September 2022

OfficeLink Updates™

IN THIS ISSUE

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

Lots of functions — some new — available on Availity®

View authorization status letters and our enhanced claims status responses, request prior authorizations, and find out how to submit coordination of benefits (COB) claims electronically. | *PAGES 24–30*

Behavioral health access-to-care standards

Aetna® wants to ensure the safety of our members. We know that your patients trust you and that often you are the first person they will call when they are experiencing a crisis.

Both behavioral health MDs and non-MDs are required to have a notification system or designated practitioner backup. Find out more. | *PAGE 32*

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.

Claim and Code Review Program (CCRP) update

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

Beginning December 1, 2022, you may see new claim edits. These are part of our CCRP. These edits support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. You can view these edits on our **Availity provider portal**.

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

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

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

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

With the exception of Student Health, you'll also have access to our code edit lookup tools. To find out if our new claim edits will apply to your claim, log in to the **Availity provider**

portal.* You'll need to know your Aetna® provider ID number (PIN) to access our code edit lookup tools.

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

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

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

Changes to our National Precertification List (NPL)

This update applies to both our commercial and Medicare members.

The following precertification changes become effective January 1, 2023.

We will require precertification for:

- Additional codes for arthroscopic hip surgery to repair impingement syndrome, including labral repair
- Vertebroplasty
- Kyphoplasty

We will require precertification for the following breast and ovarian cancer susceptibility gene testing:

- Multigene panels for hereditary breast cancer–related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer and hereditary endometrial cancer)

  Aetna® considers germline multigene panel testing for moderate- to high-penetrance breast and/or epithelial ovarian cancer susceptibility genes (must include BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11 and TP53) and full duplication and deletion analysis (i.e., detection of large genomic rearrangements) (must include BRCA1, BRCA2, MLH1, MSH2 and STK11) to be medically necessary once per lifetime for those who meet one or more National Comprehensive Cancer Network (NCCN) testing criteria for high-penetrance breast cancer susceptibility genes.

  Asymptomatic individuals who have a family history that meets criteria for testing and who do not have a causative variant already identified should not rely solely on BRCA1 or BRCA2 gene testing, since the current standard of care includes moderate-high penetrance gene analysis to guide future screening and

management recommendations. Accordingly, multigene panel tests should be submitted for this testing, which was formerly described as "BRCA testing."

Reminder: Effective July 1, 2022, we no longer require precertification for cataract surgery managed by Aetna.

Cataract surgery for Florida and Georgia Medicare Advantage members will continue through iCare. Use the telephone numbers listed below for Medicare members in those states:

- Georgia Medicare only (MEHMO and MEPPO) — contact iCare at **1-844-210-7444**
- Florida Medicare only (MEHMO and MEPOS) — contact iCare at **1-855-373-7627**

Submitting precertification requests

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

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

Learn more about **precertification**.

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

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

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Changes to commercial drug lists begin on January 1

On January 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 October 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)**.

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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 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. 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

New Jersey: Tier 1 Aetna Whole Health℠ providers are now part of the Individual Exchange network

We've selected you to be in our Individual Exchange network. This means you will be able to see patients who buy our Individual Exchange plans. Starting November 1, 2022, these plans will be available for consumer election both on and off the Get Covered New Jersey exchange. The plans are currently under regulatory review and will be effective beginning January 1, 2023.

What you need to do to participate

There's nothing you need to do.

Your rates

Your rates will be paid according to the terms of your agreement. Simply use the same process you do today to check eligibility and benefits and to submit claims.

Tier 2 Aetna Whole Health providers

Tier 2 providers are non-participating for this Individual Exchange network.

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 List**, also known as our formularies.

How to reach us

Contact us by visiting our website, calling the Provider Contact Center at **1-888 MD AETNA (1-888-632-3862) (TTY: 711)** or calling the 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.

Referrals to our Complex Case Management program

Program goal

Our Complex Case Management program is a collaborative process of assessment, planning, facilitation, care coordination, monitoring, evaluation and advocacy for options and services to meet an individual's and caregiver's comprehensive health care needs. The program assesses population needs and uses evidence-based practices in managing complex illnesses and chronic conditions. We help members understand their health care needs, benefits and how to access available community resources for which the member may be eligible.

How it works

The overall goal and objective of the Complex Case Management program is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner.

Referrals

Referrals for the program may come from the following sources:

- Primary care physicians
- Specialists
- Facility discharge planners
- Member or caregiver(s)
- Medical management programs
- The member's employer
- Other organization programs or through a vendor or delegate
- The 24-Hour Nurse Line

Referrals can be submitted through the toll-free phone number on the member's ID card.

California: 2022 Provider Appointment Availability Survey (PAAS)

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

Aetna® has contracted with the Center for the Study of Services (CSS) to administer the PAAS for 2022. Aetna will assess compliance through the PAAS and report the results to the California Department of Managed Health Care (DMHC) and to the California Department of Insurance (CDI).

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

Providers to be surveyed

- Primary Care Physicians (PCPs)
- Specialty physicians (for example, cardiovascular disease specialists, endocrinologists and gastroenterologists)
- Psychiatrists
- Non-Physician Mental Health (NPMH) providers or Substance Use Disorder (SUD) providers
- Ancillary providers who offer mammogram appointments and ancillary providers who offer physical therapy appointments

Survey questions

- Urgent appointments: Is the appointment date and time within 48 hours (for a PCP visit request) or within 96 hours (for a specialist/psychiatrist/NPMH or SUD visit request)?
- Non-urgent appointments: Is the appointment date and time within 10 business days (for a PCP/NPMH visit request or a SUD visit request) or within 15 business days (for a specialist/psychiatrist/ancillary visit request)?

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

California access standards

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

Appointment type	Time frame
Urgent care (Primary Care Physicians)	48 hours from request
Urgent care (specialists, Non-Physician Mental Health [NPMH] providers, Substance Use Disorder [SUD] providers)	96 hours from request
Non-urgent doctor appointment (Primary Care Physicians)	10 business days
Non-urgent doctor appointment (specialty physicians)	15 business days
Non-urgent mental health appointment (NPMH and SUD providers)	10 business days
Non-urgent appointment (ancillary providers)	15 business days
As of July 1, 2022 — non-urgent follow-up appointments with an NPMH or SUD provider	10 business days for those undergoing a course of treatment for an ongoing mental health or SUD condition

Note that referrals from a Primary Care Physician (PCP) or specialist are subject to the above time-elapse standards.

Exceptions to the appointment time frames above

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

Time frames for rescheduling appointments

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

Time frames for NPMH and SUD follow-up appointments

Members who are undergoing a course of treatment for an ongoing mental health or substance use disorder condition must be able to schedule a follow-up appointment with the NPMH or SUD provider within 10 business days of the prior appointment.

