Provider manual

Resources, policies and procedures at your fingertips

Aetna.com

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Table of Contents

Welcome to your provider manual

A word about compliance

You're responsible for complying with all applicable laws, regulations and guidance. We may issue notifications and update this manual with legal requirements as laws or regulations change. However, you're responsible for compliance regardless of whether we've issued a notification or included requirements in this manual. If laws, regulations or guidance are not consistent with (or are more stringent than) our policies, they may override the policies in this manual. The policies and information stated in this manual should align with the terms of your agreement with us. If they don't, the terms of your agreement govern and control.

Visit Aetna.com. Under "Compliance", you will find additional resources.

Creating a diverse, equitable and safe workplace

We are an equal opportunity employer. We believe in and promote a diverse, equitable and safe workplace environment. We count on you to do the same in your hiring practices and workplace policies.

Your provider resource

You've told us what's important to you, and we listened. Through your feedback, we continually update this manual to make it easier for you to work with us.

This manual applies to any health care provider, including physicians, health care professionals, behavioral health providers, hospitals, facilities, and ancillary providers, who contract with Aetna directly or indirectly, except when indicated otherwise. As a participating provider you must comply with our policies, many of which are described or linked within this manual. Aetna may add, delete or change policies, including those described in this manual, at any time. Please read this manual carefully.

Visit **Aetna.com** or our provider portal at **Availity.com** to find additional policies and other information, including reimbursement policies. Please note, you must register first to use our provider portal at **Availity.com**.

You'll find programs we offer that could benefit your Aetna patients and electronic transaction tools that can help save you time. You'll also find information on how to get your claims paid faster, your prior authorization requests processed promptly and your administrative burdens lessened. We want you to find what you need, quickly and efficiently.

And of course, you'll find our contact information, so you can reach us whenever you need to.

Here to help you

This manual is for you — physicians, hospital medical and facility staff, and providers who participate in our network and care for our members. It aims to:

- Help you understand our processes and procedures
- Serve as a resource for answering your questions about our products, programs or doing business with us

You'll find almost everything you need to do business with us. Go to **Aetna.com** to find other policies and procedures that are not documented in this manual.

Have questions? Contact us via Aetna.com — we're here to help.

Changes and updates

When things change, we'll let you know. You are required to provide us with your email address so we can contact you with important information, such as updates to this manual, our policies and our health plans.

We update this manual annually and as needed. When we make changes that affect you, such as to clinical policies, plan names or ID cards, we'll let you know. We'll notify you by mail, email or Aetna OfficeLink Updates™, our provider newsletter. **If your office hasn't heard from us or your contact information has changed, you must let us know.** To learn more about updating your information, review **the provider data updates** section in this document.

Our provider newsletter is typically published quarterly — March 1, June 1, September 1, and December 1. It can include changes to policies that may affect your practice or facility. We also may send notices and reminders throughout the year.

You can **subscribe to receive OfficeLink Updates** and other important news.

You can also visit our **OfficeLink Updates library**.

New to the Aetna network?

We have tools and resources to help you work with us.

- **Aetna at a Glance:** Read our **quick-reference guide** to help you learn about various tools and transactions. It also has key contact information.
- **Aetna Product Overview — Aetna Benefits Products booklet:** This easy-to-use resource gives an overview of Aetna benefits products. It provides clear, concise information about our commercial plans, primary care physician (PCP) selection, referral requirements and precertification instructions. You can go to **Aetna.com** to access the **Aetna Product Overview booklet** on our **Provider Manual** page.
- **Provider portal:** You'll notice the term "provider portal" used throughout this manual. You can perform a variety of electronic transactions through this website. That includes submitting professional and institutional claims, checking patient benefits and eligibility, requesting precertification, making edits to existing authorizations and submitting clinical information. You must register to use the website. Just go to **Availity.com**, select "Register" and then follow the instructions. See the **Electronic solutions** section of this manual for more information.
- **Webinars:** On our provider site, you can **sign up for webinars and learn how to work with us**.
- **Local network information:** Regulations and Aetna program requirements will vary from state to state. You can find regional information in our regional manual supplements, which are available in our online **Provider Manuals**. They include some market-specific information and provide access to important contacts, including website addresses and telephone and fax numbers.

How to apply

Whether you're with a facility that's new to Aetna or you're a health care professional who's joining an existing group, it's easy to apply for participation in our network. To start the application process, go to the "**Request to join the Aetna Network**" section of our website.

Credentialing and recredentialing

You must be credentialed in order to initially participate in our network. Thereafter, to continue to participate, you must be recredentialed every three years, unless otherwise required by state regulations, federal regulations or accrediting agency standards.

All credentialing and recredentialing activities are performed by a National Committee for Quality Assurance (NCQA)-certified credentialing verification organization. When using the Council for Affordable Quality Healthcare (CAQH), or any other approved credentialing application vendor, remember that you must designate Aetna as an authorized health plan to access your credentialing application.

Facilities

During the credentialing process for facilities, we review to determine if the facility is in good standing with both state and federal regulatory bodies and if it is accredited by an Aetna-recognized accrediting entity. If it is not accredited by an Aetna-recognized accrediting entity, we check to see if a Centers for Medicare & Medicaid Services (CMS) survey, a state survey or other on-site quality assessment was conducted.

Health care professionals

During the credentialing process for health care professionals, we review the provider's qualifications, practice and performance history.

- In most states we use CAQH ProView to get your credentialing application, unless otherwise required by state regulation.
- We use ARCCVS for physicians located in Arkansas.

How to check the status of your application

Call Aetna Credentialing Customer Service at **1-800-353-1232 (TTY: 711).**

Questions?

Please contact any of the organizations below.

- CAQH ProView Help Desk: **1-888-599-1771**
- One Health Port and Medversant Help Desk: **1-800-973-4797**
- Arkansas State Medical Board: **501-296-1951**

Radiology accreditation

We require accreditation to be eligible for reimbursement for the technical component of advanced diagnostic imaging procedures. Accreditation can be from:

- The American College of Radiology (ACR)
- The Intersocietal Accreditation Commission (IAC)
- The Joint Commission (TJC), and/or RadSite

The following types of providers require this accreditation:

- Independent diagnostic testing facilities
- Freestanding imaging centers
- Office-based imaging facilities
- Suppliers of advanced diagnostic imaging procedures

For these purposes, advanced diagnostic imaging procedures exclude X-ray, ultrasound, fluoroscopy, and mammography. Included are:

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Computed tomography (CT)
- Echocardiograms
- Nuclear medicine imaging, such as positron emission tomography (PET)
- Single photon emission computed tomography (SPECT)

***Note**: Providers not accredited by the ACR, IAC, TJC and/or RadSite will not be eligible for payment for advanced diagnostic imaging services. The accreditation process can take 9 to 12 months.*

Provider identification numbers

To comply with HIPAA regulations, providers who are required to have an NPI should include their NPIs on HIPAA standard transactions.

The HIPAA standard transactions are:

- Claims
- Eligibility and benefits inquiry
- Claims status inquiry
- Precertification add
- Referral add

In addition to an NPI, claims must also include the **billing provider's tax identification number (TIN)**.

Share your National Provider Identifier (NPI)

If you're a provider who's required to have an NPI, be sure to **share your NPI with us**. In addition, share your NPI with other providers who may need it to conduct electronic claims, referrals or precertification requests.

Aetna provider identification number (PIN)

Physicians, hospitals and health care professionals contracted with us also have an Aetna-assigned PIN, which is used in our internal systems and in certain transactions on our **provider portal**.

You should use your NPI in electronic transactions for purposes of identifying yourself as a provider. However, you can use your PIN or TIN to identify yourself when contacting us by other methods.

Accessibility standards and participation criteria

Providers are required to comply with applicable regulatory requirements, as well as Aetna participation requirements, which are available in our **Network Participation Criteria Manual**.

Primary care physician/provider (PCP) responsibilities

PCPs will arrange the overall care and covered services for members according to their plan. This includes urgently needed or emergency services.

We have standards for member access to primary care services, which are listed in our participation criteria, along with other PCP criteria.

Note: *Aetna Open Access® HMO, Aetna Choice® POS, Aetna Choice® POS II, and Aetna Medicare℠ Plan (PPO) members are not required to select a primary care physician. However, these members are encouraged to select one so they can take advantage of certain programs that require members to access care through their primary care physicians.*

Specialty care provider responsibilities

We have standards for member access to specialty care services. Each specialty care provider is required to have appointments available, in person or via telehealth, within these time frames:

- Routine care: within 30 business days
- Urgent/emergent matter: immediately or referred to the emergency room, as appropriate

In addition, all participating specialty care providers must have a reliable 24/7 answering service or machine with a notification system for call-backs. A recorded message or answering service that refers members to emergency rooms is not acceptable. More stringent state requirements supersede these accessibility standards and are located in the **Provider Manual State Supplement**.

Verifying your network participation

To verify your network participation, you can use any of the options below.

- Review your contract
- Call the Provider Contact Center
- Go to **Aetna.com** and check the online provider search tool
- You can also visit the **search tool** directly. This search tool shows those providers that are working with us at a product level. You can also find network participation in **Availity.com** as you're viewing eligibility.

Compliance and ethics

Overall, you're responsible for complying with all applicable laws, regulations and guidance. Please read the section "**A word about compliance**" in this manual.

Nondiscrimination

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of a number of factors. These include:

- Race
- Ethnicity
- Gender
- Creed
- Ancestry
- Lawful occupation
- Age
- Religion
- Marital status
- Sex
- Sexual orientation
- Gender identity
- Mental or physical disability
- Medical history
- Color
- National origin
- Place of residence
- Health status
- Claims experience
- Evidence of insurability (including conditions due to domestic violence)
- Genetic information
- Source of payment for services
- Status as private purchasers of a plan or as participants in publicly financed programs of health care services
- Cost or extent of provider services required
- Medicare or Medicaid beneficiary status

All participating physicians should have a documented policy regarding nondiscrimination. All participating physicians or health care professionals may also have accommodation obligations under the federal Americans with Disabilities Act. The Act requires that they provide physical access to their offices and reasonable accommodations for patients and employees with disabilities.

Please refer to the participation criteria with respect to telehealth accessibility standards for members with disabilities. You're required to conform to all such standards as well as any additional applicable federal and state disability laws.

There are additional requirements for physicians or health care professionals that are covered entities under the Section 1557 Nondiscrimination in Health Programs and Activities Final Rule.

They are required to provide access to medical services, including diagnostic services, to an individual with a disability.

Participating physicians or health care professionals may use different types of accessible medical diagnostic equipment, or ensure they have enough staff to help transfer the patient, as may be needed, to comply.

Closed panel

Participating providers must notify us if they are not accepting our members as new patients. To prevent discrimination, our expectation is that participating providers will not accept new patients from a competitor while they are not accepting our members as new patients.

Physician-requested member transfer or termination of patient relationship

Some cases may require a participating physician to ask an Aetna member to leave their practice when repeated problems prevent an effective physician–patient relationship. Such requests can't be based solely on:

- The filing of a grievance or appeal, requesting an external review, or taking any other action related to coverage by the patient
- High usage of resources by the patient
- Any reason that's not permitted under applicable law

When requesting to end a specific physician–patient relationship, you are required to send the patient a letter informing them of the termination. The letter should be sent by certified mail. A copy must also be sent to your local Aetna network manager. For the mailing address, call your local Aetna office or **1-800-872-3862 (TTY: 711)**.

In the case of a PCP, we'll send the member a letter informing the member that he or she must select a new PCP and providing instructions on how to select another PCP.

Support the patient's continuity of care by giving them enough notice to make other care arrangements. This is consistent with the American Medical Association Code of Medical Ethics, Opinion 8.115.

In addition, upon request, within 30 days of the initial notification to the member, the physician shall:

- Provide resources or recommendations to the patient to help locate another participating provider
- Offer to transfer records to the new physician upon receipt of a signed patient authorization

Members rights and responsibilities

We want you to have a good relationship with our members and vice versa. That's why we advise our members of their **rights and responsibilities** as they relate to their selection and interactions with providers.

Advance directives and the Patient Self-Determination Act (PSDA)

The PSDA is a federal law designed to raise public awareness of advance directives. An advance directive is a written statement, completed in advance of a serious illness, about how one would want medical decisions to be made if they are no longer capable of making these decisions for themselves. The two most common forms of advance directives are the living will and the durable power of attorney for health care.

The Centers for Medicare & Medicaid Services (CMS) strongly urges all practitioners to include documentation in the medical record regarding whether a Medicare member has completed an advance directive. This is also an Aetna medical record documentation requirement.

The patient should complete the Advance Directive Notification Form. We recommend that each patient return this form to their PCP so that it may be placed in their medical file.

We encourage you to discuss advance directives with your patients.

Note: *The PSDA impacts all Aetna members over the age of 18.*

Informed consent

All participating physicians and other health care professionals should:

- Understand and comply with applicable legal requirements regarding patient informed consent
- Adhere to the policies of the medical community in which they practice and/or hospitals where they have admitting privileges

In general, it's the participating physician's duty to:

- Give patients adequate information
- Be reasonably sure the patient understands this information before treating them

Price transparency and no surprises

It is your responsibility to comply with all applicable law, including the federal Health Care Price Transparency Act and the No Surprises Act. In accordance with applicable law, our contracts do not prevent participating providers from disclosing rate or payment information when required. They also do not contain clauses that "gag" or prevent Aetna or payers from disclosing price, quality, and other information in violation of applicable law.

We encourage providers to discuss issues openly with their patients. We want our members to have the comfort of knowing their providers have the right and obligation to speak freely with them. Providers should discuss with their patients:

- Pertinent details regarding the diagnosis of their conditions
- The nature and purpose of any recommended procedure
- The potential risks and benefits of any recommended procedure
- The potential risks and benefits of any recommended treatment
- Any reasonable alternatives to such recommended treatment

Federal Continuity of Care requirements

In addition to state law, the federal No Surprises Act requires compliance by terminated providers with its continuity of care requirements.

The Federal Continuity of Care requirements apply to members who are continuing care patients, meaning they are:

- Undergoing a course of treatment for a serious and complex condition
- Undergoing a course of institutional or inpatient care
- Scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery
- Pregnant and undergoing a course of obstetrical treatment for the pregnancy
- Determined to be terminally ill (if the individual has a medical prognosis that the individual's life expectancy is 6 months or fewer) and receiving treatment for such illness

A continuity-of-care triggering event occurs, if, while a member is a continuing care patient:

- The provider contractual relationship with Aetna is terminated
- Benefits provided under the health plan are terminated because of a change in the terms of the participation of the provider in the health plan
- The contract between the plan sponsor and Aetna is terminated, resulting in a loss of benefits provided under the plan

Providers cannot balance bill members who are continuing care patients for more than their in-network coinsurance, cost share or deductible rate.

Providers must also continue to accept, as payment in full, the rates in the services and rate schedule that were in effect prior to termination.

Several states also have continuity/transition of care requirements that are applicable to fully insured members. In these situations, the federal requirements are applied first with state requirements filling in any potential gaps (e.g., balance billing). If the federal and the state requirements conflict, the better benefit for the member will be applied.

Telehealth and virtual care services

Telehealth is the use of telecommunications and information technology to provide clinical health care from a distance. It's used to overcome distance barriers and improve access to services. There are states that have coverage and service requirements for telehealth and virtual care services. Please see our **participation criteria** and visit **Aetna.com** for information on approved telehealth and virtual care services.

Provider data updates

Federal and state law requires Aetna and providers to work together to maintain accurate provider directory lists.

The law requires you and Aetna to keep your information current and to confirm its accuracy at least every ninety (90) days. However, Aetna may require confirmation upon request as well.

Updating your data

Our provider directories include provider data information to help patients find care. Being in our directories allows new patients to find out if you are accepting new patients, where you're located, and how to reach you. Additionally, by making sure we have your current information, we can send you timely communications and reminders.

Remember to notify us of your data changes. Failure to do so will result in corrective action in accordance with your agreement with us and applicable law.

Here is how to update your information

Go to **Availity.com** to update your information. (If you can't use **Availity.com**, submit a Request Changes to Provider Data Submission Form found on **Aetna.com**.)

Here are some examples of information you can update:

- Primary address indicator
- Service location address
- Provider name
- Appointment phone
- Accepting new patients
- Specialty
- Handicap accessibility
- Office hours
- NPI
- Gender
- Language
- Board certification
- Education/degree
- Hospital affiliation
- Office staff language
- Race
- Ethnicity

Health Equity

The quality of the patient-provider relationship plays an influential role on patient outcomes. 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.*

Aetna is committed to reducing health disparities and improving the health of all communities. We're encouraging providers to voluntarily identify their race and ethnicity for Aetna members to use in our provider online directory.

Provider roster submission requirements

These requirements apply to provider groups and entities who are approved by us to submit updated provider rosters.

A Delegated Credentialing Entity or Delegate is a hospital, group practice, credentials verification organization (CVO) or other entity that we have given the authority to perform specific provider credentialing functions. When credentialing responsibilities are delegated to you, you are known as the Delegated Entity. For more information on provider delegation, review our **Provider Manuals page** on **Aetna.com** and select "Delegation management guide".

To get a roster template, email **PDIU_Delegation@Aetna.com** and put "Roster template request" in the subject line.

Roster data quality

The information contained on rosters directly impacts our provider directories and other systems (for example, claim payment systems) and must be maintained, completed and accurate in accordance with applicable law.

