on covered services under your patient's plan, less the patient cost share.
- As a participating provider with us, the terms of your agreement apply.

How to submit claims

You can submit claims in two ways:

- Electronic claims submission: Use our electronic payer ID #60054.
- Paper claims submission: Submit all paper claims for covered services using an Aetna claim form — the CMS-1500 form or the UB-04 form. Send the form to:

  Aetna
  PO Box 981106
  El Paso, TX 79998-1106

Providers get a better experience when they join our network

Your practice cares about your patients' specific health needs and so do we. By joining our national Medicare PPO and HMO networks, providers get:

- The support needed to treat patients
- Electronic transactions, quick claim payments and online resources that make it easy to do business with us
- A growth opportunity for your practice because all Aetna Medicare Advantage PPO and HMO plan members will be able to locate you quickly through our online provider directory

If another provider at your practice wants to join our network, they can apply on our **provider site**. Scroll to "Explore our resources" and select "Join our network." They can also call **1-800-624-0756 (TTY: 711)**, Monday–Friday, 8 AM–5 PM local time.

Additional support for your patients

With the Aetna Medicare Advantage plan, members get added benefits at no extra cost. These programs are meant to complement the care you give your patients.

Our programs can help your patients:

- **Manage a chronic condition, such as diabetes or high blood pressure.** Let your patients know we offer personalized nurse support to help them. Our nurses can:

    - Ensure they're taking their medications as prescribed
    - Help them make healthy lifestyle choices
    - Answer questions they may have about their condition

    In some cases, they may benefit from having a case manager assigned to help coordinate their care. Members can call **1-866-409-1265 (TTY: 711)**, Monday–Friday, 5 AM–6 PM PT.

- **Find resources in their community.** A Resources For Living® life consultant can refer members to services in their area that make life easier and more enjoyable. We can help with resources in the following categories:

    - Help at home
    - Social and recreational activities
    - Caregiver support, and more

    Members will have to pay for any services they decide to use. They can call **1-866-370-4842 (TTY: 711)**, Monday–Friday, 8 AM–6 PM all continental time zones.

- **Get nonemergency transportation to appointments.** Your patients can get up to 24 one-way nonemergency trips to medical appointments, with up to 60 miles per trip. Members can call **1-855-814-1699 (TTY: 711)**, Monday–Friday, 8 AM–8 PM all time zones.

- **Treat depression and anxiety.** Help your patients get fast, affordable and convenient access to virtual behavioral health services. They can confidentially meet with an MDLIVE® licensed therapist or board-certified psychiatrist by phone or video appointment. MDLIVE providers are specially trained in common issues such as anxiety, depression, grief and loss, stress management and more. Members can visit **MDLIVE** or call **1-888-865-0729 (TTY: 1-800-770-5531)**.

- **Get answers to health questions.** The 24-Hour Nurse Line offers 24-hour access to nurses who can help answer members' health questions. It doesn't replace care from a regular doctor, but it can help members get the information they need after hours. They can call **1-855-493-7019**, 24/7.

- **Check for health, wellness and safety concerns in their home.** Your patients can sign up for a Healthy Home Visit. A licensed doctor or nurse will come to their home to:

    - Review their health needs
    - Do a home safety assessment
    - Review medications
    - Ask about their medical and family history

    During the visit, the doctor or nurse might recommend services we offer to help support their health journey. Members can call **1-877-503-5802 (TTY: 711)**, Monday–Friday, 5 AM–5 PM PT or visit **SignifyHealth** to schedule an appointment.

Caring for Dual-Eligible Special Needs Plan (DSNP) members from out of state

Medicare Advantage (MA) members enrolled in an HMO DSNP have access to any provider participating with their health plan's network. DSNP members living near a state border may choose to receive services from a provider located outside of their residential state.

Register with Medicaid in bordering states to receive payment

To receive Medicaid payment for treating an out-of-state DSNP member, you must register with the state Medicaid agency where the member resides. Failure to register for Medicaid in the member's residential state can result in delayed or denied payments.

Registering with the state's Medicaid program does not obligate a provider to accept Medicaid patients.

Contact the Department of Health in bordering states

The registration process for each state varies. For assistance with out-of-state Medicaid registration processes, you can contact the Department of Health for each bordering state. Your state rules and policies regarding payments for Medicaid cost-share and Medicare/Medicaid combined services may differ from those of the member's residential state.

Aetna® HEDIS® data collection is underway

We will be reaching out soon 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 defined by the National Committee for Quality Assurance (NCQA).

The Centers for Medicare & Medicaid Services (CMS) requires us to send health care quality data for our Aetna Medicare Advantage organizations. Most data is collected from claims and medical encounters. We also gather data from medical records.

What we may need from you

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

Meeting HIPAA guidelines

Either our staff or a contracted representative will contact your office. Our contracted representatives, Ciox Health, Sharecare Inc., and MRO, serve as our Business Associates 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.

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

All trademarks and logos are the intellectual property of their respective owners.

Aetna® complies with the CMS 2024 Part C and D Final Rule

Find out about the Two Midnight Benchmark and how we determine medical necessity.

Effective January 1, 2024, the Centers for Medicare & Medicaid Services (CMS) introduced regulations and changes related to Medicare Advantage (MA) plans regarding prior authorization, coverage criteria and access to care, as set forth in the 2024 Part C and D Final Rule.[1,2]

Our MA plans follow the "Two Midnight Benchmark"

- Under the Two Midnight Benchmark, surgical procedures, diagnostic tests and other treatments will generally be considered appropriate for inpatient hospital admission and payment under Medicare when the physician expects the patient, based on specific complex medical factors documented in the medical record (such as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of adverse event), to require a hospital stay that crosses at least two midnights and admits the member to the hospital based upon that expectation.
- Our MA plans are not required to follow the Two Midnight Presumption.

Our medical necessity reviews

- We will review the stay to determine whether the inpatient admission was appropriate.
- We may review the entire medical record to support or refute the reasonableness of the physician's expectation, but we may use entries after the point of the admission order to interpret what the physician reasonably should have known or reasonably should have expected at the time of admission.
- It is important that you provide us with detailed clinical records to support the physician's judgement.

Our internal coverage criteria

- We have created publicly accessible **internal coverage criteria (PDF)** to use when coverage criteria are not fully established under the Medicare statute, regulation, national coverage determinations (NCDs) or local coverage determinations (LCDs).
- Our internal coverage criteria are based on current evidence in widely used treatment guidelines or clinical literature and comply with CMS requirements.

[1]Centers for Medicare & Medicaid Services. **Reviewing short stay hospital claims for patient status: admissions on or after January 1, 2016 (PDF)**. December 31, 2015. Accessed on January 24, 2024.

[2]Centers for Medicare & Medicaid Services. **2 midnight inpatient admission guidance and patient status reviews for admissions on or after October 1, 2013 (PDF)**. Accessed on January 24, 2024.

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