Corrective action for not meeting time frames

The Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) regulations require that Aetna® monitor its provider network and investigate and request corrective action (via a Corrective Action Plan, or CAP) if it doesn't provide timely access to care. Therefore, we ask that you please take time to review the California appointment standards with your staff. Our goal is to work with your office to ensure that our provider networks are compliant with these California Timely Access requirements.

Referral requests for capitated specialists

In some of our plans, members are assigned, or capitated, to certain specialists. For example, a member might be assigned to a certain clinic or lab for X-rays or lab services. When you submit a referral for a member using your preferred solution (that is, on **our Availity provider portal*** or one of our other **participating vendors or clearinghouses**), be sure to submit the referral request to the correct specialist. (Submit an Eligibility and Benefits Inquiry transaction to see who the capitated specialists are for the member.)

If you submit a referral request for a non-capitated provider, we'll automatically update it to the correct one.

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Check your Aetna Premier Care Network status

Now is a good time to check our **online provider directory** to see if you're participating in our Aetna Premier Care Network (APCN)/Aetna Premier Care Network Plus (APCN Plus) programs for 2023.

For 2023, we performed a designation review of provider performance; in some markets we have changed the underlying network configuration — for example, converting a broad network to an Aetna Whole Health® arrangement.

If you have questions, call us at **1-888-632-3862 (TTY: 711)**. You can also visit our **provider website** and send us any questions.

Notable 2023 changes

- San Diego, California: High Performance Specialist only network
- Central Valley, California: High Performance Specialist only network
- Northern California: High Performance Specialist only network
- Arizona: Banner|Aetna joint venture
- Kansas City, Kansas/Missouri: I35 Preferred
- New York metro area: New York Aetna Whole Health℠
- Cleveland, Ohio: Cleveland Clinic Aetna Whole Health℠
- Portland, Oregon: Moving to the broad network
- Tulsa, Oklahoma: High Performance Hospital and Specialist network
- Louisiana: Willis-Knighton Health Plus of LA Aetna Whole Health℠
- Council Bluffs, Iowa; and Omaha, Nebraska: Moving to the broad network
- Odessa, Texas: Savings Plus network

Overview of APCN/APCN Plus

Aetna Premier Care Network (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.

Aetna Premier Care Network Plus (APCN Plus) includes a combination of performance networks across the country, but also includes accountable care organizations (ACOs) and joint ventures (JVs) in certain areas. Members in these networks will have APCN Plus and the name of the ACO/JV on their ID card for identification.

Submitting claims for the Aetna Signature Administrators® plan

The member ID card

The member ID card generally has three identifiers:

- The payer's logo
- The Aetna® logo
- The words "Aetna Signature Administrators®" with "PPO" directly below

Send claims to the correct payer

Send claims to the payer. You'll find the payer ID (for electronic claims) and address (for paper claims) on the member's ID card.

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

For more support

You can direct your questions to the appropriate payer on the ID card. The payer will contact us if needed.

Oregon: New pre-approval requirements

Our Enhanced Clinical Review program with eviCore healthcare requires authorization for certain procedures. As we previously communicated in a direct mailing, this program became effective for Oregon on August 1, 2022. It affects Oregon members in our commercial Aetna® products.

Services that require pre-approval

- High-tech outpatient diagnostic imaging procedures such as MRI/MRA, nuclear cardiology, and PET scan and CT scan, including CTA
- Nonemergent outpatient stress echocardiography
- Nonemergent outpatient diagnostic left and right heart catheterization
- Insertion, removal and upgrade of elective implantable cardioverter defibrillator, cardiac resynchronization therapy defibrillator and implantable pacemaker
- Polysomnography (attended sleep studies)

- Interventional pain management
- Radiation therapy services — these include complex and 3D conformal; Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT); brachytherapy; hyperthermia; Intensity-Modulated Radiation Therapy (IMRT)/Image Guided Radiation Therapy (IGRT); proton beam therapy; neutron beam therapy; and radiopharmaceuticals

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

Submitting authorization requests

Before members receive services, eviCore healthcare's board-certified physicians will review authorization requests for medical necessity. For you to get paid for services, you must send authorization requests before providing those services.

If treatment started before August 1, 2022, and you haven't already called Aetna, contact eviCore healthcare to request continuity-of-care authorization. This will allow claims for dates of service after August 1, 2022, to be considered.

Radiation therapy services are reviewed in accordance with nationally recognized clinical and billing guidelines of the American College of Radiation Oncology, American Society of Radiation Oncology, other recognized medical societies, and **Aetna Clinical Policy Bulletins (CPBs)**.

Asking eviCore healthcare for approval

- Go to **eviCore.com**.
- Call **1-888-622-7329 (TTY: 711)** during normal business hours.

Note that fax request forms are available online.

- Send a fax to **1-800-540-2406** for all radiology, cardiology and radiation therapy requests.
- Send a fax to **1-866-999-3510** for sleep requests.
- Send a fax to **1-855-774-1319** for interventional pain requests.

Urgent requests

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

Important information to know

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

Questions?

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

You can also see eviCore healthcare's criteria and get request forms at **eviCore.com**.

Starting October 3, certain states need to start using Anna™ software for the concurrent review process

This article applies to Delaware, Indiana, New York, Pennsylvania and West Virginia.

Aetna® has partnered with Post-Acute Analytics (PAA) to automate the concurrent review process by using its Anna™ software platform. Starting October 3, you must use the platform for the skilled nursing facility (SNF) concurrent review process.

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

What's changing?

Starting October 3, 2022, all SNFs in Delaware, Indiana, New York, Pennsylvania and West Virginia that admit Aetna MA members who reside in and receive care in those states will be required to work with PAA and use Anna to:

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

The precertification and concurrent management process

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

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

How to start using Anna

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

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

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

Sending "continued stay" documentation

Use the **Anna portal** (which is the preferred method) to send "continued stay" documentation. Note that you should continue to send pre-certification documentation through our **Availity provider portal**.*

How to reach us

If you have questions for Aetna about this change, you can **send us an email message**.

If you have questions about the Aetna utilization review process, you can contact your facility's assigned utilization review nurse or the Provider Contact Center at **1-888 MD AETNA (1-888-632-3862 (TTY: 711)**.

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Starting November 1, certain states must use Anna™ for the SNF concurrent review process

This article applies to Florida, Georgia, Massachusetts, Minnesota, New Hampshire, North Carolina and Vermont.

Aetna® has partnered with Post-Acute Analytics (PAA) to automate the concurrent review process by using its Anna™ software platform. Starting November 1, you must use the platform for the skilled nursing facility (SNF) concurrent review process.

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

What's changing?

Starting November 1, 2022, all SNFs in Florida, Georgia, Massachusetts, Minnesota, New Hampshire, North Carolina and Vermont that admit Aetna MA members who reside in and receive care in those states will be required to work with PAA and use Anna to:

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New ICD-10 coding for Post COVID-19 condition, unspecified (U09.9)

Providers should list U09.9 secondary to specific codes for ongoing conditions after a COVID-19 infection, such as shortness of breath (R06.02), fatigue (R53), myalgia (M79.1), multisystem inflammatory syndrome (M35.81), and others, according to new tabular instructions for the code.