We reserve the right to analyze and score each roster received and will return poor-quality rosters for correction and resubmission to us.

Continued submission of poor-quality roster information may result in:

- A request for corrective action
- Omission of providers from the search tool
- Our refusal to accept any further rosters from your group
- A requirement for your group to maintain demographic data through other means (such as through Availity)
- Termination of Delegated Entity status

*FOR HEALTH DISPARITIES SOURCE: 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. Available at: **jamanetwork.com/journals/jamanetworkopen/fullarticle/2772682**. Accessed January 6, 2025.

Provider roster submission requirements

Delegates or other groups who are approved by us to submit rosters are required to:

- Submit a complete and accurate roster in Excel or similar columnar format. (Word and PDF files are not acceptable)
- Include all necessary roster fields on submissions. (For examples, see the "Roster fields" section.)
- Submit the following minimum information at least monthly and quarterly:
  - Monthly additions, changes and deletions
  - A quarterly full roster of all providers
- Contact each provider in your network at least once a quarter to validate that their demographic information is correct.

Roster fields

The roster includes but is not limited to following separated fields for each element.

Provider information

- Date of birth
- Degree
- Ethnicity
- Gender
- Practice name
- Provider first name
- Provider last name
- Provider middle initial
- Race
- Role (primary care provider, specialist, or both)
- Provider language (if other than English)

Licenses and identification numbers

- Board certification (board name, effective date, and expiration date)
- Controlled dangerous substance (CDS) expiration date
- Controlled dangerous substance (CDS) number
- Credentialing date (most recent)
- Credentialing date (original)
- Medicare expiration date
- Medicare number
- National Provider Identifier (NPI) number
- National Provider Identifier (NPI) type
- State license effective date and expiration date
- State license number
- State license state of issue
- Tax ID number
- Tax ID owner name
- U.S. Drug Enforcement Administration (DEA) registration number
- U.S. Drug Enforcement Administration (DEA) registration number expiration date
- U.S. Drug Enforcement Administration (DEA) state of issue

Service contact information

- Service location appointment phone number
- Service location email
- Service location fax number
- Service location street address
- Service location suite number
- Service location city
- Service location state
- Service location ZIP code
- Primary location (Y or N)

Services provided

- Accepting new patients (Y or N)
- Accessible to persons with disabilities (Y or N)
- Ages treated
- Description of services (see patients regularly, covering only, Hospital based)
- Directory print (Y or N)
- Languages spoken by staff
- Office hours
- Specialty
- Telehealth services (Y or N)
- Virtual Care Only (Y or N)

Billing information

- Billing location street address
- Billing location suite number
- Billing location city
- Billing location state
- Billing location ZIP code
- Billing location phone number
- Billing location fax number

Medical records

Record keeping — participating practitioner medical record criteria

Aetna health plans have established medical record criteria and documentation standards. Their intent is to facilitate communication and coordination of care and promote effective patient care. These criteria provide a guideline for organizing and documenting diagnostic procedures and treatments.

We require all participating practitioners to comply with these documentation standards, as well as state laws and regulations that require biennial medical record audits. We use the same criteria to score those audits, which are as follows:

- We award one point for each element documented compliantly.
- We award zero points for those that are not compliant.

Performance goals are established to assess the quality of medical record keeping practices, and audits are conducted no less than every two years. We calculate the audit score by dividing the number of compliant points by the total number of applicable points. The performance goal is 85%.

Organization

Note: *The below "entry" requirements are assessed for Medical Record Keeping Practices based on guidelines from the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), insurance regulations and Aetna.*

- Each page has member's name and date of birth on it.
  - The member's name and date of birth should be recorded on each page of the medical record (for example, all notes, lab reports and consult reports). (1 point)
- The member's personal data (gender, date of birth, address, occupation, home and work phone numbers, marital status) is documented.
  - Each record must contain appropriate biographical and personal data including age, sex, race, ethnicity, address, employer, home and work telephone numbers, emergency contact and marital status.
  - All members must have their own chart — no family charts. (1 point)
  - A centralized medical record for the provision of prenatal care and all other services must be maintained (prenatal only). (1 point)
- All entries in the record contain the author's signature or initials or electronic identifier (stamped signatures are not acceptable).
  - The provider of service for face-to-face encounters must be appropriately identified on medical records via their signature and their physician-specialty credentials (for example, MD, DO and DPM). Here are examples of acceptable physician signatures:
    - Handwritten signature or initials on all pages
    - Electronic signature with authentication by the respective provider
    - Facsimiles of original written or electronic signatures

    This means that the credentials for the provider of services must be somewhere on the medical record — either next to the provider's signature or preprinted with the provider's name on the group practice's stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider. (1 point)
- All entries are dated. (1 point)
- All entries are legible to someone other than the writer.
  - The medical record should be complete and legible. Illegible medical record entries can lead to misunderstanding and serious patient injury. (1 point)
- Medications are noted, including dosages and dated status of prescription (active or discontinued) or date of initial or refill prescription.
  - Evidence of prescribed medications, including dosages and dates of initial or refill prescriptions must be present in the record. This list should be updated each visit. (1 point)
- Medication allergy and adverse reactions or lack thereof prominently noted.
  - Allergies and adverse reactions to medications are prominently noted in chart or the lack thereof is noted as NKA (no known allergies) or NKDA (no known drug allergies). (1 point)
- An up-to-date problem list is completed including significant illnesses and medical and psychological conditions.
  - A problem list recorded with notations must be present and include any significant illness or medical and/or psychological condition found in the history or in previous encounters. The problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-10 diagnosis code on the date of service. A problem list should be either a classical separate listing of problems or an updated summary of problems in the progress note section (usually a periodic health exam). The latter type list should be updated at least annually and

should include health maintenance. A repetitive listing of problems within progress notes is acceptable. A blank problem list receives a score of zero. (1 point)

- Past medical history is completed (for members seen three or more times) and is easily identified and includes dates of serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to dates of prenatal care, birth, operations and childhood illnesses.
  - Past history including experiences with illnesses, operations, injuries and treatments must be documented. Family history including a review of medical event, diseases and hereditary conditions that may place the member at risk must be documented. (1 point)
- History and physical (H&P) documents have subjective and objective information for the presenting problem.
  - Past medical history including physical examinations, necessary treatments and possible risk factors for the member relevant to the particular treatment are noted. (1 point)
- For members 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for members seen 3 or more times, substance use history must be queried).
  - For members 14 years and older, a score of 1 requires a response to an inquiry concerning alcohol, smoking and/or substance use history as part of risk screening in support of preventive health. For members under the age of 14 years, the score will be N/A. (1 point)
  - Note regarding follow-up care, calls and visits. Specific time of return is noted in weeks, months or as needed.
  - Encounter forms or notes have a notation regarding follow-up care, calls or visits when indicated. The specific time of return is noted in weeks, months or as needed (i.e., PRN). (1 point)
- An immunization record has been initiated for children and a history for adults.
  - An immunization record (for children) which includes the name of the vaccine and date of administration or disease (for example, chickenpox) is up to date or an appropriate history has been made in the medical record (for adults). Member-reported data is acceptable. (1 point)
- Preventive screenings and services are offered according to Aetna guidelines.
  - There is evidence that preventive screenings and services are offered in accordance with the organization's practice guidelines. Preventive screenings specific to the member's age, gender and illness (for example, mammography, immunizations, Pap smear, human papilloma virus (HPV), body-mass index (BMI) value for adults, BMI percentiles for ages 15 and under, colorectal cancer screening, diabetic eye exams) are documented. Documentation should include screening date and result. (1 point)
  - For children and adolescents there should be documentation of counseling for nutrition and physical activity.
- Documentation about advance directives (whether executed or not) is in a prominent place in the member's record (except for those under age 18).
  - There is evidence of advance directives noted in a prominent place in the record (1 point) and whether or not the advance directive has been executed in the chart for members over 18 years of age. (1 point)
- Treatment plan is documented.
  - There is documentation of clinical findings and evaluation for each visit (presenting complaints, pain management, diagnosis and treatment plan, prescription, referral authorization, studies, instructions). (1 point)
- Working diagnoses are consistent with findings.
  - There is a documented reason for the visit. The progress note contains appropriate subjective and objective information pertinent to the member's presenting complaints for each visit. (1 point)
- There is no evidence that the member is at inappropriate risk. Possible risk factors for the member relevant to particular treatment are noted.
  - There is no evidence that the member is placed at inappropriate risk by a diagnostic or therapeutic procedure. Diagnostic and therapeutic procedures are appropriate for the member's diagnosis and risk factors. Examples: a) Member has complaint of right-hip pain and an X-ray of the right hip is ordered; b) Abnormal lab and imaging study results do not have an explicit note regarding follow-up plans. (1 point)

Examination

Blood pressure, weight, height, BMI value or BMI percentile measured and recorded at least annually, if the member accesses care. (1 point)

Studies

- Lab and other studies are ordered, as appropriate.
  - If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the evaluation and management (E/M) encounter, the type of service — for example, lab work or an X-ray — should be documented. (1 point)
  - There is evidence that the physician has reviewed lab, X-ray or biopsy results (signed or initialed reports), and the member has been notified of results before filing in the record.
  - There is evidence of physician review of lab work, X-ray or biopsy results or other studies by either signing or initialing reports or documentation of the

results in the progress notes. Abnormal lab and imaging study results have an explicit note regarding follow-up plans. (1 point)

Communication

- There is documentation of communications contact with referred specialist.
  - The PCP or managing practitioner coordinates and manages the care of the member. If a consultation or referral is made to a specialist, there is documentation of communication between the specialist and the PCP with a notation that the physician has seen it. And there is evidence of discharge summaries from hospitals, home health agencies (HHAs) and skilled-nursing facilities (SNFs), if applicable. If there is no evidence of referral or other facility services, mark N/A. (1 point)
- There is documentation indicating the patient's preferred language (California only).
- There is documentation of an offer of a qualified interpreter, and the enrollee's refusal, if interpretation services are declined (California only).

Records maintenance and access

Maintenance

You need to maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards. You are required to keep our members' information confidential and stored securely. You must also ensure your staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

Member record access

We or our vendors have the right to access confidential medical records of Aetna members for the purpose of claims payment, assessing quality of care (including medical evaluations and audits), and performing utilization management functions. We or our vendors may also request medical records (including, but not limited to, patient charts), for reporting purposes (e.g., as a part of our participation in the Healthcare Effectiveness Data and Information Set (HEDIS®); for reporting to CMS/HHS or state regulatory agencies, and for risk adjusted reporting and auditing purposes). HIPAA privacy regulations allow for sharing of protected health information (PHI) for the purpose of making decisions around treatment, payment or health plan operations.

Privacy practices

Protecting our members' health information is one of our top priorities. Our members expect and rely on us to protect their protected health information (PHI). Information about privacy and security practices at Aetna, including the following documents, are available at the **Aetna Privacy Center**:

- The Aetna Notice of Privacy Practices by plan type
- The Aetna Web and Mobile Privacy Statement

Participating providers are covered entities under HIPAA. They are required to keep PHI confidential, and to adhere to their obligations under the HIPAA Privacy Rule. The federal Department of Health and Human Services provides helpful information. This includes but is not limited to information on the obligations of Covered Entities.

You can access that information at **HIPAA for Professionals**.

Electronic solutions — eligibility, cost estimation, claims and more

Go to Availity.com to register or sign into our provider portal.

We're committed to making it easy for you to work with us electronically. Register at **Availity.com** to take advantage of our suite of electronic transactions that could increase your efficiency. Below are key features and benefits of our electronic transactions.

Note: *If you perform transactions through a vendor portal other than our provider portal, Availity, functionality may vary.*

Eligibility and benefits inquiry

Our Eligibility and Benefits Inquiry transaction enables you to request patient eligibility status quickly and easily. It can help you verify member eligibility and demographics and find detailed financial information, including deductible, copayment and coinsurance for individual and family plans. Check eligibility prior to a patient's visit since coverage could have expired or been suspended. Depending on plan details, transaction results may include:

- Copay, deductible and coinsurance
- Some exclusions and limitations
- Visits used and visits remaining
- Referral requirements

Here are some tips to help you complete a transaction:

- Search up to 24 months prior to Date of Service.
- Select "Benefit Type" to jump to a specific benefit.
- Under the "Eligibility" link, access your rosters for HMO capitation.
- Search using the patient's full first and last names and date of birth if you don't have the member ID number.

Patient cost estimator

Our patient cost estimator tool enables you to request an estimate of your patient's financial responsibility based on the active coverage in place at the time the transaction is submitted. With this tool, you can:

- Learn our estimated payment amount
- Get reliable estimates of patient copayments, coinsurance and deductibles
- Access printable information to help guide financial discussions with patients prior to (or at the time of) care
- Reduce, and possibly remove, after-the-fact financial surprises for you and your patients

Note: *The patient cost estimator tool does not apply to any Aetna Medicare Advantage plans.*

Authorization adds, inquiries and updates

Our Authorization Request and Authorization Inquiry transactions are an easy way to request or check the status of an authorization. Benefits include:

- Access to all submitted authorizations and real-time updates
- Ability to view and download digital authorization status letters
- Notification if an authorization is required prior to all data being input
- The ability to confirm an authorization resides in Aetna systems (and, if present, the details of the request and status in the review process)
- The ability to make limited updates to an authorization prior to services being rendered

Complete an Authorization Inquiry transaction and click on the "Update" link in the upper right corner of the response. From there you can:

- Change an admitting or attending provider, facility, or vendor
- Add up to five new diagnosis codes
- Add a note in the comments field
- Update or change admission details prior to services being rendered
- Add, update, or cancel up to five procedure codes
- Electronically submit clinical information in support of pending and new authorization requests

Users can upload supporting information (such as medical records or additional information forms) through our provider portal on Availity using the Authorization Submission or Authorization Inquiry transaction.

Users can upload up to six electronic files at a time, with a size of 32MB per file, by clicking the Add Files button. We accept the following file types:

- Microsoft® Word (.doc, .docx)
- Microsoft® Excel® (.xls, .xlsx)
- Adobe® PDF (.pdf)
- Images (.gif, .jpg, .jpeg, .png, .tiff)
- Rich text format (.rtf)

The files are uploaded securely, so you don't need to password-protect them.

For certain procedures, you may be asked to complete a questionnaire to provide additional clinical information. Upon completion and submission, you may receive an immediate approval.

Referral add and inquiry

Referral Add and Referral Inquiry transactions are an easy way to request or check the status of a referral and may be used for any Aetna plans that require a referral. Use the Referral Inquiry transaction to find referrals submitted on our provider portal or by vendor or clearinghouse, fax, and mail submissions. You can use our online **referral directory** to search for participating providers in your patient's plan.

Primary care physicians (PCPs) may request a referral to a specialty care provider or hospital visit and inquire about the status of a referral using the Referral Inquiry transaction.

Claim submissions

You can submit all claims electronically and get reimbursed faster than submitting paper claims. By submitting claim electronically, you can:

- Submit batch claims and check which files you've submitted
- Receive an automatic acknowledgement for all submitted claims
- Submit coordination of benefits (COB) claims electronically

Visit our **electronic claims page** to see how you can submit claims electronically.

On our provider portal **Availity**, you can submit professional and institutional claims at no charge, including COB claims and corrected and voided claims.

If we pend your claim for additional information from you, you can upload your supporting documents electronically through our provider portal or through another EDI Claim Attachment vendor. Log in and complete a Claim Status Inquiry transaction. Then, upload your documents through the "Send Attachments" button.

Users can upload up to five 32MB documents at a time by clicking the Attach button. We accept these file types:

- Microsoft Word (.doc, .docx)
- Microsoft Excel (.xls, .xlsx, .csv)
- Adobe PDF (.pdf)
- Images (.gif, .jpg, .jpeg, .png, .tiff)
- Web pages (.json, .xml)

Be sure to include an electronic copy of your Explanation of Benefits (EOB) statement or Explanation of Provider Payment (EPP) as one of your documents. The EOB statement contains a code we use to route your documentation to the correct area for handling. You can find EOBs on Availity's Remittance Viewer. Please allow us a reasonable amount of time to review your documentation and claim.

Documents are uploaded securely, so you don't need to password-protect them.

By uploading information electronically, you no longer need to fax or mail requested information to us.

Claim status transaction

Our claim status transaction allows you to check on the status of submitted claims. You can:

- Use Claim Status Inquiry for single member inquiries
- Review the payment details and any remark codes
- Download the Explanation of Benefits (EOB) for the claim
- Send attachments if the claim is in a pended or finalized status
- Potentially dispute claims

Claim disputes and appeals

For commercial and Medicare claims, submit your electronic appeal, reconsideration, and rework requests by any of the ways below. (Both use the same time frame requirements.)

Provider portal

A claim must be in Finalized status before you can dispute it.

To dispute a claim on our **provider portal**, complete a "Claim Status" transaction and select the claim you want. Select the "Dispute Claim" button to initiate the dispute. Users may receive one of three possible responses:

Initiated: Your claim is eligible for dispute. Go to the Appeals dashboard to complete submitting your dispute. Upload any supporting documentation during this step. Then select "Submit."

Submitted: This is a duplicate request. Go to the Appeals dashboard to search for the dispute and current status.

Not eligible: Due to technical reasons, you may not be able to dispute all claims on the **provider portal**. If that happens, go to the **Disputes and appeals** page on our website to dispute a claim.