This guidance went into effect on October 1, 2021.

Correct coding matters

Please **code correctly and caringly** so we can understand the real-world evidence related to COVID-19 and its complicated sequelae.

Long COVID-19 defined

- World Health Organization (WHO):

Long COVID-19 starts three months after the original bout of illness or positive test results.[1]

- Centers for Disease Control and Prevention (CDC):

  Long COVID-19 — or post-COVID-19 conditions — is a wide range of new, returning or ongoing health problems people may experience more than four weeks after being first infected with SARS-CoV-2.[2]

What to know

Use the new ICD-10 coding for "Long COVID," or post-acute sequelae of COVID-19. This is a critical step for long-term patient care as well as for tracking and research purposes.

[1]World Health Organization (WHO). **A clinical case definition of post COVID-19 condition by a Delphi consensus**. October 6, 2021. Accessed June 16, 2022.

[2]Centers for Disease Control and Prevention. **Long COVID or post-COVID conditions**. May 5, 2022. Accessed June 16, 2022.

Site-of-service precertification requirements

We implemented site-of-service precertification requirements for certain procedures effective December 1, 2021.

- We do not require precertification for certain services performed in an ambulatory surgical facility or an office.
- We do require precertification for certain procedures performed in an outpatient hospital setting.

View our lists and search by CPT code

You can view our precertification lists and search by CPT code on our **Precertification Lists** page. Or go to our **Availity provider portal*** to get a list of procedure codes that require precertification under this policy. Once there, go to Aetna Payer Space > Resources > Site of Service Outpatient Surgical Procedure list.

We need the site of service when you call for precertification

When you contact Aetna® for precertification, you must provide the site where the service is to be performed. Failure to do so may result in denied services.

Use Availity® to submit your authorization requests electronically

Use the Authorization Add transaction on Availity to submit your request electronically. There's no need to call in your requests.

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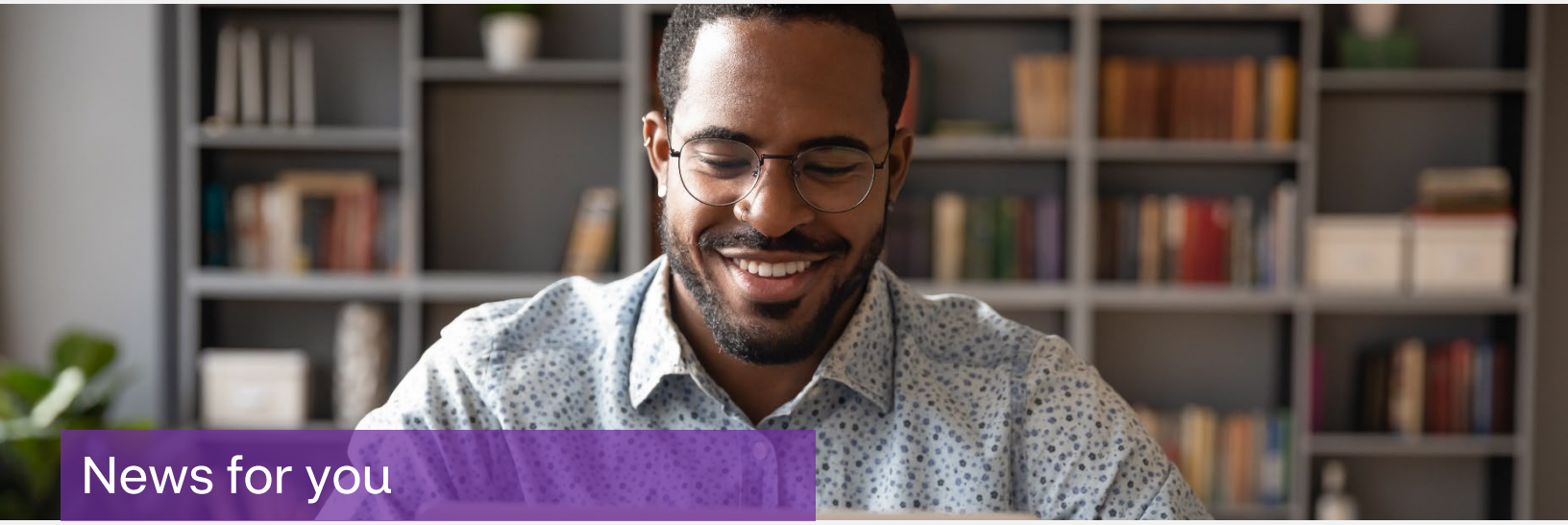
Colorado: language services available

We offer aids and services, at no additional cost, to people with disabilities. We also offer language services, at no additional cost, to people whose primary language is not English. These include language interpreters and plan details written in other languages. If a patient needs these services, call the number on the patient's ID card.



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.

Manage blood tests for your patients with diabetes

Along with blood glucose monitoring, there are other important lab tests to help manage diabetes and other related conditions like cardiovascular disease and chronic kidney disease (CKD).

Testing can contribute to a patient's journey to optimal health.

Order regular hemoglobin A1c (HbA1c) tests

An HbA1c test measures a patient's average blood sugar (glucose) level for the past two to three months. If a patient's diabetes remains controlled, test less often. Until then, create a reminder to have blood sugar checked two to four times a year.

Keep tabs on low-density lipoprotein (LDL) cholesterol

LDL cholesterol is considered the "bad" cholesterol; an elevated level is associated with an increased risk of heart disease or stroke.

Kidney support

One in three adults with diabetes may have CKD. This population can have early kidney-function loss and damage without any symptoms.[1] That's why it's important to talk to your patients about their risk for CKD and testing.

A simple blood test called the estimated glomerular filtration rate (eGFR) test is used to ascertain kidney function. The urine albumin-creatinine ratio (uACR), determined by a urine test, can reveal kidney damage. Other additional tests can help diagnose and manage CKD.

Don't skip these important tests for your patients

- HbA1c two to four times per year
- LDL cholesterol tests
- Annual CKD tests

Refer your patients to one of our three preferred national labs: Quest Diagnostics®, Labcorp or BioReference.

[1]Centers for Disease Control and Prevention. **Chronic kidney disease in the United States, 2019 (PDF)**. March 5, 2019. Accessed June 10, 2022.

California, Delaware, Illinois and New Jersey providers: Aetna® to enter the individual exchange market

We're expanding! As previously shared, we re-entered the ACA exchanges in Arizona, Florida, Georgia, Missouri, Nevada, North Carolina, Texas and Virginia on January 1, 2022.

On January 1, 2023, we will enter new states and expand further into the existing states noted above. California, Delaware, Illinois and New Jersey will see the new Aetna CVS Health™ Affordable Care Act (ACA) insurance product (subject to regulatory approval) on the individual exchange market starting January 1. Look for "QHP" (qualified health plan) on member ID cards.

The product

The new insurance product gives members access to a quality network of health care providers and telehealth services, and it provides members with convenient and affordable health care offerings at MinuteClinic® locations, including those within CVS® HealthHUB™ locations, and at CVS Pharmacy® locations.

The plan uses the reach of CVS Health® — its health insurance, pharmacy benefits, retail-based health services, mental well-being programs, telehealth services, digital capabilities and more — to provide greater value for individual consumers.

How members can enroll

Enrollment begins on October 1 for California, and November 1 for all other states. Interested members can go to the **Aetna CVS Health page** to enroll. And they can visit **HealthCare.gov** for more information about the individual exchange and how to qualify for plan credits and discounts.

Check your participation status

- If you practice in California, Delaware, Florida, Georgia, Illinois, Missouri, Nevada, New Jersey, North Carolina or Texas, go to the **Aetna CVS Health provider directory** to check your status.

- If you practice in Arizona, go to the **Banner Aetna directory** to check your participation status in the Banner|Aetna Performance Network.

- If you are an Aetna provider in Virginia, go to the **Aetna CVS Health provider directory** to check your status. If you are an Innovation Health provider in Northern Virginia, you can check the **Innovation Health provider directory**.

Questions?

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

Aetna®, CVS Pharmacy®, and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic®-branded walk-in clinics) are part of the CVS Health® family of companies.

View authorization status letters on Availity®

Now, you don't need to wait for authorization status letters to be delivered by mail. You can access them right from your authorization dashboard.

In this first release of the new function, you get access to six different authorization status letters, which will no longer be mailed to you. The six letters are:

- Standard Insufficient Info Request
- Standard Coordination of Benefits
- Medicare Notice of Auth of Service
- Medicare Notice of Denial of Coverage
- Standard Medical Necessity/Admin Denial or Combo
- Standard Medical Necessity/Admin Approval

Throughout this year, we'll continue to digitalize all our paper authorization letters. As they are completed, we'll make them available on Availity* and stop mailing paper letters to you.

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

How to use the Provider Contact Center (PCC) when you have claims issues

We hear you. We want you to know that Aetna® is committed to reviewing your feedback and providing information to make it easier to work with us.

Recently, some of you asked about PCC inquiry restrictions.

The PCC allows you to address claims issues on three members per call, not three individual claims. For example, if one member has 10 claims, we will review all 10 claims as part of that one inquiry. You can then ask about one or two additional members and their claims, if needed, during that same call.

Advantages to the three-member-inquiry limit

An internal study found that only 5% of callers had claims inquiries for more than three members. As a result, we implemented the three-member-inquiry limit. The limit helps reduce the average time spent on one phone call, which shortens transfers and wait times for everyone.

Other ways to reach us

We encourage you to use the self-service options on our **Availity provider portal*** or the Aetna Voice Advantage® (AVA) system. We find that many provider calls are about claims status, and that information is readily available without having to speak to a representative.

Learn how to do business with us electronically

If you're still calling us to complete your administrative tasks, let us show you how you can work with us electronically. Attend a live Aetna® webinar. We've designed our webinars with you, our providers, in mind. Spend an hour with us now and barely lift a finger later. Let us show you how to get valuable time back in your day. These webinars showcase the electronic transactions and tools available on our **Availity provider portal**.

We offer three different webinars:

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

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

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We're ready to receive unsolicited claim attachments using a new secure solution

In a previous article, we updated you on a new solution for receiving supporting documentation electronically. We're pleased to let you know we've completed the first phase of this work. We're ready to receive your unsolicited claim attachments using the X12N 275 transaction.

How to begin

We're working with three clearinghouses: **Change Healthcare**, **PNT Data** and **Waystar**. If you submit claims through any of these companies, contact them to see how to get set up to send us your unsolicited supporting documentation electronically. Not sure whether your claims go through one of these clearinghouses? Do you go through a sub-vendor to submit your claims? Ask your vendor if they use one of these companies.

Even if your clearinghouse isn't ready yet, you might be able to work with other companies to implement the solution. Check out our **vendor list** and look for "Claim Attachments" in the "Transactions Available" column. We'll update the list every time a new company is ready.

We're just getting started

Soon to come: accepting unsolicited supporting documentation for prior authorization requests. We hope to have that function ready sometime this year. We're also working on accepting solicited supporting documentation for both claims and prior authorization requests.

We've enhanced our claims status responses on our provider portal

You asked. We delivered. We enhanced our claims status responses on our **Availity provider portal**.*

We already return lots of information in our claims status responses. With these added fields, we made our responses even better. Now you won't need to call us to get the information you can get electronically and at your convenience.

The changes apply to both professional and institutional claims, as applicable.

What you'll now see

Your most-requested change was to display proprietary remarks from our Explanations of Benefits (EOB) statements. You can now find our EOB remarks within our claims status responses. No more reading our claims status responses and then reading our EOB statements for greater detail. You'll now find all the details in our claims status responses, saving you time.

Other fields we'll now display

Patient information

- Group number
- Funding arrangement (fully insured, self-insured)

Claims and payment information

- Bill type and description
- Financial details; amounts for health care account; interest or penalty; patient responsibility; allowed; coinsurance, copayment and deductible; and other insurance paid

Join us for a live webinar — we'll show you the new fields

Try our Claim Status Inquiry transaction today. We've already added the new fields to the responses. Or join us for a live webinar. We'll show you sample claims status responses and how to get the most out of working with us on Availity®. **Get the schedule and register** for either the "Working with Aetna on Availity" or the "Claim Management Using Availity" webinar (or both).

We look forward to seeing you at a future webinar.

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Request prior authorizations on Availity®

We're making it easier to request authorizations and submit requested clinical information for selected procedures, such as:

- Shoulder arthroplasty
- Endoscopic nasal balloon dilation
- Hip surgery to repair impingement syndrome
- Functional endoscopic sinus surgery (FESS)
- Excessive skin excision
- Blepharoplasty, canthopexy
- Spinal fusion scoliosis
- Pre-implantation genetic testing
- Breast reconstruction
- Breast reduction
- Venous ligation
- Cochlear device and/or implantation
- Gastroplasty

Just use our **Availity provider portal**.*

How to request authorizations

Requesting authorizations on Availity is a simple two-step process. Here's how it works:

1. Submit your initial request on Availity with the Authorization (Precertification) Add transaction.
2. Complete a short questionnaire, if asked, to give us more clinical information.

You may even get an approval right away after completing the questionnaire. There's no need to call in requests or fax medical records.

Why use Availity?

Completing the questionnaire on Availity:

- Keeps everything in one place
- Saves you time
- Helps expedite our review
- Eliminates calls from us asking for more clinical information

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

Tips for submitting secondary claims electronically

You're already sending us your primary claims electronically. Did you know that we can accept your secondary, or coordination of benefits (COB), claims electronically, too? In fact, we prefer that you send us your secondary claims electronically. When you send us the right information up front, we process your secondary claims faster. And when we process claims faster, you could get your claims payments faster, too.