Note: *Disputes that remain in an "Initiated" status are not submitted to the payer. Please make sure you're completing the entire dispute process to ensure your dispute is getting to the payer for review.*

Our website

Use the **Dispute and appeals process FAQs** page on our website, **Aetna.com**, to learn about the process and get links to the forms you need.

Rules for electronic submission

You can submit claims electronically using the Health Insurance Portability and Accountability Act (HIPAA) ASC X12N 837 format for professional claims, the ASC X12N 837 format for institutional claims, or a future named successor standard.

We ask that you use electronic real-time, HIPAA-compliant transactions for:

- Authorization (also called precertification)
- Claims Status Inquiry
- Eligibility and Benefits Inquiry
- Referrals

Electronic payment methods

Providers must enroll in order to receive deposit payments by electronic funds transfer (EFT). Providers who do not enroll to receive direct deposit payments may receive virtual credit card (VCC) payments. Visit **Aetna.com** for more information and to access **Availity**, where you can enroll and make changes.

EFT payments allow you to get your payments up to a week faster than waiting for checks to arrive in the mail. This option also allows you to:

- Save paper and manage your business effectively with a convenient audit trail
- Sign up to receive emails when payments have been transmitted to your bank

When you receive EFT payments, we will assign each payment a unique trace number. If you are not enrolled to receive electronic remittance advice (ERA), you can retrieve electronic copies of our Explanation of Benefit (EOB) statements from our provider portal. Use the same trace number to view or download EOB statements.

To enroll in EFT, go to **Payer Enrollment Services**. If you do not enroll in EFT, we may issue future payments as a VCC.

VCC payments work in the same way as processing credit card payments without having the card present. Processing payments is a simple two-step process:

1. First, you will receive an Explanation of Payment (EOP) with a one-time-use 16-digit card number by fax or by mail.
2. Then you can manually enter the number and the full amount of the payment into your credit/debit point of sale (POS) terminal before the card's expiration date.

You will receive your funds in the same time frame as you get other credit card payments today. We do not charge a fee to enroll in or to accept VCC payments. You will just pay your standard merchant fees like any other credit card payment you process through your POS terminal.

You may choose to disenroll from VCC, but you must enroll in EFT first and agree to process any outstanding VCC payments.

To sign up for VCC, send an email to **VirtualCardPaymentProvider@Aetna.com** with your practice name, TIN and contact information. We'll follow up with you.

Note: *Virtual credit cards can't be offered in certain states due to legislation. EFT email notifications are not available for virtual credit card payments.*

Online claims Explanation of Benefits (EOB) statements

Through our provider portal, you can save more paper by:

- Accessing available EOB statements online, 7 days a week, within 24 hours of claims processing
- View, download and save as a PDF, or print EOB statements
- Use the Remittance Viewer tool on our provider portal to get Explanation of Benefits (EOB) statements. You can search for EOB statements using the:
  - Check or electronic finance transaction (EFT) trace number
  - National Provider Identifier (NPI)
  - Payer name
  - Tax ID

Electronic remittance advice (ERA)

When you sign up for ERA, with compatible software, you can post details of your patients' statements automatically. You'll need an ERA **vendor** to get ERA files.

Our ERA transaction provides EOB statement information electronically. This allows you to:

- Automate your posting processes
- Receive separate ERAs for the same tax ID number for all associated billing addresses and National Provider Identifiers (NPIs)

When you receive both ERA and EFT, your trace number will be the same for both your ERA file and your EFT.

Visit **our website** for more information and to access **our portal** — where you can enroll and make changes.

Encounter data

If you're paid on a capitated basis, you need to provide us with member encounter data. To ask for more information on submitting encounters, visit **our website** and select the "Contact us" link.

Working through clearinghouse vendors: transactions by vendor

Learn more about our various **electronic transactions**, connectivity options and web-enabled products on our website. You can also view a listing of our **electronic vendors** and the transactions they support.

Verifying member eligibility

How to interpret a member ID card

There are several types of cards, which differ by member ID number style and copayment information. The information on member ID cards may also vary depending on several factors, like the plan sponsor's benefits selections, state mandates and plan availability.

For certain products, there are no member ID cards. Contact the payer (the claims adjuster, if known) or employer to confirm.

Member identification and verification of eligibility

The following are ways to identify whether a patient is an Aetna plan member.

Digital ID cards

Twenty-four (24) hours after the plan effective date, members can access and view their digital ID cards on their member website, **Aetna.com**, and on the Aetna Health℠ mobile app. Members can easily print replacement ID cards from their Aetna member website. Digital ID cards are identical to plastic ID cards. Providers can also view an electronic version of the member's physical ID card. ID cards allow you to easily see all the information you need and verify the patient's eligibility at the same time. You can view your Aetna patient's ID card right from our **provider portal**.

Member ID cards

Members should receive an ID card within four weeks of enrollment. At each visit, your office can confirm eligibility by any of the methods mentioned here and collect the appropriate copayment, as applicable.

Note: *Some members will have digital ID cards. These members may present their mobile device or a printed copy when getting care.*

Members can access and print some of the information that appears on their ID card via the Instant Eligibility feature on their Aetna member website. This information includes:

- Member ID number
- Member name
- Group number
- Member Services telephone number(s)
- Claims address

Providers can access and print member ID cards from our provider portal. To access the electronic image of the card, the user must first submit an eligibility request for a member. When a successful eligibility response is returned, a tab which contains an image of an ID card will display on the screen. The user can click the image to view a copy of the actual member ID card.

A paper or digital version of the member's information should be accepted in lieu of an actual member ID card.

No ID card? Use the Eligibility and Benefits Inquiry transaction available on our **provider portal**. Enter the patient's full name and date of birth to easily find patient coverage and detailed benefits information. It's accurate and provides greater detail than the ID card.

Group enrollment form or temporary identification

Members may present a copy of a group enrollment form to your office. If they do, you should accept it as a temporary ID. This temporary form is valid for 30 days after the effective date specified on the form.

- Federal Employees Health Benefits Program (FEHBP) members may present to your office:
  - A copy of the Federal Form 2809 Enrollment Form
  - An electronic confirmation of their enrollment from Employee Express or Annuitant Express

When accepting an allowable temporary form of identification, note the following:

- Primary care physicians should check the form to ensure their Aetna primary care office number is designated (if applicable for the plan). If the incorrect doctor or office is listed, claims may be denied, or payments may be misdirected.
- Examine the form to verify the correct copayment.
- Make sure the plan sponsor's signature is present on the bottom of the form.

With the EZenroll® online enrollment option, members may enroll with Aetna online. Members fill out the application online and send it to their employer and then the employer submits it to Aetna. As proof of enrollment, members should present an enrollment validation form printed from their personal printer.

The EZenroll option is not available to Aetna Medicare℠ Plan (HMO) members or in certain states.

Newborn enrollment

This policy applies to most plans, excluding Aetna Medicare Advantage plans.

Members are instructed to contact their human resources department to find out their employer's rule for the time frame to enroll a newborn.

Members are required to list the selected primary care office for the newborn on the newborn's enrollment form.

Note for FEHB: *Under Federal Employees Health Benefits (FEHB) Program guidelines, FEHB members do not need to complete an enrollment form if they are currently enrolled for "family" coverage. They should call Member Services to add additional members to a family contract.*

It may take several weeks to process the newborn's member ID card once the newborn is enrolled. In the meantime, use the parent's member ID card. If the newborn does not receive their own member ID card after the appropriate time frame, check for a digital ID card using **Availity**. You can also contact our Provider Contact Center with the number on the subscriber's ID card. If the subscriber does not enroll the child as a dependent within the appropriate time frame, the subscriber must wait until their next open enrollment period to enroll the child. The child will not be eligible for coverage in the interim. Contact Member Services for additional information on newborn enrollment.

Note for primary care physicians: *If your office provided routine newborn hospital care, submit your bill electronically to us. If a referral is necessary for a newborn not yet appearing on the primary office member list, use the parent's member ID number.*

Verifying benefits

Our Eligibility and Benefits Inquiry Transaction tool on our **provider portal** enables you to request patient eligibility status quickly and easily. It can help you verify member eligibility and demographics and find detailed financial information, including deductible, copayment and coinsurance for individual and family plans. Please refer to the **Eligibility and benefits inquiry** section of this manual for more information.

Emergencies

State regulations and contractual provisions regarding emergency admissions may, in some cases, overrule the procedures described in this manual.

Medical emergencies

If an Aetna member requires emergency care, they're covered 24 hours a day, 7 days a week, anywhere in the world. In the event of a medical emergency, regardless of whether they are in or out of an Aetna service area, we advise our members to follow the guidelines below when accessing emergency care:

- Call 911 or go to the nearest emergency facility. If a delay would not be detrimental to the patient's health, call the primary care physician.
- After assessing and stabilizing the patient's condition, the emergency facility should contact the primary care physician so they can assist the treating physician by supplying information about the patient's medical history.
- If the member is admitted to an inpatient facility, the patient, a family member or friend acting on behalf of the patient should notify the primary care physician or Aetna as soon as possible.
- All follow-up care should be coordinated by the primary care physician, where applicable (medical only).

An "emergency medical condition" involves acute symptoms that are severe enough that someone with an average knowledge of health could expect that the absence of medical attention would result in serious harm. For pregnant women, the health of both the woman and her unborn child must be taken into consideration. State mandates may apply.

Depending on the benefits plan, members traveling outside their service area or students who are away at school are covered for emergency and urgently needed care.

Claims submitted to us by the provider that supplied care must appear to meet the standards for emergency or urgent care. Otherwise, we may need to review the records from the emergency visit. In this situation we will send a request to the treating facility for the records of the visit and notify the member of the request. If the member wishes, they may provide us with additional information regarding the circumstances of the visit.

Follow-up care after emergencies

The primary care physician should coordinate all follow-up care. In all cases, the primary care physician must record all information regarding the emergency visit in the patient's chart. We require precertification before we cover any out-of-network follow-up care, either inside or outside the Aetna service area. You can obtain precertification electronically or by calling the number on your patient's member ID card. Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.

Claims and billing

Member billing

Billing members for non-covered services — consent requirements

All our member plans include certain exclusions. Common exclusions include services that are considered experimental and/or investigational (see **Medical Clinical Policy Bulletins** for examples). Of course, services that are not medically necessary are also generally excluded.

It's very important that our members have a clear understanding of their financial responsibilities before they accept services their plan does not cover. For this reason, we look to you to inform them if their plan does not cover those services. If you're uncertain whether a service is covered, call us before providing the service.

If you intend to provide a noncovered service to one of our members, we require that you do both of the following prior to providing the service:

- Notify the member that their insurance will not cover the service. To avoid misunderstandings, we strongly recommend you provide this notification in writing at each specific occurrence of a noncovered service. A general financial responsibility form is not sufficient.
- Obtain the member's signature to a written consent statement that says they:
  - Understand the service is not covered by their insurance
  - Agree to be financially responsible for the cost of the service

It's important that you retain this signed consent statement. In the event of a dispute, we may hold you financially responsible if you can't produce it.

Billing and balance billing members

You may bill or charge our members applicable copayments, coinsurance and/or deductibles. Your provider contract addresses the circumstances under which you can bill our members.

However, we want to protect our members from unnecessary or inappropriate billing. Therefore, you may not bill or balance bill members in situations including but not limited to the following:

- Claims are denied for administrative reasons such as lack of referral or authorization when one was required.
- There is a dispute or payment delay involving a payer (for example, a self-funded plan sponsor). If there is an issue with a payer, we require that you contact our Provider Services, advise them of the situation and consult if they can provide guidance on the best way to move forward.

If member is incorrectly billed, balance billed or overcharged, we ask you to remedy the situation, and if necessary, promptly refund the member. We may terminate you as a network provider if you incorrectly balance bill our members.

Other billing situations

Billing a member who has exhausted their benefits

When a member has exhausted their benefits, you cannot charge them more than the contracted rate if you continue to see them. For example, if a plan covers 10 visits but you provide 12.

In this situation, you cannot bill the member more than the contracted rate for the two extra visits. And as noted above, you are also required to:

- Notify the member that their insurance does not cover the two extra visits
- Obtain the member's prior written consent to pay for the two extra visits

Billing a member for services we denied

We may adjust or deny payment for covered services upon utilization management (UM) review. You cannot bill a member for a service that we denied as a result of our UM review. If your bill for a covered service is adjusted because of a UM or bill review, you cannot balance bill the member for the amount that we do not pay.

An example of this would be if a member is approved to stay in a hospital for eight days but the hospital does not release them for 10 days. In this situation:

- We will not cover the two extra days
- The hospital cannot bill the member for the two extra days

Billing members who were not with us when services were provided

You may bill or charge individuals who were not our members at the time that you provided services.

Initiating a collection action against a payer

We require that you provide written notice before you initiate any collection action against a payer (for example, a self-funded plan sponsor). We require that this notice:

- Be given to us and to the payer
- Be given at least 30 days in advance of the collection action

Concierge medicine

Concierge care means that a provider charges a membership or other fee for a patient to access services or amenities.

We do not cover membership or administrative fees for concierge care, and we discourage the provision of concierge care services by participating providers.

You may charge concierge fees to our members under the limited circumstances described in the next paragraph. However, participating providers may not charge concierge fees for a plan member to access covered services and/or standard administrative services. In other words, you can't charge a member a fee to join or remain in your practice. You also can't charge a separate concierge fee for any standard administrative services, such as prescription orders or renewals, referrals, medical record maintenance, or returning phone calls.

While discouraged, you may charge reasonable concierge fees for a member to access other amenities, such as a fee in return for preference in scheduling appointments. You can't ever discriminate against our members in concierge pricing, and you can't bill our members more than you bill any other members for concierge services.

Of course, all concierge fees must comply with all applicable state and federal laws and regulations, and you may never bill the member's plan for concierge fees.

If your practice is going to charge concierge fees, you must inform your Aetna network manager in advance. We reserve the right to indicate whether a provider practices concierge care in our provider search tool and other materials.

Note: *Concierge fees are prohibited for Aetna Medicare Advantage members.*

Claims information

Go to **Aetna.com/health-care-professionals/claims-payment-reimbursement** to find all our claims, payment and reimbursement tools and guidelines.

Electronic claims submission

Submit all claims electronically for your patients, regardless of their benefits plans.

- If you are already using a vendor, add Aetna to your list of payers.
- Visit **Aetna.com/health-care-professionals/claims-payment-reimbursement/electronic-transaction-vendors** to view a list of our participating claims vendors.
- If you don't already have an electronic claims vendor, send professional and institutional claims free of charge from our **provider portal**.

Unsolicited claim attachments

We typically do not need attachments. If we do, we'll let you know what we need. Then you can submit your supporting documentation electronically through our provider portal. You can also submit attachments through selected claims vendors.

View our **list of participating vendors** to see which allow electronic attachments through the claims attachment transaction (X12N 275).

Solicited claim attachments

The Solicited Health Care Request For Additional Information (277RFAI) transaction enables Aetna to send a request for additional information for a claim quickly and securely. View our **list of participating vendors** to see which support this transaction.

Claims submission tips

To ensure accurate and timely claims payment:

- Review rejection reports from your vendor
- Correct and resubmit rejected claims electronically through your vendor
- Ensure the member and patient names and ID numbers are correct
- Ensure procedure and diagnosis codes are valid

Claims addresses

If your practice management or hospital information system requires a claims address for submission of electronic claims, or if your office does not have electronic capabilities, refer to the table below for the claims address for your state.

Medical provider location by state	Claims mailing address
AL, AK, AR, AZ, CA, FL, GA, HI, ID, LA, MS, NC, NM, NV, OR, SC, TN, UT, and WA	Aetna PO Box 14079 Lexington, KY 40512-4079
CO, CT, DC, DE, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MT, ND, NE, NH, NJ, NY, OH, OK, PA, RI, SD, TX, VA, VT, WI, WV and WY	Aetna PO Box 981106 El Paso, TX 79998-1106

For all **Aetna Medicare Advantage and Aetna Student Health℠ plans**, use the El Paso, TX, claims mailing address.

For all **Aetna Voluntary Plans**, use the Lexington, KY, claims mailing address and the payer ID "57604."

For **Aetna Signature Administrators® plans, Meritain Health® and Schaller Anderson (Medicaid)**, refer to the member ID card.

Clean claims

We know it's important to you that your office gets paid promptly. To reduce payment delays, have your office submit "clean claims." A clean claim is a claim that is received in a timely manner and includes all the information we need to process it for payment.

Unless otherwise required by law or regulation, clean claims include all of the following:

- Detailed and descriptive medical and patient data
- A corresponding referral (whether in paper or electronic format), if required for the applicable claim
- All the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to member identification number, National Provider Identifier (NPI), date(s) of service, and a complete and accurate breakdown of services)

In addition, a clean claim:

- Doesn't involve coordination of benefits
- Has no defect or error — such as any new procedure without a Current Procedural Terminology (CPT®) code, experimental procedures or other circumstances not contemplated at the time of execution of your agreement — that prevents timely adjudication

Coordination of benefits

Coordination of benefits (COB) establishes the order in which benefits are paid and the amount by which the secondary plan may reduce its benefits. COB ensures that the combined payments of all plans do not add up to more than the covered health care expenses.

We coordinate benefits as allowed by state or federal law following the National Associations of Insurance Commissioners (NAIC) guidelines. If there is no applicable law, then we coordinate according to the member's plan.

We use two different methods to calculate COB:

- 100% Allowable (Standard Allowable Calculation)
  - This is the method used under most state laws.
  - The benefits paid by both plans will equal no more than the total allowable expense.
    - An allowable expense is defined as any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom the claim is made.
- Maintenance of Benefits (MOB)
  - This is a method used by many self-funded plans.
  - Under MOB, a secondary plan may reduce its benefits to the lesser of the following two calculations:
    - What it would have paid had it been the primary plan
    - What it would have paid minus the primary plan's payment

If the primary plan benefit is:	Then:
Equal to or more than the Aetna benefit	Aetna will not pay a benefit
Less than the Aetna benefit	Aetna will pay the difference between the primary plan's benefit and the Aetna benefit

Coordination of benefits with commercial carriers

We follow the National Association of Insurance Commissioners (NAIC) Order of Benefits Determination (OBD) rules to determine which plan pays primary.

Refer to Section 6 **"Rules for Coordination of Benefits" in the NAIC Coordination of Benefits Model Regulation document** for OBD rules.

Below are examples of the most common rules:

- COB Rule vs. No COB Rule
- Non-Dependent/Dependent Rule
- Dependent on Spouse's Plan and Dependent on Parent's Plan(s) Rule
- Dependent Child/Parents Not Separated or Divorced Rule (Birthday Rule)
- Dependent Child/Parents Separated/Divorced/Not Living Together Rule
- Active/Inactive Employee Rule
- Continuation Rule (also known as COBRA)
- Longer/Shorter Rule

Coordination of benefits with Medicare

When a member has Medicare in addition to an Aetna group policy, we follow the Center for Medicare & Medicaid Services (CMS) guidelines to determine if Aetna or Medicare pays primary. Affordable Care Act individual insurance plans coordinate with Medicare coverage only. If the member is eligible for and elects Medicare coverage, then Medicare will always be primary. Learn more about **How Medicare works with other insurance** and how coverage is affected because of **end-stage renal disease (ESRD)**.

Below are examples of the most common rules:

Aetna coverage type	Medicare due to disability (under age 65)	Medicare due to age (65 and over)
Active policy (active employment)	Aetna policy has 100 or more employees Aetna primary Medicare secondary	Aetna policy has 20 or more employees Aetna primary Medicare secondary
Active policy (active employment)	Aetna policy has 99 or fewer employees Medicare primary Aetna secondary	Aetna policy has 19 or fewer employees Medicare primary Aetna secondary
Inactive policy (retiree, disabled, COBRA)	Medicare primary Aetna secondary	Medicare primary Aetna secondary

Medicare is the secondary payer to group health plans (GHPs) for individuals entitled to Medicare based on ESRD for a coordination period of 30 months, regardless of the number of employees and whether the coverage is based on current employment status.

Aetna coverage type	Medicare due to end stage renal disease (ESRD)
Active policy (active employment)	Aetna policy primary for coordination period Medicare primary after coordination period
Inactive policy (retiree, disabled, COBRA)	Aetna policy primary for coordination period Medicare primary after coordination period

Coordination of benefits with automobile insurance/no-fault benefits

We coordinate benefits with personal injury protection (PIP) as allowed by state or federal law following the National Association of Insurance Commissioners (NAIC) guidelines. If there is no applicable law, then we coordinate according to the member's plan. Our standard fully insured plans prohibit COB with no-fault automobile insurance. We do not coordinate with no-fault auto insurance:

- When state law prohibits COB with no-fault
- When states don't have a no-fault law

Self-funded plans follow the COB provision in the plan sponsor contract.

The National Advantage™ Program

The **National Advantage Program (NAP)** provides medical cost management on covered services that are not provided within the network.

If member's plan includes the NAP, Aetna may apply the commercial product rates. Not all member ID cards for plans that participate in NAP include its logo.

Coding and claim edit policies

As changes to coding are published by nationally recognized coding entities, we will update our internal systems and practices, as appropriate. Updates may include assignment/reassignment of codes to service groupings and/or other updates that are consistent with Aetna policies and applicable law. Until any updates are complete, services may be subject to the standards and coding set for the prior period. The rates and compensation under your agreement are subject to the Aetna coding/claim edit policies (e.g., diagnosis-related group (DRG) assignment), which may be updated from time to time, and which may consider actual services performed and the setting in which they are provided.

Claims payment policy — rebundling

We rebundle claims to the primary procedure codes for those services considered part of, incidental to, or inclusive of the primary procedure. Rebundling allows for other adjustments such as inappropriate billing or coding. Examples of these include:

- Duplicative procedures or claim submissions
- Mutually exclusive procedures
- Gender and procedure mismatches
- Age and procedure mismatches

The commercial software packages that we use include rebundling logic. This logic is based on Medicare and/or other industry standards.

Overpayment

When Aetna, payer and/or member has been overcharged, you are obligated to promptly reprocess the claim. For commercial plans, company will notify the provider of overpayment typically within 24 months of the original payment issue date or other time frame required by applicable law.

For Medicare plans, overpayment notifications are typically sent within 36 months of the payment issue date.

Both commercial and Medicare time frames are subject to change in order to comply with regulatory or legislative requirements.

Diagnosis-related group (DRG)

A diagnosis-related group (DRG) is the most widely used strategy for classifying acute care hospital patients and measuring the case mix. The most common principal diagnosis is the condition primarily responsible for the admission of the patient to the hospital for care.

Our payment policies are designed to help us pay providers based on the code that most accurately describes the procedures/services that were performed.

A DRG interim bill

An interim bill (also known as a split bill) allows a hospital to submit a claim for a portion of the patient's hospital stay.

We will reimburse the first interim bill from a facility with a DRG payment methodology, based on the admitting information, and will reimburse the balance when we receive the final bill.

DRG review

Claims billed with a DRG may be reviewed on a pre-pay or post-pay basis through a medical record review process. In this case, once the medical record review process is complete, a narrative and proposed DRG revision is sent to the provider, at which point we have opportunities to address disagreements. A DRG short-stay review is a post-service, post-payment review of Medicare risk inpatient claims paid under a DRG methodology. This review is done to validate that the provider appropriately billed and received payment for the setting of care in which the patient was treated.

Disagree with a claim decision?

Initiate a claim dispute by using any of the following ways:

- **Online -** If you are registered for our provider portal, run the Claim Status Inquiry transaction. If the claim is eligible to dispute, you'll see a Dispute Claim button. (Read more about how dispute a claim online in the **Claim disputes and appeals section of this manual**).
- **Mail -** Write to the PO box that's listed on the EOB statement or the denial letter related to the issue being disputed. In your letter, include the reasons for the disagreement.
- **Phone -** Call our Provider Contact Center (see **Key contacts** section).

Go to **Aetna.com/health-care-professionals/disputes-appeals** for more information.

Clinical management — clinical policy bulletins and more

Aetna clinical policy bulletins

Aetna clinical policy bulletins (CPBs) are internally developed policies that we use as a guide for determining health care coverage for our members. Our CPBs are written on selected clinical issues, especially addressing new medical technologies such as devices, drugs, procedures, and techniques. CPBs apply to all Aetna medical benefit plans and are used in conjunction with the terms of the member's benefit plan and other Aetna-recognized criteria to determine health care coverage for our members. Our benefit plans generally exclude from coverage medical technologies that are considered experimental and investigational, cosmetic and/or not medically necessary.

CPBs are continually reviewed and updated to reflect current information.

We review new medical technologies and new technology applications regularly. We determine whether and how such technologies will be considered medically necessary and/or not experimental/investigational under our benefits plans.

Our process of assessing technologies begins with a complete review of the peer-reviewed medical literature and other recognized references concerning the safety and effectiveness of the technology. This evaluation involves analyzing the results of studies published in peer-reviewed medical journals.

We consider the position statements and clinical practice guidelines of medical associations and government agencies, including the Agency for Healthcare Research and Quality (AHRQ). When applicable, we consider the regulatory status of a drug or device, including:

- Review by the U.S. Food and Drug Administration (FDA)
- Centers for Medicare & Medicaid Services (CMS) coverage policies

We develop our CPBs from a review of relevant information regarding a particular technology. CPBs are published on our website for public reference.

Medical necessity and medically necessary

Under most plans, the term "medically necessary" and "medical necessity" refer to health care services that a physician provides to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms.

These services adhere to the following generally accepted standards of medical practice:

- They are clinically appropriate in terms of type, frequency, extent, site, place of service and duration, and considered effective for your illness, injury or disease.
- They are not primarily for the convenience of the patient, physician or other health care provider.
- They are not more costly than an alternative or sequence of services that are at least as likely to produce equivalent results.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. These standards are generally recognized by the relevant medical community or otherwise consistent with the standards above.

Note: *Each state may have its own definition of "medically necessary" or "medical necessity." You may be required to adhere to those standards imposed by the state's definition based on the state you practice in.*

Clinical practice and preventive service guidelines

Evidence-based clinical practice and preventive services guidelines from nationally recognized sources promote consistent application of evidence-based treatment methodologies. This helps to provide the right care at the right time. For this reason, we make these guidelines available to our network providers to help improve health care.

These guidelines are provided for informational purposes only. They aren't meant to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines don't dictate or control a provider's clinical judgment regarding the appropriate treatment of a patient in any given case.

Evidence-based guidelines can be found on various nationally recognized sources. Here are links to some of those sources.

Clinical practice guidelines

- **American College of Cardiology Guidelines**
- **American Diabetes Association (ADA): Standards of Medical Care in Diabetes**
- **Centers for Disease Control and Prevention Opioid Prescribing Guideline**

Please see the Behavioral Health section at the end of this manual for behavioral health-specific clinical practice guidelines.

Preventive services guidelines

- **Centers for Disease Control and Prevention Immunization Schedules**
- **U.S. Preventive Services Task Force**
- **Health Resources and Services Administration (HRSA) Women's Preventive Services Guidelines**

Case management

According to the Case Management Society of America's website:

> **Case management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The case manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the client and the reimbursement source. Case management services are best offered in a climate that allows direct communication between the case manager, the client, and appropriate service personnel, in order to optimize the outcome for all concerned.***

Case management is a standard component of most Aetna medical plans. The basis of the case management program is evidence-based medical literature and clinical practice guidelines. There are both automated and manual processes to identify members for case management through a variety of methods.

Case managers coordinate care and services for complex, standard and low-risk case management members who require the extensive use of resources as a result of a critical event or diagnosis. Case managers assist these members with navigating the health care system in order to facilitate the appropriate delivery of care and services.

*FOR CASE MANAGEMENT QUOTE SOURCE: Case Management Society of America. What is a Case Manager? 2022. Available at: **CMSA.org/who-we-are/what-is-a-case-manager/**. Accessed January 7, 2025.

Case management screening occurs before member outreach in order to determine member eligibility and the appropriateness of case management services. We welcome referrals from treating physicians to our case management program. You can submit a referral through the toll-free phone number on the member ID card.

Once we determine the level of case management needed and the member or caregiver agrees, we make an individualized plan that's specific to the member's situation and needs.

Clinical care management staff, in coordination with the attending practitioner, member, or the member's representative, develop an individualized case management plan based upon an assessment of the member's situation and needs. The case management plan includes:

- Documentation of prioritized goals, which are specific, measurable, time-bound and reflective of issues identified in the member assessment
- The supporting rationale for each selected goal

Clinical care management staff review, monitor and evaluate progress against case management plans and goals, and makes adjustments as needed for each member active in case management. Case closure occurs once there is resolution of all member issues and barriers and/or the member meets case closure criteria.

Utilization management

Overview

Our care management model integrates available programs and services. This includes utilization management, case management, disease management, and specialty programs such as behavioral health. Our role is to help coordinate health care and to encourage members to be informed participants in health care decision-making.

Our activities for hospitalized members include:

- Focused discharge planning to help with the member's transition to the next level of care
- Targeted, concurrent review of the member's hospital course of treatment to evaluate the appropriate level of coverage for medical services

Note: *For these purposes, coverage means either of the following:*

- *The determination of whether or not the particular service or treatment is a covered benefit pursuant to the terms of the particular member's benefits plan*
- *The determination of where a provider is required to comply with our utilization management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement*

Utilization management and standards

We use utilization review to promote adherence to accepted medical treatment standards. Additionally, utilization review encourages participating physicians to minimize unnecessary medical costs consistent with sound medical judgment. We require participating providers to adhere to the following requirements:

- Participate, as requested, and collaborate with Aetna utilization review, care management and quality improvement programs and with all other related programs (as modified from time to time) and decisions with respect to all members.
- Regularly interact and cooperate with Aetna clinicians.
- Adhere to Aetna **participation criteria** and processes, including site visits and medical chart reviews, and submit to these processes when applicable.
- Cooperate to help us review and transition members hospitalized in a nonparticipating facility to a participating facility.
- Obtain advance authorization from Aetna prior to any nonemergency admission. In addition, when a member requires an emergency hospital admission, notify us, according to our rules, policies and procedures in effect.
- To the extent medically appropriate and required by the plan's terms, refer or admit members only to participating providers for covered services. Provide complete information on treatment procedures and diagnostic tests performed prior to the referral or admission.
- Abide by CMS's Medicare Outpatient Observation Notice (MOON) requirement provided to members and related to observation services.

You may have an Aetna patient who requires services under an Aetna specialty program. If so, we expect you to work with us to transfer the member's care to a specialty program provider.

Utilization review policies

Summaries of utilization review policies, including precertification, concurrent review, discharge planning and retrospective review are located on our public website to determine:

- Whether or not the particular service or treatment is a covered benefit under the member's benefits plan
- When a provider is required to comply with Aetna utilization management programs
- Whether or not the particular service or treatment is payable under the terms of the provider agreement

How we determine coverage

Coverage determinations staff and guidelines

Aetna medical directors make all coverage denial decisions that involve clinical issues. Only Aetna medical directors and licensed dentists, oral and maxillofacial surgeons, psychiatrists, psychologists, board-certified behavior analysts-doctoral (BCBA-D) and pharmacists make denial decisions for reasons related to medical necessity. (Licensed dentists, pharmacists and psychologists review coverage requests as permitted by state regulations.) Where state law mandates, utilization review coverage denials are made, as applicable, by a physician or pharmacist licensed to practice in that state.

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

- State-mandated use of particular criteria and guidelines
- MCG Care Guidelines (Seattle, WA: MCG Health, LLC)
- Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)
  - This is used in place of The American Society of Addiction Medicine (ASAM) for chemical dependency treatment provided in New York
- Clinical Policy Bulletins (CPBs), Pharmacy Clinical Criteria, and Medicare Part B UM Drug Coverage Criteria as appropriate
- Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and the Medicare Benefit Policy Manual
- National Comprehensive Cancer Network (NCCN) Guidelines
- Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care/Service Intensity Utilization System and Child and Adolescent Service Intensity Instrument (CALOCUS-CASII)
- Aetna's Applied Behavior Analysis (ABA) Medical Necessity Guide
- Custodial Care Guidelines
- The American Society of Addiction Medicine (ASAM) Criteria: Treatment for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition. This content is copyrighted. Contact the American Society of Addiction Medicine at **ASAMcriteria@asam.org** for information on how to purchase it.

Participating physicians may ask for a hard copy of the criteria that were used to make a determination by contacting our Provider Contact Center at **1-888-632-3862 (TTY: 711)**.

Peer-to peer-review

We base decisions on the appropriateness of care and service. We review coverage requests to determine if the requested service is a covered benefit under the terms of the member's plan and is being delivered consistent with established guidelines.

Aetna offers providers an opportunity to present additional information and discuss their cases with a peer-to-peer reviewer as part of the utilization review coverage determination process. The timing of the review incorporates state, federal, CMS and NCQA requirements. If we deny a request for coverage, the member (representative, which may include an attorney or a physician acting on the member's behalf) may appeal this decision through the **Complaint and appeal process**. Depending on the specific circumstances and member's benefit plan, the appeal may be made, as applicable to:

- A government agency
- The plan sponsor
- An external utilization review organization that uses independent physician reviewers

We do not reward physicians or other individuals who conduct utilization reviews for issuing denials of coverage or for creating barriers to care or service. Financial incentives for utilization management decision-makers do not encourage denials of coverage or service. Rather, we encourage the delivery of appropriate health care services. In addition, we train utilization review staff to focus on the risks of underutilization and overutilization of

services. We do not encourage utilization-related decisions that result in underutilization.

How to contact us about utilization management issues

You may call us during and after business hours via toll-free phone numbers.

Health care providers may contact us during normal business hours (8 AM to 5 PM, Monday through Friday) by calling the toll-free precertification number on the member ID card. When only a Member Services number is on the card, you'll be directed to the Precertification Unit through a phone prompt or a Member Services representative.

Our staff, including medical directors, are also available after hours, on weekends and on company holidays to assist with provider and member inquiries regarding utilization management issues via the toll-free numbers.

Note: *For all continental U.S. time zones; hours of operation may differ based on state regulations. Texas: 6 AM to 6 PM CT, Monday through Friday, and 9 AM to noon CT on weekends and legal holidays. (For all other times, phone recording systems are used.)*

Precertification

Precertification is the process of collecting information before inpatient admissions and certain ambulatory procedures and services. Precertification applies to:

- Procedures and services on the Aetna Participating Provider Precertification List
- Procedures and services on the Aetna Behavioral Health Precertification List
- Procedures and services that require precertification under the terms of a member's plan
- Any organization determination requested by a Medicare Advantage member, appointed representative or physician for a coverage decision

The Centers for Medicaid and Medicare Services (CMS) defines an appointed representative ("representative") as an individual appointed by an enrollee or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in the grievance or appeal. Unless otherwise stated, the representative will have all of the rights and responsibilities of an enrollee or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the grievance or appeals process, subject to the applicable rules described in 42 CFR 422 Subpart M. To meet the CMS definition of appointed representative, the member and the member's appointed representative must both sign and date a representative form.