What we need (and what we don't)

First, ask your patients whether they have other coverage. They might forget to tell you. Without that information, your claim payments could be denied or delayed. Once you learn about their other coverage, we'll need some information on the patient's primary plan and what they may have already paid you. (We're looking for this information in the 2320 and 2330 loops of the electronic claim transaction. Check with your software vendor to ensure you're entering the information in the correct fields to transmit to us.)

If the patient has no other coverage, we ask that you leave those fields blank. Don't enter non-COB information, such as information on discount programs or life insurance, in those fields. If you enter any incorrect information, we must verify the information ourselves. That takes time and may delay processing your claim.

Here are the fields we're reviewing when the patient has another insurance plan, and we're paying second:

Demographic information

- The other plan's name
- The other plan's policy number, if applicable
- The other employer's name, if applicable

Financial information

- Payer-paid amount: When we pay second, we need to know the amount the primary carrier paid you. This amount is equal to total charges minus claims and line-level adjustments. Be sure you don't confuse the payer-paid amount with the patient-paid amount.
- Patient-paid amount: These amounts include those applied toward deductibles, coinsurance amounts and copayments.
- Line-level-adjustment reason codes and associated amounts (professional claims only): These show why the other insurer paid less than billed. Amounts include those applied toward deductibles, coinsurance amounts, copayments and any write-offs.

Keep your demographic information current

Good health starts with good provider–patient relationships. Our members are diverse, so when they have the option to connect with providers who share their identity, they might feel more comfortable talking about their health.

According to the Journal of the American Medical Association, health disparities and inequities are linked to a lack of racial and ethnic similarity or shared identity between providers and patients.[1] For this reason, we encourage all providers to self-identify.

It's easy

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

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

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

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

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

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

[1]Takeshita J, Wang S, Loren A, et al. **Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings**. JAMA Network Open. November 9, 2020; 3(11). Accessed June 28, 2022.

How to update your Tax Identification Number (TIN)

You can now update your TIN through the **Provider Onboarding Center (POC)** via **Aetna.com**.

You asked, we listened

Based on your feedback, we created an online form that you can use to submit TIN changes. This form will decrease processing time. Please use it if you need to update a TIN.

What you will need to complete the form

- Your new TIN. If you are updating multiple TINs, you will need to complete a separate form for each one.
- Your National Provider Identification (NPI) number
- A valid and complete W-9 associated with the new TIN (file size cannot exceed 2 MB)
- A current list of all service locations

Upon submitting the form, you will receive a pop-up confirmation and the request ID number, which you should keep for your records.

Benefits of using the form

- Quicker turnaround time
- Less follow-up work because all information is gathered up front
- Real-time confirmation of your request, including a request ID number for easy identification

Behavioral health updates

How to get better health outcomes for those with substance use disorders

Patients with alcohol and substance use disorders are more likely to have better outcomes with patient education, early treatment and follow-up care. Despite strong evidence that treatment, including Medication-Assisted Treatment (MAT), along with counseling or other behavior therapies improve patient outcomes, less than 20% of those with substance use disorders receive treatment.[1]

Please use these guidelines to help improve outcomes for your patients.

Provide adequate screening and education

Be sure to screen your patients for **alcohol use** and **substance use**, and educate them about risks. Help them **understand their diagnosis** and comorbidities. Discuss the importance of follow-up care and attending all appointments.

Manage appointments

After diagnosis, treatment should be initiated within 14 days, but the type of treatment can vary based on the severity of the symptoms as well as the member's motivation for treatment. Follow-up care should occur a minimum of 2 times within 34 days of the initial treatment visit. Avoid claims issues by using the appropriate diagnosis codes. Be sure to also include place of service and procedure code (as applicable in your contract).

Common treatment options:

- **Medication-assisted treatment (MAT)**
- Outpatient counseling
- Intensive outpatient programs
- Partial hospitalization
- Inpatient admission
- Residential treatment
- **Telehealth**

Enlist help

Encourage your patients to sign a release of information so that you can collaborate with other providers. Aetna® reimburses for coordination-of-care with other providers. The release should also allow you to include members of the patient's primary support system in treatment discussions.

You should also provide the patient and their support system with information about resources such as:

- **Shatterproof**, to learn about addiction and available resources/treatment
- **Alcoholics Anonymous**, **Narcotics Anonymous** or **SMART Recovery**, for peer support
- **Al-Anon/Alateen** for family support

We're here to support the care you give your patients. If you need help locating appropriate behavioral health providers, call the Member Services number on the patient's ID card.

[1]Substance Abuse and Mental Health Services Administration **(SAMHSA)**. **Key substance use and mental health indicators in the United States: results from the 2019 National Survey on Drug Use and Health**. Publication number PEP20-07-01-001. September 2020. Accessed July 14, 2022.

Aetna® requires you to provide after-hours availability

Aetna requires that behavioral health providers have a reliable 24/7 live answering service or voicemail system.

Aetna wants to ensure the safety of our members. We know that your patients and clients trust you and that often you are the first person a patient will call when they are experiencing a crisis. For that reason, we complete yearly surveys of our behavioral health network providers to assess compliance.

Minimum after-hours availability standards

Behavioral health MDs, at a minimum, are required to have a notification system or designated practitioner backup.

Behavioral health non-MD providers, at a minimum, must have a message system that provides 24-hour contact information for a licensed behavioral health professional.

Please see the **Aetna Behavioral Health Provider Manual (PDF)** (or visit the **Provider Manuals** page anytime for the most recent manual) for more information on access-to-care standards.

We thank you for keeping these measures in place to ensure the safety of your patients and clients.

Pharmacy

Changes to commercial drug lists begin on January 1

On January 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 October 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)**.

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

Important pharmacy updates

Medicare

Visit our **Medicare drug list** to view the most current Medicare plan formularies (drug lists). We update these formulary documents regularly during the benefit 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. 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

Starting October 3, certain states need to start using Anna™ software for the concurrent review process

This article applies to Delaware, Indiana, New York, Pennsylvania and West Virginia.

Aetna® has partnered with Post-Acute Analytics (PAA) to automate the concurrent review process by using its Anna™ software platform. Starting October 3, you must use the platform for the skilled nursing facility (SNF) concurrent review process.

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

What's changing?

Starting October 3, 2022, all SNFs in Delaware, Indiana, New York, Pennsylvania and West Virginia that admit Aetna MA members who reside in and receive care in those states will be required to work with PAA and use Anna to:

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

The precertification and concurrent management process

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

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

How to start using Anna

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

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

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

Sending "continued stay" documentation

Use the **Anna portal** (which is the preferred method) to send "continued stay" documentation. Note that you should continue to send pre-certification documentation through our **Availity provider portal**.*

How to reach us

If you have questions for Aetna about this change, you can **send us an email message**.