Note: *The term "precertification" (used here and throughout the office manual) refers to the utilization review process used to determine if a requested service, procedure, prescription drug or medical device meets our clinical criteria for coverage. It does not mean precertification as defined by Texas law. Texas law defines precertification as a reliable representation of payment of care or services to fully insured health maintenance organization (HMO) and preferred provider organization (PPO) members.*

Precertification process

Precertification is the process of determining the eligibility for coverage of the proposed level of care and place of service. The process includes:

- Confirmation of member eligibility
- Assessment of medical necessity
- Communicating a coverage decision to the treating practitioner and/or member before the procedure, service or supply
- Identifying members for pre-service discharge planning
- Identifying and registering members for covered Aetna specialty programs, such as case management and disease management, behavioral health, the National Medical Excellence Program and the Aetna Women's Health Program

If we need to review the applicable medical records, we may provide you with, and you need to agree to accept, a precertification reference pending or tracking number. The reference number is not an approval. You will be notified once a coverage decision is made.

Use our online tools to help you determine if precertification is required for a particular procedure. Then, submit precertification requests for those services.

- Precertification Code Search tool — allows you to enter up to five CPT codes at a time to determine whether a medical precertification is required for your patient.
- Online Precertification transaction — allows you to add a precertification request for those services that require it and inquire to see if a precertification has been approved.

You can submit a precertification by electronic data interchange (EDI), through our **provider portal** or by phone, using the number on the member's ID card. Based on historical experience, we may sometimes allow particular providers to follow a streamlined precertification process for certain services.

You may also submit unsolicited medical records using one of our participating vendors through an electronic attachments transaction (X12N 275). View our list of **participating precertification vendors that accept unsolicited attachments for precertification**.

Visit our website to learn more about **precertification** and check out our **precertification lists**.

Note: *Precertification may be the member's responsibility in certain plan types that offer out-of-network benefits. Per Medicare laws, rules and regulations, there is no penalty to Medicare Advantage plan members if they do not get precertification.*

Admissions protocol

The admitting physician must electronically submit or contact us for preadmission authorization. Our precertification staff can take authorization requests directly from hospital admissions personnel. Members can begin the precertification process with Aetna independently. However, if the preadmission information isn't complete, we contact the admitting physician for clarification. If the admission is precertified for surgical cases, we assign a recommended length of stay (RLOS).

This determines when a review will start. For other cases, we give specific guidelines with the admission precertification. The RLOS determination is primarily based on MCG Care Guidelines.

Notice for emergency and other inpatient admissions

We need to be notified of all inpatient admissions, including those through the emergency department, within two business days of the admission. If a patient is unable to provide coverage information, you must contact us as soon as you become aware of their Aetna coverage. You must also explain any extenuating situation at the time of your notification.

You may contact us by phone (call the number on the patient's member ID card) or through electronic data interchange (EDI) through our **provider portal**. Certain admission exclusions may apply. The timely Notification Policy and all Aetna payment policies can be found on **Availity**; or you can call the Provider Contact Center. To sign up for Availity, follow instructions on **Aetna.com**.

Audits

Hospital bill audit

The purpose of a hospital bill audit is to review the itemized bill against the claim and the medical record. This audit is used on claims where we pay a percentage of billed dollars (charges). In addition, the audits identify items that may not have been ordered by the physician or were not supported in the medical record.

The audits exclude outpatient hospital claims paying a percentage of billed dollars (charges).

Outpatient validation audit

Outpatient coding audits are performed by clinical coders and verify the code assignment and reimbursement using medical records. The results are based on the medical record review, audit overpayment findings and recovery of those dollars.

Implant audit

Implant audits ensure providers are complying with the contract cost limitation language on implants and high-cost drug reimbursement. This audit focuses on claims that bill with revenue codes 274–279. Implant audits may occur before or after payment. Implant audits occur through review of implant log/invoice and Medication Administration Record. A detailed narrative is sent to the provider with the audit findings.

Prepayment review audit

As allowed by law, we may review our members' medical records before certain claims are processed. This review includes, but is not limited to, itemized bills or more specific detail for claims contracted on a percentage-of-charges basis. The review may result in payment being denied for duplicate charges, errors in billing or categorization of capital equipment. The itemized bill review may also occur on a post-payment basis.

OrthoNet

We use OrthoNet to review our members' medical records before certain claims are processed. When a claim is selected for review, we'll ask the provider for copies of the patient's medical records. OrthoNet will compare the claims coding to the services provided.

Affected specialties:

- Dermatology
- Ear, nose and throat (otolaryngology)
- Hand surgery
- Neurology
- Neurosurgery
- Orthopedic surgery
- Pain management
- Physiatry
- Plastic surgery
- Podiatry
- Sports medicine
- Urology

Where to send us records

If your office is asked to send records to Aetna, use any of the ways below to do so.

- Fax: **859-455-8650**
- Mail: Aetna, PO Box 14079, Lexington, KY 40512-4079

When faxing or mailing records, be sure to include a cover sheet with "**CODE: ONET**" at the top of the page.

We'll also need the following information:

- Aetna member ID
- Date of service
- Servicing provider name
- Servicing provider tax identification number and/or the Aetna provider ID number

Referrals

Referral Policies

Referrals may be authorized for consultation and treatment (C&T) using CPT code "99499." In most areas, C&T referrals do not need to specify the procedures to be performed by the specialist. Specialists will be reimbursed for any associated covered procedure performed in an office setting, in accordance with current claims processing guidelines. In benefits plans that require the issuance of referrals for specialist care, the primary care provider (PCP) is responsible for coordinating their patients' health care.

If it's necessary for the patient to see a specialist, other than for direct-access services or emergency care, the PCP must issue a referral prior to the patient's visit to the specialist. The referral must be for covered benefits under the plan. To confirm covered benefits, you can submit an inquiry through the Eligibility and Benefits Inquiry transaction or call the number on your patient's member ID card. Referrals should not be retroactive. We may adjust or deny payment for retroactive referrals. If your patient visits a specialist without a referral, depending on their plan type, the patient may be responsible for payment for all services rendered or for paying a deductible and coinsurance.

Note: *Referrals in Texas are only valid for thirty (30) calendar days. After that time frame, the provider must provide a new referral.*

Referral requirements

In addition to the requirement that PCPs review every referral issued by their practice, we recommend that the initial consultative referral be authorized for one visit, except when the patient is either known to have a predicted need for more visits or involved in an ongoing process of care. This encourages communication from the specialist to the PCP. After an initial consultation, additional referrals from the PCP are required if the specialist:

- Wishes to provide additional services not originally requested on the referral
- Refers their patient to a second specialist
- Requires visits that will exceed the number of visits initially authorized by the PCP
- Will need an extension beyond the referral expiration date

We require specialists to communicate with the referring provider in a timely fashion. After receiving the consultation report from the specialist, the PCP can consider the appropriate course of treatment (for example, referrals for additional services and/or follow-up care, if needed). Referrals do not permit specialists to refer members to another specialist for care. If this is necessary, patients must get a referral from their PCP to see another specialist. This referral is not a guarantee of payment. Payment is subject to eligibility on the date of service, plan benefits, limitations and exclusions, pre-existing condition limitations, and patient liability under the plan.

When referrals are not required

Some plans do not require the issuance of a referral. In those plans, a patient may self-refer to either participating or nonparticipating providers. The patient is responsible for paying any applicable copayment, deductible and/or coinsurance for self-referred benefits. See the **Utilization management** section of this manual for rules

regarding prior authorization for certain services. In Aetna Open Access® plans, referrals also are not necessary. A patient may self-refer to any participating provider.

No plans require a referral for emergency services.

Ownership interest in referred providers

You must notify Aetna in writing any time you obtain a financial ownership interest in a provider that may be utilized for referrals or treatment of Aetna members. This notification must be completed within thirty (30) days of the acquisition of the ownership interest and include the name, address, and TIN of the provider.

We may terminate our agreement if you refer members to nonparticipating providers without one of the following:

- Sound clinical reasons
- Our advance approval
- Emergency services
- The member's request for referral to a nonparticipating provider after notice and informed consent of the patient has been documented in writing

Member's consent for nonparticipating provider referrals

In the event you refer a member to a nonparticipating provider, in accordance with Company policies and the member's plan, you must acquire the member's written consent. This consent must be obtained at the time the referral is made and, unless an emergency exists, be done in advance of the date of scheduled procedure, or appointment with the nonparticipating provider. The obligation to obtain this consent cannot be delegated to the nonparticipating provider or facility.

Note: *For plans that are subject to state laws of Maryland, Virginia and the District of Columbia, the member should be directed to their PCP for referrals for laboratory and radiology services.*

The consent should state that the member has been advised of the following:

- If the hospital, facility, or provider is not a participating provider
- If the member's plan may provide reduced benefits
- If the nonparticipating provider will not be restricted to seeking payment only from Aetna
- If the provider may bill the member for amounts other than deductibles, copayments, coinsurance and medical services not covered under the plan
- Any affiliation or financial ownership interest you may have in or with the nonparticipating provider
- Such consent must include an approximate amount that will be charged by the nonparticipating provider and advise the patient of his or her personal financial responsibility.

Referral processes

Electronic referrals should be issued for all plans that require referrals (see the **Aetna Benefits Products Booklet**). For information on submitting electronic referrals, see the **Electronic Solutions** section of this Provider Manual. For obstetric testing or infertility services, refer to the **Women's Health Program page** on our website.

Note: *Providers who participate with us through an independent practice association (IPA) or physician hospital organization (PHO) should consult their IPA or PHO on plan policies and procedures. Some of these referral guidelines may not apply. (Providers and other health care professionals in upstate New York should continue to work with Aetna and/or their respective IPA in their usual manner.)*

Providers who provide telehealth services on a hybrid or virtual-only basis should refer to the **Participation Criteria** *for additional referral criteria.*

Coordination of care

Importance of collaboration

We monitor and try to improve coordination and collaboration between treating providers of care. Results from our annual Physician Practice surveys have shown that physicians continue to be concerned that they do not regularly receive reports about their patients' ongoing evaluation and care from other practitioners and facilities. These include medical specialists, behavioral health practitioners, skilled nursing facilities, home health agencies, surgical centers or hospitals. The increased focus on patient safety in the medical community also highlights the critical nature of improving collaboration between treatment providers.

Sharing patient information

Increased treatment compliance and improved outcomes have been attributed, in part, to collaboration between providers.* In addition, the quality of communication is rated as an important factor considered by primary care physicians when choosing a specialist to whom they can refer their patients.*

To this end, we strongly encourage you to send progress notes and discharge summaries to your patients' other treating practitioners. Forms are available on our public website on **Aetna.com** and include the **Physician Communication Form** and the **Specialist Consultant Report**. These can be used to share information between a primary care physician and specialty care physicians in order to document a patient's diagnosis, medications, procedures and status.

Accessing communication forms

You can access these forms on our **public website**.

We appreciate your efforts to close the communication gap between specialists, facilities and primary care physicians and promote improved patient care and safety.

Transition and continuity of care

What is the difference between transition of care and continuity of care?

Transition of care (TOC) is a type of extended coverage that allows certain qualifying members the ability to request to continue receiving care from their current out-of-network provider at in-network cost level for a defined period of time under certain situations. Transition of care can provide a temporary bridge for members at the time of plan enrollment or renewal.

Continuity of care is a type of extended coverage that allows certain qualifying members the ability to request to continue to receive care from their current provider if that provider is no longer working with the member's plan, and is now considered out-of-network, at in-network cost level for a defined period of time under certain situations. It applies to members who are in an active course of covered treatment when the participation agreement between physician or other health care professional terminates, and they are no longer in the Aetna network.

How do TOC and continuity of care work?

Members in an active course of covered treatment that meets clinical coverage criteria/guidelines with a treating provider may be eligible for transition of care coverage consideration. The treating provider must fall under one of these categories:

- Is not a contracted provider in the member's plan
- Is not a practitioner designated for inclusion within a tiered network (Aetna Performance Network)
- Is not included within a plan sponsor-specific network

Additionally, the treating provider must be an individual practitioner (for example, a specialist, physical therapist, or speech therapist) or home care agency in order to be eligible for the transition of care process.

Transition of care and continuity of care do not apply to nonparticipating durable medical equipment (DME) vendors or pharmacy vendors. Transition of care and continuity of care do not apply to nonparticipating facilities, with the exception of facilities in which:

- The Aetna contract has terminated (for reasons other than quality issues)
- A treating participating practitioner temporarily has privileges only at the nonparticipating facility

The TOC and continuity of care process applies to all benefits plans except Traditional Choice® and Aetna Medicare Advantage PPO ESA (Extended Service Area) plans.

Again, TOC and continuity of care are limited to a fixed period of time.

Note: *Federal law takes precedence over state laws and Aetna standards. However, if state law and/or Aetna standard are stricter or more favorable to the member, such standard will apply.*

An "active course of treatment" is defined as a program of planned services that:

- Starts on the date a physician or other health care professional first renders a service to correct or treat the diagnosed condition

*FOR COMPLIANCE AND OUTCOME SOURCE: Scotten M, Manos EL, Malicoat A, et al. Minding the gap: interprofessional communication during inpatient and post discharge chasm care. Patient Education and Counseling, an official journal of EACH, the International Association for Communication in Health Care, and the Academy of Communication in Healthcare. July 2015. Available at: **DOI: 10.1016/j.pec.2015.03.009**. Accessed April January 8, 2025.

*FOR QUALITY OF COMMUNICATION SOURCE: Mohr DC, Benzer JK, Vimalananda VG, et al. Organizational coordination and patient experiences of specialty care integration. The Journal of General Internal Medicine, the official journal of the Society of General Internal Medicine. May 2019. Available at: **DOI: 10.1007/s11606-019-04973-0**. Accessed January 8, 2024.

- Covers a defined number of services or period of treatment
- Includes a qualifying situation (for example, a surgical follow-up)

Note: *State variations from our definition of "active course of treatment" exist. In those cases, use the state definition instead of our definition.*

The four steps for requesting TOC

1. The member asks for a Transition Coverage Request Form from Member Services or their employer. The member completes the form with help, as needed, from the nonparticipating treating physician.
2. The member or nonparticipating treating physician faxes the completed form to the Aetna fax number on the form.
3. We review the information. When necessary, an Aetna Medical Director evaluates the treatment program. The director may also contact the treating physician or health care professional.
4. We send a letter about the coverage decision to the member and the nonparticipating treating physician or health care professional. If coverage is approved, the letter also includes the length of time the transition benefits apply. We also send a letter to the member's primary care physician, as applicable.

Pharmacy management and drug formulary (non-Medicare)

Overview of the pharmacy plan drug list (formulary)

This section does not apply to Aetna Medicare plans.

Providers should prescribe medications according to the applicable drug formularies. We may modify the drug formularies from time to time.

Note: *Medicare members have separate pharmacy benefits and drug formularies. Please refer to the* ***Medicare*** *section of this manual for more detail on Medicare pharmacy management and drug formularies.*

Plan formularies

Our pharmacy benefits plans use a **Pharmacy Plan Drug List** (formulary) to help maintain access to quality, affordable prescription drug benefits for patients.

Coverage is not limited to drugs on the list. In some benefits plans, certain non-preferred drugs are excluded from coverage, unless a medical exception is obtained. These drugs are on our Formulary Exclusions List.

How your patients can learn more

To learn more, encourage members to visit their **Aetna member website**. Once logged in, instruct them to select "**Pharmacy**" at the top of the page.

Note: *Not all members with Aetna medical benefits have Aetna pharmacy benefits.*

Electronic prescribing

Physicians use e-prescribing technology to input prescriptions through an electronic medical record (EMR) using a tablet, smartphone, or desktop computer.

Physicians can send orders electronically to the patient's pharmacy, eliminating the need for patients to physically take the prescription to their pharmacy. Electronic prescribing also helps:

- Reduce paperwork and result in faster, more accurate information
- Simplify the prescribing process for physicians and patients
- Reduce medication errors resulting from unreadable, handwritten prescriptions

The CVS Health® Payer Solutions tries to integrate our pharmacy information with our clinical support tools. Our goal is to make insightful connections that can help us identify and act on opportunities to help improve member health.

Visit our website to learn more about **electronic prescribing services**.

Pharmacy clinical policy bulletins

The Aetna **pharmacy clinical policy bulletins (PCPBs)** are used as a guide when determining coverage for members with benefits plans that cover outpatient prescription drugs. They also describe the medical exception clinical coverage criteria for drugs on our:

- Formulary Exclusions List
- Precertification List
- Step-Therapy List
- Quantity Limits List

Precertification

Most members with Aetna pharmacy benefits may have a plan that includes precertification. These drugs require an extra coverage review before they are covered.

Precertification is based on current medical findings, FDA-approved manufacturer labeling information and guidelines, and cost and manufacturer rebate arrangements.

Visit our website to determine which medications may require precertification. If you have questions, call us at **1-800-Aetna-Rx (TTY: 711)** or **1-800-238-6279 (TTY: 711)**.

Step therapy

Some commercial plan members may have a plan that includes step therapy. With step therapy, certain drugs are not covered unless members try one or more preferred alternatives first. Step therapy is based on:

- Current medical findings
- U.S. Department of Food and Drug Administration (FDA)-approved manufacturer labeling information
- FDA guidelines
- Cost and manufacturer rebate arrangements

Quantity limits

We also limit coverage on the quantity of certain drugs. Quantity limits are established using medical guidelines and FDA-approved recommendations from drug manufacturers. The quantity limits include the following:

- Dose efficiency edits: limits coverage of prescriptions to one dose per day for drugs that are approved for once-daily dosing
- Maximum daily dose: a message is sent to the pharmacy if a prescription is less than the minimum, or higher than the maximum, allowed dose
- Quantity limits over time: limits coverage of prescriptions to a specific number of units in a defined amount of time

Note: *If it is medically necessary, you can request a medical exception to the* ***step therapy*** *or* ***quantity limits****. We'll then contact you with our decision. All medically necessary outpatient prescription drugs will be covered. To request a medical exception, see the* **Medical exception and precertification** *section in this manual for contact information.*

Generic drugs

Under Aetna commercial closed formulary plans, generic drugs are generally covered. Those that aren't covered are on the Formulary Exclusions List.

Many commercial formulary plans have a lower copay for covered generic drugs. However, several generics are considered nonpreferred and may be subject to a higher, nonpreferred copay in some plans.

To control health care costs, consider prescribing preferred generic drugs when appropriate. In some plans, if the member or their physician requests a brand-name drug when a generic drug is available, the member may have to pay more. They have to pay the difference in cost between the brand-name drug and the generic drug, in addition to their copay.

Many state laws encourage or require the pharmacy to dispense generic drugs if the prescriber permits.

Specialty pharmacy network

An in-network specialty pharmacy can fill patient prescriptions for specialty drugs. These are the types of drugs that may be injected, infused, or taken by mouth. They often need special storage and handling. A nurse or pharmacist may monitor your patient during treatment, if needed. With this type of pharmacy, patients can get this medicine sent right to their home.

Ordering prescriptions through our specialty pharmacy is easy. CVS Specialty® works hard to monitor the FDA pipeline. It is part of our effort to get access to new specialty therapies quickly. If CVS Specialty gets a prescription order for a therapy that we don't have access to, our team responds without delay. We return the referral/prescription back to the sending source advising them who can service (if known).

Ordering through CVS Specialty is easy. You can use any method below.

- E-prescribe: NCPDP ID# 1466033
- Fax: **1-800-323-2445**
- Phone: **1-800-237-2767** (TTY: **711**)

Physicians can enroll for ePrescribe by visiting the **CVS Specialty website**. Prefer to fax? Print and complete an **enrollment form**.

CVS Caremark® Mail Service Pharmacy

Patients can have maintenance drugs sent right to their home or anywhere else they choose by CVS Caremark Mail Service Pharmacy. These are drugs that are taken regularly for chronic conditions like diabetes or asthma. Depending on their plan, they can get up to a 90-day supply of medicine for less cost. It's fast and convenient, and standard shipping is always free.

You can submit prescriptions using one of these options:

- Online: **Caremark.com**
- Fax: **1-877-270-3317** (only providers may fax prescriptions) make sure to include:
  - Mailing address on the fax cover sheet
  - Member ID number
  - Date of birth

Medical exception and precertification

You can ask for a medical exception for coverage of drugs on the Formulary Exclusions List or the Step Therapy List or request prior authorization or exceptions to quantity limits. Physicians, patients or a person appointed to manage the patient's care can contact the Aetna Pharmacy Precertification Unit.

To contact us, see the options below.

	Phone	Fax	Online/Mail
Commercial	Non-specialty **1-800-294-5979** **(TTY: 711)** Specialty **1-866-814-5506** **(TTY: 711)**	Non-specialty **1-888-836-0790** Specialty **1-866-249-6155**	Go to **Availity.com** Mail the completed request form to: Medical Exception to Pharmacy Prior Authorization Unit 1300 East Campbell Road Richardson, TX 75081
Medicare part D	**1-800-414-2386** **(TTY: 711)**	**1-800-408-2386**	On **Aetna.com**, see the "**Forms**" section.
Commercial precertification for specialty drugs on the Aetna National Precertification List	**1-866-752-7021** **(TTY: 711)**	**1-888-267-3277**	Go to **Availity.com** to access the Novologix® platform.
Medicare Part B drug precertification request	**1-866-503-0857** **(TTY: 711)**	**1-844-268-7263**	Go to **Availity.com** to access the Novologix® platform.

Complaints and appeals

We have a formal complaint and appeal policy for physicians, health care professionals and facilities. The complaint and appeal process has **one level of appeal**.

Physician, health care professional and facility appeals involve payment decisions (claims). A provider may also appeal pre-service or concurrent medical-necessity decisions. However, those appeals will be handled through the **member appeal process**.

Note: *State-specific laws do not apply to Medicare Advantage appeals. Commercial plans may vary based on state-specific requirements.*

Physician and health care professional post-service appeals may either be on the provider's behalf or on the member's behalf. An appeal is not considered to be on behalf of the member unless it:

- Explicitly says "on behalf of the member"
- Includes written authorization from the member that was submitted by the physician or health professional

To learn more, see the **Claims disputes and appeals** section of this manual.

In accordance with CMS requirements, we have a formal process for Aetna Medicare Advantage plan provider dispute resolution for non-contracted providers. To begin, please submit the **Medicare Non-Contracted Provider Complaint and Appeal Request form**.

Aetna Medicare Advantage plans must comply with CMS requirements and time frames when processing appeals and grievances received from Aetna Medicare Advantage plan members. Refer to the "Medicare" section for further information.

Note: *Aetna Medicare Advantage plans must comply with CMS requirements and time frames when processing appeals and grievances received from Aetna Medicare Advantage plan members. Refer to the "**Medicare**" section of this manual for further information.*

Member programs and resources

We offer many programs that some of your Aetna patients may benefit from. If they qualify, there's no extra charge for them to join.

We review our members' records to see who a good candidate for some of these programs might be. If we feel a member would benefit from joining, we reach out to them directly. We inform them about the program and invite them to participate. These programs are not a substitute for regular visits to a physician. They are meant to support the member's physician. Through some of these programs, we work directly with the member. If that is the case, we apprise the physician of the member's health status as appropriate.

If you feel any of your Aetna patients would benefit from one of these programs, let us know by calling the Provider Contact Center. Your Aetna patients can also contact us about these programs by calling the number on their member ID cards.

Member programs

Care management

Our care management programs are designed to help our members achieve their optimal health. Program areas include:

- Disease management
- Case management
- End of life
- Transplant
- Women's health and maternity
- Integrated clinical programs for behavioral health, disability and pharmacy, as well as wellness programs

For more information, go to the **care management page** on our public website.

Aetna Lifestyle and Condition Coaching program

The Aetna Lifestyle and Condition Coaching program offers members a comprehensive health strategy. It provides lifestyle management, disease, well-being and chronic condition support through one unified holistic member experience that blends personal and digital approaches to support the member. The program is designed to encourage sustained participation and help members:

- Form long-term healthy habits
- Reinforce and broaden existing healthy behaviors
- Improve lifestyle choices
- Successfully manage their chronic conditions

We deliver the program through a single-coach model with the support of a multidisciplinary team. The program engages members using diverse delivery channels and resources. This holistic, unified approach enables members to receive the right support they need, when and where they need it.

Aetna Women's Health Program

Visit our **Women's Health Program page** to learn more about our programs and policies for reproductive health, maternity benefits and more.

Member resources

24-Hour Nurse Line

The 24-Hour Nurse Line puts members in touch with registered nurses 24 hours a day, 7 days a week. The nurses can provide information on thousands of health issues, medical procedures and treatment options. They can also offer members suggestions for communicating more effectively with their doctors.

Aetna Institutes

Please visit our **Aetna Institutes** page on **Aetna.com** for more information about our institutes.

Institutes of Excellence® network

Institutes of Excellence is our network of participating facilities for the following services:

- Infertility services
- Solid organ, blood and marrow transplants
- Transplant-related services, including evaluation and follow-up care
- Chimeric antigen receptor (CAR) T-cell therapy

Institutes of Quality® designation

Institutes of Quality is a designation that facilities can achieve for meeting certain clinical quality and cost efficiency metrics in bariatric surgery, cardiac surgery and selected orthopedic procedures. We also base this designation on our evaluation of their processes and outcomes (for example, readmission rates and mortality rates) for these procedures. These designations are reviewed every 3 years. The Institutes of Quality program requirements can be found on our **Aetna Institutes website**.

Aetna Institutes® Gene-based, Cellular and Other Innovative Therapies (GCIT®) Designated Networks

The Aetna Institutes GCIT Designated Networks program helps patients who have been diagnosed with certain genetic conditions that can be treated with the use of innovative GCIT products that have been approved by the U.S. Food and Drug Administration (FDA).

To be part of the GCIT Designated Network, a health care facility must meet specific GCIT program criteria.

Aetna Language Assistance Program (LAP)

Use our Aetna Language Assistance Program (LAP) if you need help giving care to non-English-speaking Aetna members. At clinical points of contact, Aetna CVS Health® has instructed its providers (e.g., physicians, ancillary providers, dentists, behavioral health practitioners, and all facilities) to call a single dedicated toll-free telephone number **855-380-5345 (TTY: 711)** to access interpretation services for their Aetna CVS Health members at no additional cost to the enrollee or provider 24/7. This telephone number bypasses the Provider Service Center and links directly to qualified interpreters at Language Line.

Provider performance programs

We use practitioner and provider performance data to help improve the quality of service and clinical care our members receive if certain thresholds are met. Accrediting agencies require that you let us use your performance data for this purpose.

Quality, accreditation, review and reporting activities

We require providers to cooperate with any of our quality activities, or any review of Aetna, a payer or a plan by:

- The National Committee for Quality Assurance (NCQA)
- The Utilization Review Accreditation Commission (URAC) or other applicable accrediting organizations
- A state or federal agency with authority over Aetna and/or a plan, as applicable

We expect our network providers to comply with our reporting requirements. These include Healthcare Effectiveness Data Information Set (HEDIS®) and similar data collection and reporting requirements.

Aexcel® network of specialist doctors

Aexcel is a designation within the Aetna Performance Network. Aexcel designation helps distinguish physicians in 12 specialty categories who have met certain clinical performance and efficiency standards. Aexcel providers are identified by a blue star.

We evaluate participating specialists in the 12 specialty categories at least once every two years for Aexcel designation. The evaluation process is made up of four key components:

- Case volume
- Clinical performance
- Efficiency
- Network adequacy

To find Aexcel physicians online, look for a blue star next to their names.

Pay for performance (P4P)

Participation is through a direct contract. It's available in all markets to all providers that include PCPs. It's executed via a signed amendment to the provider's current participation agreement.

Our nationally available physician performance incentive programs apply the strengths of our data aggregation and national data repository resources to local-market initiatives. This allows for customized measures and goals. Annual goals are:

- Negotiated agreements between the provider group and Aetna
- Based on a provider's own year-over-year performance

We provide detailed information on each individual physician's results on each measure.

Our physician performance incentive programs identify and target areas of opportunity for quality improvement. The objective is to help improve the overall quality, safety and cost efficiency of health care. These programs set targets for improvements and deliver performance measurement results for:

- Independent practice associations (IPAs)
- Physician-hospital organizations (PHOs)
- Physician groups

We incorporate group and physician-level data into our online and other tools. This provides actionable, patient-level information to physicians. Physicians earn reward payments only when they either improve toward their targeted performance results or maintain their high-performing levels of achievement.

We annually reset target goals and, in some cases, add and/or drop measures. Physicians are not paid for this component of their compensation until we have measured and compared their performance to targets. As a result, performance payments are not included in initial claims payments.

More broadly, we believe that performance incentive program success requires:

- A clear and specific understanding between payers and providers on the parameters of the program's measurements, incentive opportunities and targets
- National consensus measures
- A focus on continuous quality improvement

- A commitment to retire measures after there have been several periods of top-level performance (for example, 95% and above) and replace them with new measures that give physicians new opportunities for improvement
- Collaboration to identify new sources of actionable information, and creative ways to encourage and engage with physicians and physician groups effectively
- A commitment across all commercial payers to include performance incentives in the overall reimbursement strategy. We recognize that when physicians improve their practices, all patients benefit

Medicare

Medicare coverage

Traditional Medicare has two parts, Medicare Part A and Medicare Part B.

Medicare Part A

Medicare Part A provides coverage for:

- Inpatient care in a hospital
- Skilled nursing facility care
- Hospice care
- Some home health care

Medicare Part B

Medicare Part B provides coverage for:

- Doctors visits
- Outpatient care
- Medical supplies — durable medical equipment (DME)
- Limited outpatient drugs

Medicare Advantage plans

Medicare Advantage (MA) plans, sometimes called "Part C" or "MA plans," are an "all in one" alternative to traditional Medicare, administered by private insurance companies like us. These "bundled" plans include Medicare Part A and Part B coverage and often include drug coverage, known as Medicare Part D.

Enrollment in MA plans replaces the enrollment for Medicare Part A and Part B.

Medicare Part D

It is possible that an individual may be covered under both a Part D Medicare prescription drug plan and another health plan that provides prescription drug coverage or financial assistance to Medicare Part D–eligible individuals (including non-Medigap individual market insurance policies). In that event, covered benefits must be coordinated between such plans in accordance with CMS requirements and any subsequent guidance from CMS.

Medicare estimation

When a member is eligible for Medicare Part B but does not enroll in Medicare, we may estimate Medicare's benefits and coordinate with the estimated amounts. We will estimate benefits when allowed by state legislation or when elected by the plan sponsor.

It is important for members to enroll, as estimation of Medicare benefits leaves the member with higher cost-share amounts.

Medicare and Medicaid dual eligibles

Medicare and Medicaid "dual eligibles" are individuals who are entitled to both Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

Dual eligibles receive their prescription drug benefit (Part D) through Medicare. Dual eligibles may enroll in stand-alone Medicare prescription drug plans (PDPs) or Aetna Medicare Advantage (MA) plans that incorporate a prescription drug benefit (MAPDs). We offer both types of insurance products to Medicare-eligible beneficiaries.

Provider billing for dual eligibles

If a dual eligible enrolls in an Aetna MA plan, then the provider must bill Aetna as the primary payer and the state Medicaid plan as the secondary payer. The provider must notify patients prior to providing services if the provider does not accept payments from state Medicaid plans as payment in full.

Note: *State mandates may supersede Aetna standards.*

Aetna Medicare Advantage plans

Aetna Medicare Advantage plans (HMO and PPO)

Aetna contracts with the Centers for Medicare & Medicaid Services (CMS) to offer Aetna Medicare Advantage (MA) plans. As such, we're considered a Medicare Advantage organization (MAO). All MA plans are required to offer Medicare Parts A and B medical benefits and to follow CMS' national and local coverage decisions. MA plans may also offer Medicare Part D benefits (MAPD).

We offer both individual and employer group-sponsored MA products. Aetna Medicare Advantage HMO plans are available in select counties and states throughout the country. Aetna Medicare Advantage PPO plans are available to individuals in select counties and states throughout the country and for employer groups in all 50 states, plus the District of Columbia. Go to the Medicare page on **Aetna.com** for specific Aetna Medicare Advantage plan information. Individuals may choose from several Aetna Medicare Advantage plans, depending on their location, budget and needs. Go to **AetnaMedicare.com** to see the plans available within a specific geographic area.

View our Aetna Medicare Advantage plans Quick Reference Guide for a summary of how our Aetna Medicare Advantage plans work with primary care physician (PCP) selection, referrals and out-of-network benefits.

Note: *Aetna HMO and PPO Prime plans consist of a limited network of providers. Providers should review the Medicare Provider Referral Directory or call the Provider Contact Center to verify participation.*

Aetna Medicare prescription drug plan

We administer a stand-alone prescription drug plan (PDP) portfolio of products referred to as SilverScript®. There are several different national PDP plan options available to individuals. In select service areas, Medicare prescription drug benefits are also offered to individuals for their retirees through our MA plans that include Medicare prescription drug coverage (MAPD) plans.

In addition, employer groups nationwide may select Medicare prescription drug coverage for their retirees through Aetna Medicare Rx® offered by SilverScript for PDP or Aetna Medicare for MAPD.

MAPD plans and PDPs must meet applicable benefits requirements under the Medicare Part D program.

Please note the following provisions for 2024 and the new provisions for 2025:

2024 provisions:

- Deductible: Not to exceed $545 for 2024
- Coverage gap: Once a member reaches $5,030 in covered Medicare Part D drug expenses, he or she will pay no more than 25% for covered generics and 25% for covered brand drugs, including a manufacturer discount of up to 70% off covered-brand drug costs until reaching the True Out-of-Pocket (TrOOP) threshold of $8,000. Most individual and group PDP and MAPD plans provide supplemental gap coverage.
- Insulin Cost Share: Beginning January 1, 2023, people with Medicare drug coverage who take insulin will see their out-of-pocket costs capped at $35 for a month's supply of each covered insulin product. Also, a Part D deductible won't be applied to covered insulin products.
- Catastrophic coverage level: For 2024, once a member reaches $8,000 in TrOOP costs for covered Part D drugs, the member's cost share will be $0 for all covered Part D drugs.