If you have questions about the Aetna utilization review process, you can contact your facility's assigned utilization review nurse or the Provider Contact Center at **1-888 MD AETNA (1-888-632-3862 (TTY: 711)**.

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Starting November 1, certain states must use Anna™ for the SNF concurrent review process

This article applies to Florida, Georgia, Massachusetts, Minnesota, New Hampshire, North Carolina and Vermont.

Aetna® has partnered with Post-Acute Analytics (PAA) to automate the concurrent review process by using its Anna™ software platform. Starting November 1, you must use the platform for the skilled nursing facility (SNF) concurrent review process.

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

What's changing?

Starting November 1, 2022, all SNFs in Florida, Georgia, Massachusetts, Minnesota, New Hampshire, North Carolina and Vermont that admit Aetna MA members who reside in and receive care in those states will be required to work with PAA and use Anna to:

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- Conduct concurrent review processes, including providing clinical documentation to receive authorization of additional days beyond the initial approved days

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Avoid a network status change — complete your required Medicare compliance training by December 31, 2022

Participating providers in our Medicare Advantage (MA) plans, Medicare-Medicaid Plans (MMPs) and/or Dual Eligible Special Needs Plans (DSNP) must meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related (FDR) entities as outlined in the **FDR program guide (PDF)**.

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

How to complete your Medicare compliance FDR or FDR/DSNP training and, if applicable, attestation

Training materials and attestation links are posted on our **Medicare page**.

Our training materials include:

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

Where to get more information

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

Contact your Medicare patients to schedule their annual wellness visit (AWV)

What's an AWV?

AWVs allow practices to gain information about patients, including medical and family history, health risks and vitals. An AWV, which should not be confused with a complete physical examination, reviews the patient's wellness and develops a personalized prevention plan.

AWV components

- Establish medical and family history
- Establish a list of current providers and suppliers
- Take height, weight, BMI and BP
- Detect any cognitive impairment
- Review potential depression risk factors
- Review functional ability and level of safety

AWVs can be performed by a physician, physician assistant, nurse practitioner, certified clinical nurse specialist or a medical professional under direct supervision of a physician (including health educators, registered dietitians and other licensed practitioners).

Provider benefits of performing AWVs include:

- Building a complete medical history
- Strengthening the provider/patient partnership
- Increasing patient engagement
- Providing proactive care to patients
- Gathering quality metrics

Patient benefits of receiving an AWV include:

- Overall wellness and prevention
- Early disease detection and prevention
- Maximized wellness

AWV documentation

Document diagnoses and conditions to accurately reflect severity of illness and risk of high-cost care.

AWV coding

Aetna® covers the cost of the beneficiary's AWV. The beneficiary has zero out-of-pocket expenses for an AWV.* A copay becomes applicable when a separately billed, medically necessary service is performed on the same day (append modifier -25 to the evaluation and management code).

The three Healthcare Common Procedure Coding System (HCPCS) codes used to report AWV services are:

- G0402-IPPE Welcome to Medicare visit (once per lifetime within the first 12 months of coverage)
- G0438-Initial visit (once per lifetime if IPPE was not received within the first 12 months of coverage)
- G0439-Subsequent visits/annual benefit for beneficiaries (no lifetime limit)

ICD-10 Z codes must be reported for wellness exams.

- Z00.00-Encounter for general adult medical examination without abnormal findings
- Z00.01-Encounter for general adult medical examination with abnormal findings

For additional information, **send us an email message**.

*Patients might have to pay all or part of the cost for additional services (lab, X-rays, etc.) ordered during an AWV. Please discuss any additional services with the patient beforehand so that they understand their financial responsibility.

Advance Beneficiary Notice of Noncoverage (ABN) documents aren't valid for Aetna® Medicare Advantage members

Providers should be aware that an ABN document is not a valid form of 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 is and isn’t covered

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

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

When providers cannot hold members financially responsible for services

Providers in a Medicare Advantage plan can’t charge a Medicare Advantage member for a service not covered under their plan unless that member gets a preservice organization determination (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 copayment or coinsurance amounts.

When providers can hold members financially responsible for services

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’ll be able to hold an Aetna Medicare Advantage 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

Initiating an OD notice of denial

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.

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

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

What's new?

Here's what you'll find:

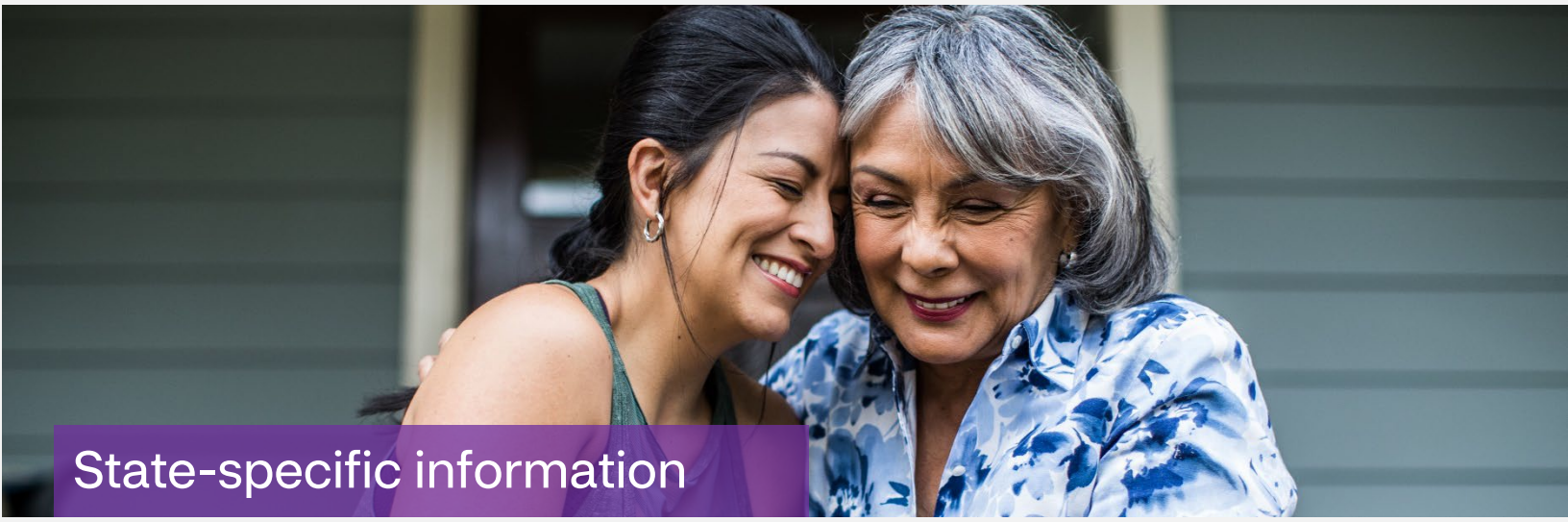
- A state-by-state DSNP provider FAQ for all providers that service Aetna DSNPs
- A glossary to assist you with locating answers to specific questions
- Helpful tools and resources, including information on how to access Medicaid information, member eligibility, ID cards and patient benefits

We also understand the challenges that DSNP providers face when it comes to billing. Refer to our **Medicare Resources page** for help with understanding the billing and cost-sharing process.