2025 provisions:

- Deductible: Not to exceed $590 for 2025
- Coverage gap : None
- Prescription Coverage: annual out-of-pocket capped at $2,000 (RX OOP) Catastrophic phase is reached based on member reaching $2,000 RX OOP.
- Insulin Cost Share: Beginning January 1, 2023, people with Medicare drug coverage who take insulin will see their out-of-pocket costs capped at $35 for a month's supply of each covered insulin product. Also, a Part D deductible won't be applied to covered insulin products.
- Catastrophic coverage level: For 2025, once a member reaches $2,000 in out-of-pocket costs for covered Part D drugs, the member's cost share will be $0 for all covered Part D drugs.

Requirements for Medicare Part B drugs

Under Medicare Advantage plans, some medically administered Part B drugs, like injectables or biologics, may have special requirements or coverage limits. Our plans leverage utilization management criteria that aligns with Medicare national and local coverage criteria and CMS level of evidence. Additionally, our plans use step therapy, in which we require a trial of a preferred drug to treat a medical condition before covering another non-preferred drug.

To see the coverage criteria and details on our Part B step therapy program, go to the **Aetna Part B webpage.**

Note: *All formularies applicable to MAPD plans and PDPs are reviewed and approved by CMS.*

Aetna Medicare Part D Formulary

The Aetna Medicare Part D prescription drug formularies (also known as the "Aetna Medicare Drug List") differ from the formularies applicable to Aetna commercial pharmacy plans.

- Go to **AetnaMedicare.com/formulary** to see a list of Medicare prescription drug formularies used for individual PDP and MAPD members.
- Group MAPD plan and PDP members visit our retiree plans website at **AetnaRetireePlans.com** to see a list of Medicare prescription drug formularies.

Note: *Quantity limits, step therapy and precertification requirements apply to certain prescription drugs and are detailed in the formulary links above.*

Part D drug rules

Here are three general rules that apply to Medicare Part D drug prescription coverage:

- Medicare Part D cannot provide coverage for a drug that would be covered under Medicare Part A or Part B.
- Medicare Part D cannot provide coverage for a drug that is purchased outside the United States and its territories.
- Medicare Part D usually cannot provide coverage for "off-label use." Generally, coverage for "off-label use" is allowed under Medicare Part D only when the use is supported by a CMS-compendia-recognized resource such as:
  - The American Hospital Formulary Service Drug Information
  - The DRUGDEX Information System
  - The United States Pharmacopeia-Drug Information (USP DI) or its successor

Also, by law, the following categories of drugs are not covered by Medicare Part D unless enhanced drug coverage is included or offered under a particular Medicare Part D plan or benefit:

- Nonprescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra and Caverject
- Drugs used for the treatment of anorexia, weight loss or weight gain
- Outpatient drugs that the manufacturer is selling, only if the associated tests or monitoring services are also purchased from the manufacturer

The amount a member with Medicare Part D coverage pays when filling prescriptions for these non-D-covered drugs does not count toward the plan deductible, initial coverage limit or qualifying for the catastrophic coverage phase. Also, those eligible for the Low-Income Subsidy will not pay the plan cost-share in place of their subsidized cost-sharing.

Note: *Most injectable medications and oral drugs not covered under Medicare Part B will be considered Medicare Part D drugs, but coverage will be determined by the formulary. Precertification is required for Medicare Part B situational drugs.*

If you have questions regarding whether a medication is covered under Medicare Part B versus Medicare Part D, contact the Aetna Pharmacy Precertification Unit at **1-800-414-2386 (TTY: 711)** for assistance.

Part D transition-of-coverage (TOC) policy

CMS requires Part D plan sponsors, like Aetna, to have an appropriate TOC process. Members who are taking Part D drugs that are not on the plan's formulary or that are subject to utilization management requirements can get a transition supply of their drug in certain circumstances. This gives members the opportunity to work with their doctors to complete a successful transition and avoid disruption in their respective treatments.

Aetna Medicare has established a TOC process in accordance with CMS requirements that applies to new members as well as current members who remain enrolled in their Aetna Medicare plan from one plan year to the next.

Summary of the key features of Aetna Medicare's TOC process.

Newly enrolled members who are taking a Part D drug that is not on the Aetna Medicare formulary or is subject to a utilization management requirement or limitation (such as step therapy, prior authorization or a quantity limit), are entitled to receive a maximum of a 30-day supply of the Part D drug within the first 90 days of their enrollment. (The period of time in which they are entitled to receive the transition supply is called their "transition period.")

Existing members who renew their Aetna Medicare coverage and are taking a Part D drug that is removed from the formulary or is subject to a new utilization requirement or limitation at the beginning of the new plan year, are entitled to receive a maximum 30-day supply during their transition period. For existing members who renew their Aetna Medicare coverage from one year to the next, their transition period is the first 90 days of the new plan year.

Whether an individual is a new or renewing member, if the member's initial prescription is for less than the full transition amount (30 days), the member can get multiple fills up to the 30-day supply. If a member lives in a long-term care facility and is entitled to a transition supply, Aetna will cover a 31-day supply (unless the prescription is for fewer days).

Members may also be entitled to receive a transition fill outside of their transition period in certain circumstances. We send a TOC notice to members via first-class mail within 3 business days from the date the transition fill claim is processed. The letter:

- Notifies members that the transition fill was a temporary supply
- Describes the options available to the member if the drug for which they received the transition fill is not on the formulary or is subject to a utilization management requirement or restriction (including changing to a therapeutic alternative, or seeking an exception or prior authorization, as appropriate)
- Describes the procedures for requesting an exception or prior authorization
- Encourages members to work with their respective doctors to achieve a successful transition so they can continue to receive coverage for the drugs they need

A duplicate copy of the notice is sent to the prescribing physician.

See our transition-of-coverage policy to view the transition rules for our Medicare prescription drug process.

Medicare prescription drug plan (PDP and MAPD) coverage determinations and exceptions process

Coverage determinations

Medicare beneficiaries enrolled in PDPs and MAPDs have the right to request a coverage determination concerning the prescription drug coverage they're entitled to receive under their plan, including:

- Basic prescription drug coverage and supplemental benefits
- The amount, including cost sharing, if any, that the member is required to pay for a drug

An adverse coverage determination constitutes any unfavorable decision made by or on behalf of Aetna regarding coverage or payment for prescription drug benefits a member believes they are entitled to receive.

The following actions are considered coverage determinations:

- A decision not to provide or pay for a prescription drug that the member believes should be covered by the plan. (This includes a decision not to pay because the drug is not on the plan's formulary, is determined to not be medically necessary, is furnished by an out-of-network pharmacy, or we determine is otherwise excluded under section 1862(a) of the Social Security Act, if applied to Medicare Part D.)
- The failure to provide a coverage determination in a timely manner when a delay would adversely affect the health of the member.
- A decision concerning an exceptions request for a plan's tiered cost-sharing structure.
- A decision concerning an exceptions request involving a nonformulary drug.
- A decision on the amount of cost sharing for a drug.

We have both standard and expedited procedures in place for making coverage determinations.

Exceptions process

The exceptions process can be initiated for:

- Requests for exceptions involving a nonformulary Part D drug
- Requests for exceptions to a plan's tiered cost-sharing structure

A decision by a Part D plan sponsor concerning an exceptions request constitutes a coverage determination. Therefore, all of the applicable coverage determination requirements and time frames apply.

The member, their appointed representative or the prescribing physician can submit an exceptions request either orally or in writing, via phone or fax.

- Phone: **1-800-414-2386 (TTY: 711)**
- Fax: **1-800-408-2386**

Medicare coverage determinations and exception requests have a strict turnaround time for completion. It is critical that you send your requests to the correct areas of Aetna Medicare so we may handle them appropriately for our members. Send all Medicare prescription drug requests via phone or fax.

- Phone: **1-800-414-2386 (TTY: 711)**
- Fax: **1-800-408-2386**

A complete description of our coverage determination and exceptions process, and how to contact us if you are assisting a member with this process, is available on our Aetna Medicare Plans website.

Additional prescription drug plan information

Preventive Vaccines

Our plan covers many Part B and Part D vaccines at no cost to the member when obtained from a participating provider. To assure members the lowest disruption and inconvenience, vaccines should be obtained at any of one our broad network of over 64,000 pharmacies. Network pharmacies submit vaccine claims electronically and never leave a member having to pay in advance or to seek reimbursement. Additionally, most pharmacies do not require an appointment and readily stock vaccines.

Some Part D vaccines, such a shingles, require follow up, for these vaccines the pharmacy does not charge the member, will create an appointment, and will call to remind the member if an appointment is missed. This can save the member money by not assessing an additional provider copay.

For MAPD members, contracted providers are in-network and eligible to administer part B and D vaccines for members. For PDP members, non-pharmacy administration of vaccines is out-of-network. If a member chooses not to get their vaccine at a network pharmacy, providers need to submit vaccine claims according to their CMS coverage. B vaccines can be submitted with other medical claims. D vaccines must be submitted Pharmacy Management using the address and form below for Part D claims reimbursement.

Download, complete, and submit the paper claims Part D form here: **Aetna - Medicare Prescription Drug Claim Form**

For Part D preventative vaccine claims from the provider office (including vaccines for shingles, RSV, Tdap, and more) requests must be mailed to:

Aetna Pharmacy Management
PO Box 52446
Phoenix, AZ 85072-2446

Supply limits

Days supply: Generally, a 1-month prescription may be filled for up to a 30-day supply. Members may obtain extended day supplies of maintenance medications from either a participating retail pharmacy or through a participating mail-order vendor. Individual MAPD members may get up to a 100-day supply of most maintenance medications; Group MAPD and PDP members may get up to a 90-day supply.

Mail-order drug option: Individual MAPD members may get up to a 100-day supply. All others may get up to a 90-day supply.

Specialty pharmacies fill high-cost specialty medications that require special handling. Although specialty pharmacies may deliver covered medications through the mail, they are not considered “mail-order pharmacies.” CVS Specialty® pharmacy can support Medicare members in need of specialty medications and support as well as other in network pharmacies based upon the member’s benefit. Search tools for the pharmacy network are available on the member’s benefit page to assist in selecting a retail, mail or specialty pharmacy for prescription access.

In 2014, CMS instituted a feature that allows PDP and MAPD plan members in some instances to pay prorated cost sharing for prescriptions written for less than a 30-day supply. For example, prorated cost sharing may apply when an initial prescription is written for a short supply to ensure the member can tolerate the drug, or when a member wishes to synchronize their prescriptions to fill on the same day. However, limitations apply to this plan feature. For example, prepackaged drugs cannot be broken, and this plan feature does not apply to antibiotics and some other drugs.

Preferred pharmacies

Most of our plans have a pharmacy network which includes access to preferred pharmacies.

Our members generally pay less when they fill their prescription at one of our preferred pharmacies.

All of our network pharmacies must meet strict discount standards. But preferred pharmacies offer us even bigger discounts. And we pass those discounts on to our members, in the form of lower-cost sharing.

Preferred pharmacies are identified with a circled "P" in our directories. Or go to **Find an Aetna Medicare network pharmacy** to search online.

Note: *Members who qualify for Low-Income Subsidy assistance are not required to use preferred pharmacies.*

Home infusion

The following provisions only apply to providers who dispense home infusion drugs that are covered under Medicare Part D to Medicare members (and the Medicare member has MAPD coverage):

- The provider will be paid clean claims within 30 days, and the provider will be reimbursed at the rates agreed to by the provider and Aetna.
- Updates to prescription drug pricing used for payment will occur no less frequently than once every seven days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the home infusion drug.
- The provider will submit claims for home infusion drugs whenever the Medicare member's ID card is presented (or is on file), unless the Medicare member expressly requests otherwise.
- The provider must submit claims for home infusion drugs by means of a point-of-service claims adjudication system.
- The provider must provide Medicare members with access to the negotiated prices.
- The provider must apply the correct cost-sharing amount to the Medicare member, as indicated by Aetna.
- The provider must inform the Medicare member of any difference between the price of the home infusion drug being dispensed and the price of the lowest-priced generic version, unless the home infusion drug being dispensed is the lowest-priced generic version.
- Before dispensing, the provider must ensure that the professional services and ancillary supplies necessary for home infusion drugs are in place.
- The provider must provide delivery of home infusion drugs within 24 hours of Medicare member's discharge from an acute setting, unless prescribed later.
- The provider must submit claims for equipment, supplies and professional services associated with dispensed home infusion drugs for Medicare members covered by Medicare Part C.

Medicare Advantage (MA and MAPD) and Medicare PDP member grievance and appeal rights

Medicare beneficiaries enrolled in MA, MAPD or PDP plans members are entitled to specific CMS-mandated appeal and grievance rights. We have departments dedicated to processing all member appeals and grievances related to Medicare Advantage and Medicare Part D coverage.

Appeals and grievances are processed in accordance with the standard and expedited requirements and time frames established by CMS. Following an adverse organization determination or coverage determination, MA or MAPD plan and PDP members have the right to appeal any decision about the plan's failure to pay or provide coverage for what the member believes are covered benefits, drugs and services (including non-Medicare covered benefits). MA members can appeal for coverage of medical benefits, services and drugs covered through the Medicare medical benefit. PDP members can appeal for coverage of prescription drugs. MAPD members can appeal for any of the above.

We may ask for the cooperation and/or participation of contracted providers in our internal and external review of procedures relating to the processing of Medicare member appeals and grievances. If necessary, contracted providers should:

- Instruct the member to contact us for their MA plan appeal rights
- Inform the member of their right to receive, upon request, a detailed written notice from us regarding coverage for services
- Promptly respond to any plan requests for information needed to review an appeal or assist with grievance resolution

Members should be directed to contact Member Services using the phone number listed on their Aetna member ID card. In addition, notices sent due to an adverse organization or coverage determination provide contact information and instructions for filing an appeal.

When a Medicare member appeals a denied service, drug or other benefit they believe they are entitled to, we may need clinical records from you. We require you to handle all requests for clinical records as promptly as possible.

There are instances when we have less than 48 hours to respond to an appeal and your clinical information is imperative to making an accurate and timely decision.

Please note that CMS-mandated time frames do not stop due to weekends, holidays or any other time when your office may be closed.

Visit the **Coverage Decisions, Appeals, and Grievances page on Aetna.com** for a complete description of our MA, MAPD and Medicare PDP appeal and grievance procedures and time frames, and how to contact Aetna if you are assisting a member with this process.

Aetna MA plan programs

Aetna home assessment program

As part of our ongoing quality improvement efforts, we periodically offer in-home health assessments to our Aetna Medicare Advantage members. It's possible your patients may be asked to participate in this no-additional-cost, comprehensive assessment. It is voluntary, performed in the patient's home by a licensed provider, and allows you access to information about your patient's home condition and environment. If one of your patients participates in this program, a summary of the completed assessment will be mailed to you.

We'll use information from the assessment to identify care management programs which may benefit the member. If you have questions about the home assessment program, call our Provider Contact Center at **1-800-624-0756 (TTY: 711)**.

Quality improvement program

An annual Chronic Care Improvement Program (CCIP) is implemented in accordance with CMS requirements. It is designed and conducted to coordinate care, promote quality and help improve member satisfaction.

The goal of the CCIP is to promote effective management of chronic disease and improve health outcomes and quality of care. Programs are available to support your patients and to help them make healthy lifestyle choices.

Effective management of chronic disease can achieve positive outcomes. Examples of documented outcomes include slowing disease progression, preventing complications and development of comorbidities, reducing preventable emergency room (ER) encounters and inpatient stays, improving the member's quality of life, and providing cost savings for the member.

Fitness programs

Most individual Aetna Medicare Advantage plans offer fitness benefits through a program called SilverSneakers® which is administered by Tivity Health. (SilverSneakers isn't available for two individual MA plans in Maryland.)

The fitness benefit is offered as a buy-up option for most of our group Aetna Medicare Advantage plans. However, the Medicare member should verify this in their Evidence of Coverage document.

Medicare members and providers can contact Member Services to determine if the fitness benefit is available and which program option is offered.

Travel programs — when a member is away from home for extended period

Temporary move out of service area

CMS defines a temporary move as:

- An absence from the service area (where the member is enrolled in an MA plan) of six months or less
- Maintaining a permanent address/residence in the service area

A MA plan member is covered while temporarily out of the service area for emergent, urgent and out-of-area dialysis services. If a member permanently moves out of the MA plan service area or is absent for more than six months (12 months for members enrolled in a stand-alone Medicare prescription drug plan (PDP), the MAO must disenroll the member from the MA plan.

Coverage of renal dialysis services for Medicare members who are temporarily out-of-area

An Aetna Medicare Advantage plan member may be temporarily out of the service area for up to six months. MAOs must pay for renal dialysis services obtained by an MA plan member while the member is temporarily out of their Medicare Advantage plan's service area. These services can be from a contracted or noncontracted Medicare-certified physician or health care professional.

Care outside of the United States

If the member sees an out-of-network provider for urgent/emergency care outside of the United States and he/she has made payment to the provider, the member should submit their claims to Aetna along with documentation of any payments made to the provider.

Travel programs

Under travel programs, we let members travel out of their home service area for an additional 6 months for a total of 12 months in a row. Members travelling can get services from providers in our Medicare network for the service area they're visiting. Plan coverage rules still apply. For example, they may need referrals for some services. Our Medicare network isn't in all locations, so it is important members check for participating providers in the area they're visiting.

We offer two Medicare Advantage visitor/ traveler programs.