Connecticut: Retirees moving to an Aetna® MAPD plan

Connecticut selected Aetna as its new Group Medicare Advantage Prescription Drug (MAPD) administrator for its 58,000 retirees.

Effective January 1, 2023, all retirees enrolled in the state's MAPD plan will automatically transition from UnitedHealthcare® to an Aetna Medicare℠ Plan (PPO). We will share additional information about the MAPD plan in the next few months.



State-specific information

California, Delaware, Illinois and New Jersey providers: Aetna® to enter the individual exchange market

We're expanding! As previously shared, we re-entered the ACA exchanges in Arizona, Florida, Georgia, Missouri, Nevada, North Carolina, Texas and Virginia on January 1, 2022.

On January 1, 2023, we will enter new states and expand further into the existing states noted above. California, Delaware, Illinois and New Jersey will see the new Aetna CVS Health™ Affordable Care Act (ACA) insurance product (subject to regulatory approval) on the individual exchange market starting January 1. Look for "QHP" (qualified health plan) on member ID cards.

The product

The new insurance product gives members access to a quality network of health care providers and telemedicine services, and it provides members with convenient and affordable health care offerings at MinuteClinic® locations, including those within CVS® HealthHUB™ locations, and at CVS Pharmacy® locations.

The plan uses the reach of CVS Health® — its health insurance, pharmacy benefits, retail-based health services, mental well-being programs, telehealth services, digital capabilities and more — to provide greater value for individual consumers.

How members can enroll

Enrollment begins on October 1 for California, and November 1 for all other states. Interested members can go to the **Aetna CVS Health page** to enroll. And they can visit

HealthCare.gov for more information about the individual exchange and how to qualify for plan credits and discounts.

Check your participation status

- If you practice in California, Delaware, Florida, Georgia, Illinois, Missouri, Nevada, New Jersey, North Carolina or Texas, go to the **Aetna CVS Health provider directory** to check your status.
- If you practice in Arizona, go to the **Banner Aetna directory** to check your participation status in the Banner|Aetna Performance Network.
- If you are an Aetna provider in Virginia, go to the **Aetna CVS Health provider directory** to check your status. If you are an Innovation Health provider in Northern Virginia, you can check the **Innovation Health provider directory**.

Questions?

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

Aetna®, CVS Pharmacy®, and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic®-branded walk-in clinics) are part of the CVS Health® family of companies.

Starting October 3, certain states need to start using Anna™ software for the concurrent review process

This article applies to Delaware, Indiana, New York, Pennsylvania and West Virginia.

Aetna® has partnered with Post-Acute Analytics (PAA) to automate the concurrent review process by using its Anna™ software platform. Starting October 3, you must use the platform for the skilled nursing facility (SNF) concurrent review process.

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

What's changing?

Starting October 3, 2022, all SNFs in Delaware, Indiana, New York, Pennsylvania and West Virginia that admit Aetna MA members who reside in and receive care in those states will be required to work with PAA and use Anna to:

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

The precertification and concurrent management process

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

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

How to start using Anna

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

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

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

Sending "continued stay" documentation

Use the **Anna portal** (which is the preferred method) to send "continued stay" documentation. Note that you should continue to send pre-certification documentation through our **Availity provider portal**.*

How to reach us

If you have questions for Aetna about this change, you can **send us an email message**.

If you have questions about the Aetna utilization review process, you can contact your facility's assigned utilization review nurse or the Provider Contact Center at **1-888 MD AETNA (1-888-632-3862 (TTY: 711)**.

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

Starting November 1, certain states must use Anna™ for the SNF concurrent review process

This article applies to Florida, Georgia, Massachusetts, Minnesota, New Hampshire, North Carolina and Vermont.

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

What's changing?

Starting November 1, 2022, all SNFs in Florida, Georgia, Massachusetts, Minnesota, New Hampshire, North Carolina and Vermont that admit Aetna MA members who reside in and receive care in those states will be required to work with PAA and use Anna to:

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

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California: 2022 Provider Appointment Availability Survey (PAAS)

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

Aetna® has contracted with the Center for the Study of Services (CSS) to administer the PAAS for 2022. Aetna will assess compliance through the PAAS and report the results to the California Department of Managed Health Care (DMHC) and to the California Department of Insurance (CDI).

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

Providers to be surveyed

- Primary Care Physicians (PCPs)
- Specialty physicians (for example, cardiovascular disease specialists, endocrinologists and gastroenterologists)
- Psychiatrists
- Non-Physician Mental Health (NPMH) providers or Substance Use Disorder (SUD) providers
- Ancillary providers who offer mammogram appointments and ancillary providers who offer physical therapy appointments

Survey questions

- Urgent appointments: Is the appointment date and time within 48 hours (for a PCP visit request) or within 96 hours (for a specialist/psychiatrist/NPMH or SUD visit request)?
- Non-urgent appointments: Is the appointment date and time within 10 business days (for a PCP/NPMH visit request or a SUD visit request) or within 15 business days (for a specialist/psychiatrist/ancillary visit request)?

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

California access standards

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

Appointment type	Time frame
Urgent care (Primary Care Physicians)	48 hours from request
Urgent care (specialists, Non-Physician Mental Health [NPMH] providers, Substance Use Disorder [SUD] providers)	96 hours from request
Non-urgent doctor appointment (Primary Care Physicians)	10 business days
Non-urgent doctor appointment (specialty physicians)	15 business days

Non-urgent mental health appointment (NPMH and SUD providers)	10 business days
Non-urgent appointment (ancillary providers)	15 business days
As of July 1, 2022 — non-urgent follow-up appointments with an NPMH provider or a SUD provider	10 business days for those undergoing a course of treatment for an ongoing mental health or SUD condition

Note that referrals from a Primary Care Physician (PCP) or specialist are subject to the above time-elapse standards.

Exceptions to the appointment time frames above

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

Time frames for rescheduling appointments

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

Time frames for NPMH and SUD follow-up appointments

Members who are undergoing a course of treatment for an ongoing mental health or substance use disorder condition must be able to schedule a follow-up appointment with the NPMH or SUD provider within 10 business days of the prior appointment.

Corrective action for not meeting time frames

The Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) regulations require that Aetna® monitor its provider network and investigate and request corrective action (via a Corrective Action Plan, or CAP) if it doesn't provide timely access to care. Therefore, we ask that you please take time to review the California appointment standards with your staff. Our goal is to work with your office to ensure that our provider networks are compliant with these California Timely Access requirements.

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.

Colorado: language services available

We offer aids and services, at no additional cost, to people with disabilities. We also offer language services, at no additional cost, to people whose primary language is not English. These include language interpreters and plan details written in other languages. If a patient needs these services, call the number on the patient's ID card.

Colorado: We're updating our fee schedule

Beginning October 15, 2022, we'll adjust our standard fee schedule (the Aetna® Market Fee Schedule, or AMFS) for all plans in the Colorado market. This change affects those services for which we pay you based on AMFS. You can find these services in the compensation section of your contract.

Please note: If you have a different fee-based schedule, these adjustments apply only to the default.

How we develop fee schedules

For CPT® codes, we look at industry-standard methodologies and sources, such as the 2022 Resource-Based Relative Value Scale (RBRVS). These sources include Outpatient Prospective Payment System (OPPS) rates that the Centers for Medicare & Medicaid Services (CMS) establishes (CMS Clinical Laboratory Fee Schedule).

When we use the RBRVS, we base the fee schedule on a multiplier of 34.6062. We use the 2022 Relative Value Units (RVUs) file that CMS posts on its website.

For codes using the RBRVS, we use the "site-of-service" differential, which CMS defines in transitional RVUs. This differential adjusts payment for certain codes based on where you perform a service. To find code-specific information where we use the RBRVS and the 2022 formula for calculating the physician fee schedule, visit the **Centers for Medicare & Medicaid Services (CMS)**.

For some codes for which we don't use the RBRVS or when information isn't available, we use other sources to develop the fees. These sources include external vendor pricing models, Medicare fee schedules and nationally contracted rates.

We also adjust fees based on the Colorado Medicare Geographic Price Cost Index (GPCI). We won't apply any other changes that the CMS makes in 2022 except for new codes that Medicare values.

To get the full RBRVS schedule:

- Call the Government Publishing Office at **1-202-512-1800**.
- Visit the **Centers for Medicare & Medicaid Services (CMS)**.

Get the updated AMFS online as of October 15, 2022

Physicians, you can always check your current fee schedule on our **Availity provider portal**,* and your updated fee schedule will be available beginning October 1, 2022. Once you're logged in to Availity®, click on Claims & Payments > Fee Schedule Listing.

Please note: Only contracted physicians can access fee schedules.

- Fee schedules are not available to an office classified as a hospital, ancillary or IPA/PHO; to an office with a billing setup; or to behavioral health providers who are not MDs/DOs. Fees displayed are based on contracted amounts negotiated for specified treatments. They reflect the amounts allowed for services as if Aetna is paying each ASA/CPT/HCPCS code on a line-by-line, fee-for-service basis.
- ACO organizations: Fee schedule information will not display accurate rates for services provided to Aetna members who participate in an accountable care organization (ACO) arrangement. A member with an ACO arrangement will have a member ID card with an ACO logo and/or network name. You should use the Cost Estimator tool to estimate costs for these patients.

If you need your updated fee schedule before it's online or if you're a non-physician provider, fax your request and the CPT codes to **1-859-455-8650** after October 15, 2022.

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

Thank you for your continued participation in the Aetna network.

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Colorado: Prepare to provide proof of required anti-bias training

The Colorado Division of Insurance requires that providers and front office staff who participate in Individual and Small Group ACA plans complete anti-bias, cultural

competency or similar training annually to help patients who experience higher rates of health disparities or inequities.

Providers are responsible for coordinating their own training.

This training must be completed no later than January 1, 2023. In December, we will ask you to provide the details of the training provided, including:

- Who provided the training
- The date the training was completed
- Course duration
- The number of staff in attendance

Each carrier must report this information annually to the Division of Insurance for their provider network.

Connecticut: Retirees moving to an Aetna® MAPD plan

Connecticut selected Aetna as its new Group Medicare Advantage Prescription Drug (MAPD) administrator for its 58,000 retirees.

Effective January 1, 2023, all retirees enrolled in the state's MAPD plan will automatically transition from UnitedHealthcare® to an Aetna Medicare℠ Plan (PPO). We will share additional information about the MAPD plan in the next few months.

Massachusetts: PANDAS and PANS are now a covered benefit

The treatment pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) are now covered benefits for Massachusetts members.

New Jersey: Tier 1 Aetna Whole Health℠ providers are now part of the Individual Exchange network

We've selected you to be in our Individual Exchange network. This means you will be able to see patients who buy our Individual Exchange plans. Starting November 1, 2022, these plans will be available for consumer election both on and off the Get Covered New Jersey exchange. The plans are currently under regulatory review and will be effective beginning January 1, 2023.

What you need to do to participate

There's nothing you need to do.

Your rates

Your rates will be paid according to the terms of your agreement. Simply use the same process you do today to check eligibility and benefits and to submit claims.

Tier 2 Aetna Whole Health providers

Tier 2 providers are non-participating for this Individual Exchange network.

Oregon: New pre-approval requirements

Our Enhanced Clinical Review program with eviCore healthcare requires authorization for certain procedures. As we previously communicated in a direct mailing, this program became effective for Oregon on August 1, 2022. It affects Oregon members in our commercial Aetna® products.

Services that require pre-approval

- High-tech outpatient diagnostic imaging procedures such as MRI/MRA, nuclear cardiology, and PET scan and CT scan, including CTA
- Nonemergent outpatient stress echocardiography
- Nonemergent outpatient diagnostic left and right heart catheterization
- Insertion, removal and upgrade of elective implantable cardioverter defibrillator, cardiac resynchronization therapy defibrillator and implantable pacemaker
- Polysomnography (attended sleep studies)
- Interventional pain management
- Radiation therapy services — these include complex and 3D conformal; Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT); brachytherapy; hyperthermia; Intensity-Modulated Radiation Therapy (IMRT)/Image Guided Radiation Therapy (IGRT); proton beam therapy; neutron beam therapy; and radiopharmaceuticals

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

Submitting authorization requests

Before members receive services, eviCore healthcare's board-certified physicians will review authorization requests for medical necessity. For you to get paid for services, you must send authorization requests before providing those services.

If treatment started before August 1, 2022, and you haven't already called Aetna, contact eviCore healthcare to request continuity-of-care authorization. This will allow claims for dates of service after August 1, 2022, to be considered.

Radiation therapy services are reviewed in accordance with nationally recognized clinical and billing guidelines of the American College of Radiation Oncology, American Society of Radiation Oncology, other recognized medical societies, and **Aetna Clinical Policy Bulletins (CPBs)**.

Asking eviCore healthcare for approval

- Go to **eviCore.com**.
- Call **1-888-622-7329 (TTY: 711)** during normal business hours.

Note that fax request forms are available online.

- Send a fax to **1-800-540-2406** for all radiology, cardiology and radiation therapy requests.
- Send a fax to **1-866-999-3510** for sleep requests.
- Send a fax to **1-855-774-1319** for interventional pain requests.

Urgent requests

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

Important information to know

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

Questions?

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

You can also see eviCore healthcare's criteria and get request forms at **eviCore.com**.

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