- **Travel Advantage (HMO plans)** — Travel Advantage is offered on some Individual and Group Medicare Advantage HMOs. It's not available to California (CA) or Florida (FL) members or to those members enrolled in our Medicare Advantage Prime Plan.
  - Visitor traveler: Allows members to keep their plan coverage for an extra six months when out of the plan's service area.
  - Seamless network: Multi-state network allows HMO members to get routine services at an in-network cost share when they see a contracted Aetna HMO provider throughout the United States. An HMO member cannot see a PPO-only contracted provider.
  - Medicare Advantage Open Access HMO: Members don't choose PCPs. When enrolled in Travel Advantage, members can continue using any Aetna Medicare Advantage HMO provider without a referral.
  - Medicare Advantage non-Open Access HMO: Members whose plans need referrals and PCP choices have to change their PCP to another PCP in the service area they're visiting. The new PCP renders primary care services and refers members to other providers in the service area they're visiting.
- **Travel Explorer (PPO plans)** — Offered on some Individual Medicare Advantage PPO plans and includes "Travel Pass."
  - Visitor traveler: Allows members to stay in their plans for an extra six months when out of the plan's service area.
  - Seamless network: Multi-state network allows PPO members to get routine services at an in-network cost share when they see a contracted Aetna PPO-provider throughout the United States.
  - Travel Pass: Gives a snapshot of key health care elements such as their primary care provider, medication history, vaccine history and other information — all of which can help members direct their care while traveling.
  - For 2025, the Explorer travel program is available on some Individual Medicare Advantage PPO plans in the states listed below:
    - Alabama (AL)
    - Arizona (AZ)
    - California (CA)
    - Colorado (CO)
    - Connecticut (CT)
    - Delaware (DE)
    - Florida (FL)
    - Georgia (GA)
    - Illinois (IL)
    - Indiana (IN)
    - Kentucky (KY)
    - Louisiana (LA)
    - Maine (ME)
    - Massachusetts (MA)
    - Michigan (MI)
    - Mississippi (MS)
    - Pennsylvania (PA)
    - South Carolina (SC)
    - Tennessee (TN)
    - Utah (UT)
    - Virginia (VA)
    - Washington (WA)
    - Wisconsin (WI)
    - Wyoming (WY)

Plans rules and requirements must be followed

- Members may only change their PCP to a PCP located in another Aetna Medicare plan service area.
- If a plan requires that a PCP selection be recorded by Aetna, members must change their PCP. If they don't, their claims will be denied.
- Members must get PCP referrals in accordance with plan rules.

Urgently needed services

Urgently needed services are covered services provided to a member that are both of the following:

- Non-preventive or nonroutine
- Needed to prevent the serious deterioration of a member's health following an unforeseen illness, injury or condition

Urgently needed services include conditions that cannot be adequately managed without immediate care or treatment, but do not require the level of care provided in the emergency room.

MACRA and CMS physician incentive plans

Medicare Access and CHIP Reauthorization Act (MACRA) reimbursement

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015.

MACRA created the Quality Payment Program (QPP), which repeals the Sustainable Growth Rate (SGR) formula. It changes the way Medicare rewards physicians for value versus volume over time.

Our MACRA reimbursement policy applies to both of the payment tracks below:

- Advanced Alternative Payment Model (AAPM): Our value-based contracting reimbursement programs are known as "CPC+" or "Medicare Collaboration Premier" or "Medicare Collaboration Enhanced." They offer providers CMS-approved options to qualify for this track as an Other Payer AAPM as long as the AAPM criteria are met within your specific contract terms. However, our provider reimbursements do not adjust to include reciprocal AAPM bonuses. AAPM bonuses are based on CMS Fee-For-Service membership, not your Aetna-specific membership.
- Merit-Based Incentive Payment System (MIPS): Our provider reimbursements do not adjust to include performance-based incentive payments made under traditional Medicare as the result of MACRA. Incentive payments are based on CMS Fee-For-Service membership, not your Aetna-specific membership.

Centers for Medicare & Medicaid Services (CMS) physician incentive plan: general requirements

Aetna Medicare Advantage regulations require that MAOs and their participating providers meet certain CMS monitoring and disclosure requirements that apply to "physician incentive plans." As outlined in 42 C.F.R § 422.208(a), a "physician incentive plan" means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any MA plan enrollee.

The physician incentive plan requirements apply to an MAO and any of its first tier and downstream provider arrangements that utilize a physician incentive plan in their payment arrangements with individual physicians or physician groups. Provider downstream arrangements may include an intermediate first-tier entity. This includes, but is not limited to, an independent practice association (IPA) that contracts with one or more physician groups or any other organized group that provides administrative and/or health care services to MA members through downstream providers.

CMS imposes the following requirements on MAOs and their participating providers regarding physician incentive plan arrangements:

- MAOs and their participating providers cannot make a specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular MA enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.
- If the physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, the MAO or participating provider must ensure that all physicians and physician groups at substantial financial risk (as described in 42 C.F.R §422.208(a) & (d)) have either aggregate or per-patient stop-loss protection (as described in 42 C.F.R §422.208(f)). In addition, MAOs and participating providers must conduct periodic Aetna MA member surveys in accordance with MA regulations.
- For all physician incentive plans, the MAO must provide CMS with assurances that applicable physician incentive plan requirements are met, as well as provide information concerning physician incentive plans, as requested. To meet this CMS requirement, any participating provider with a physician incentive plan arrangement must annually provide Aetna with the following information for each physician incentive plan arrangement:
  - Whether referral services are covered by the physician incentive plan
  - The type of physician incentive plan arrangement (that is, withhold, bonus, capitation)
  - The percent of total income at risk for referrals
  - The patient panel size
  - The amount and type of stop-loss protection

We will disclose any physician incentive plan arrangements maintained by participating providers, if required to do so, under applicable laws and regulations.

CMS physician incentive plan: substantial financial risk

As more fully described in 42 C.F.R. § 422.208 (a) and (d), substantial financial risk occurs when risk is based on the use or costs of referral services and that risk exceeds a risk threshold of 25% of potential payments. (Payments based on other factors, such as quality of care furnished, are not considered in this determination.) Refer to 42 C.F.R. § 422.208 for additional information.

CMS physician incentive plan: stop-loss protection requirements

In addition, as more fully described in 42 C.F.R. §422.208(f), MAOs and their participating providers must ensure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with the following requirements:

- Aggregate stop-loss protection must cover 90% of the costs of referral services that exceed 25% of potential payments.
- For per-patient stop-loss protection, if the stop-loss protection provided is on a per-patient basis, the stop-loss limit (deductible) per patient must be determined based on the size of the patient panel. It may be a combined policy or consist of separate policies for professional services and institutional services. In determining patient panel size, the patients may be pooled, as described in 42 C.F.R. § 422.208(g).
- Stop-loss protection must cover 90% of the costs of referral services that exceed the per-patient deductible limit. The per-patient stop-loss deductible limits are set forth in 42 C.F.R. § 422.208(f).

Participating providers with physician incentive plan arrangements must maintain, at their sole expense, any stop-loss coverage they are required to maintain under applicable laws and regulations. They must also provide evidence of such coverage to us upon request.

Additional Aetna Medicare Advantage information

Standards of Conduct and Compliance policies

Your organization should distribute Standards of Conduct and Compliance Policies that explain your:

- Commitment to comply with federal and state laws
- Ethical behavior requirements
- Compliance program operations

Your policies should be distributed within 90 days of hire, when revised, and annually thereafter.

If you don't have your own documents, you can use our **Code of Conduct** and **Compliance Policies**.

Your organization must maintain Business Continuity Plans, that contain policies and procedures to ensure the restoration of those Medicare business operations that support Aetna following disruptions to business operations, which include natural or man-made disasters, system failures, emergencies, pandemic public health emergency, cyber security incidents and other similar circumstances and the threat of such occurrences.

Annual Medicare compliance attestation

Every year, all providers who participate in our MA plans are required to meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related entities (FDR).

We complete yearly random audits to help make sure you're compliant.

Required compliance and training:

- **Review Aetna FDR Medicare compliance guide (PDF)** - For all Medicare providers/delegates, for all plan types
- **Review SNP Model of Care/MOC training (PDF)** - For all providers/delegates treating SNP members

Go to our **Medicare resources for providers page** to find more about our compliance program and **check out our frequently asked questions (PDF)**.

Report concerns or questions

If you identify noncompliance or fraud, waste and abuse, you must report it to us by using the mechanisms outlined in our **Code of Conduct**. We prohibit retaliation for good faith reporting of concerns.

If you have questions about the requirements that apply to FDRs or if you have difficulty finding our **FDR Guide**, call our Provider Contact Center at **1-800-624-0756 (TTY: 711)**.

Physicians and other health care professionals and marketing of Aetna Medicare Advantage plans

MAOs and their contracted providers must adhere to all applicable Medicare laws, rules and regulations relating to marketing. Per Medicare regulations, "marketing materials" include, but are not limited to, promoting an MAO or a particular MA plan, informing Medicare beneficiaries that they may enroll or remain enrolled in an MA plan offered by an MAO, explaining the benefits of enrollment in an MA plan or rules that apply to members, or explaining how Medicare services are covered under an MAO plan.

Regulations prevent MAOs from conducting sales activities in health care settings except in common areas. MAOs are prohibited from conducting sales presentations and distributing and/or accepting enrollment applications in areas where patients primarily intend to receive health care services. MAOs are permitted to schedule appointments with beneficiaries residing in long-term care facilities, only if the beneficiary requests it.

Physicians and other health care professionals may discuss, in response to an individual patient's inquiry, the various benefits of MA plans. They shall remain neutral when assisting Medicare beneficiaries with enrollment decisions. Physicians are encouraged to display plan materials for all plans in which they participate.

For additional information, physicians and health care professionals can also refer their patients to:

- **1-800-624-0756 (TTY: 711)**
- The State Health Insurance Assistance program
- The specific MAO marketing representatives
- The CMS website at **Medicare.gov**

Physicians and other health care professionals cannot accept MA plan enrollment forms.

We follow the federal anti-kickback statute and CMS marketing requirements associated with Medicare marketing activities conducted by providers and related to Aetna Medicare plans. Payments that we make to providers for covered items and/or services will:

- Be fair market value
- Be consistent with an arm's length transaction
- Be for bona fide (genuine) and necessary services
- Comply with relevant laws and requirements, including the federal anti-kickback statute

For a complete description of laws, rules, regulations, guidelines and other requirements applicable to Medicare marketing activities conducted by providers, refer to Chapter 3 of the Medicare Managed Care Manual, and the **Medicare Communications and Marketing Guidelines** contained therein, which can be found on the CMS website.

Demographic date quarterly attestation

We require Aetna-contracted Medicare Advantage providers to validate their demographic information quarterly as noted in our provider agreement and/or provider newsletters. Availity® will send a notification each quarter for your review and attestation. As an Aetna Medicare Advantage provider, you are obligated to comply with this validation.

If you move your office, or change other demographic information, such as your email address or phone number, go to the Provider Data Maintenance function on Availity to update your profile within seven days of the change. Do not wait for the quarterly attestation process, and do not call or fax the information to Aetna. We will get the update from the vendor and process it accordingly.

It's important that you complete the validation and attestation requests from Availity within the allotted time frame. To do so, login to the provider portal and complete the attestation of your demographic information. We take this requirement very seriously and will act against providers who refuse to cooperate. Ultimately, this action can include termination of your participation in our Aetna Medicare Advantage networks.

The U.S. Centers for Medicare & Medicaid Services (CMS) is also encouraging health plans and providers to use the National Plan and Provider Enumeration System (NPPES) as a resource to improve data accuracy. We join CMS in reminding providers to review, update, and certify that their data is current in the **National Plan & Provider Enumeration System (NPPES)**. Accurate provider directories help Medicare beneficiaries identify and locate providers and make health plan choices.

Medicare Communications and Marketing Guidelines (MCMG)

Medicare marketing guidelines contain restrictions on communications and marketing materials for MA plans and providers. We summarize here some of the key requirements, but we encourage providers to review these regulations and guidelines available on the CMS website.

Per Medicare regulations, to qualify as a "marketing material," material must meet content and intent requirements set forth in CMS guidance. Materials will meet the intent requirement if they are intended to:

- Draw a beneficiary's attention to a plan or plans
- Influence a beneficiary's decision-making process when making a plan selection, or
- Influence a beneficiary's decision to stay enrolled in a plan (retention-based marketing).

To meet the content requirement, materials must include content regarding:

- The plan's benefits, benefits structure, premiums, or cost sharing
- Measuring or ranking standards (for example, Star Ratings or plan comparisons), or
- Rewards and incentives as defined under 42 CFR § 422.134(a) (for MA and section 1876 cost plans only).

Marketing or sales activities and materials are not permitted in areas where care is being administered, including exam rooms, hospital patient rooms, treatment areas, or pharmacy counter areas.

For more information refer to the MCMG guidelines at **https://www.cms.gov/files/document/medicare-communications-and-marketing-guidelines-3-16-2022.pdf**.

Receipt of federal funds, compliance with federal laws, and prohibition on discrimination

Payments received by contracted providers from MAOs for services rendered to MA plan members include federal funds. Therefore, a MAO's contracted providers are subject to all laws applicable to recipients of federal funds. These include, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45CFR part 84
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- The Americans with Disabilities Act
- Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.)
- The anti-kickback statute (section 1128B(b) of the Social Security Act)
- Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR parts 160, 162 and 164

In addition, our contracted providers must comply with all applicable Medicare laws, rules and regulations. And, as provided in applicable laws, rules and regulations, contracted providers are prohibited from discriminating against any MA plan member on the basis of health status.

Financial liability for payment for services

In no event should an MAO's contracted provider bill a MA plan member (or a person acting on behalf of an MA plan member) for payment of fees that are the legal obligation of the MAO. However, a contracted provider may collect deductibles, coinsurance or copayments from MA plan members in accordance with the terms of the member's Evidence of Coverage.

Note: *CMS issued a memo to MAOs dated September 17, 2008, ("CMS Guidance") providing guidance regarding balance billing by providers of certain individuals enrolled in both Medicare Advantage plans and a State Medicaid plan ("Dual Eligible beneficiaries"). More specifically, this CMS Guidance states that providers are prohibited from balance billing Dual-Eligible beneficiaries who are classified as Qualified Medicare Beneficiaries (QMB) for Medicare Parts A and B cost-sharing amounts.*

The CMS Guidance explains that providers must accept Medicare and Medicaid payment(s), if any, as payment in full. A QMB has no legal liability to make payment to a provider or MA plan for Medicare Part A or B cost sharing, and a provider may not treat a QMB as a "private pay patient" in order to bill a QMB patient directly. In addition, the CMS Guidance states that federal regulations require a provider treating an individual enrolled in a State Medicaid plan, including QMBs, to accept Medicare assignment.

Providers participating in Aetna Medicare networks are required to provide covered services to Aetna Medicare Dual-Eligible beneficiaries enrolled in Aetna Medicare Advantage plans ("Dual-Eligible members") and comply with all of the requirements set forth in this CMS Guidance. Participating providers must accept Aetna payment as payment in full or bill Medicaid for the Dual Eligible member's copayment.

For more information, visit our **Health Care Professionals Medicare page**.

Medicare first-tier, downstream and related entities (FDRs) compliance program requirements

CMS requires that Aetna first-tier, downstream and related entities (FDRs) fulfill Medicare Compliance Program requirements. If you are contracted to provide health care and/or administrative services for any of our Medicare plans, you are an FDR.

Our Medicare plans include:

- Medicare Advantage MA, MAPD, and/or PDP
- Medicare-Medicaid Plans (MMPs)
- Special Needs Plans (SNPs)

We describe all of CMS compliance program requirements in our First Tier, Downstream and Related Entities (FDR) Medicare Compliance Program Guide (FDR Guide). Go to **aetna.com/health-care-professionals/medicare.html** to find the **FDR Guide**.

You must review the **FDR Guide** and make sure you are complying with all of the requirements.

Oversight of your subcontractors

As outlined in Medicare laws, rules and regulations, physicians and health care professionals (and their employees, independent contractors and subcontractors) contracted with an Aetna Medicare Advantage organization ("contracted providers") must comply with various requirements. Refer to our **FDR Guide** for more information.

If your subcontractors provide health care and/or administrative services for the Aetna Medicare business, they are a downstream entity.

You must ensure that your downstream entities abide by all laws, rules and regulations. This includes ensuring your:

- Contractual Agreements contain all CMS-required provisions
- Downstream Entities comply with applicable Medicare requirements, including operational and compliance program requirements

What may happen if you don't comply

If our FDRs fail to meet these CMS Medicare-compliance program requirements, it may lead to:

- Development of a corrective action plan
- Retraining
- Termination of your contract and relationship with Aetna

Making sure you maintain documentation

You are required to maintain evidence of your compliance with the requirements for 10 years. Aetna or CMS may request that you provide documentation of your compliance with these requirements.

Exclusion list screening

Your organization should not employ or contract with an individual or entity that is excluded from participating in federally funded health care programs. Prior to contracting and monthly thereafter, you must screen employees and downstream entities against the following lists:

- **Office of Inspector General (OIG) List of Excluded Individuals and Entities**
- **General Services Administration (GSA) System for Award Management (SAM)**

If an excluded individual or entity is identified, you must notify us and immediately remove them from working on our Medicare business. This individual or entity should not bill for Medicare-covered services, and Aetna cannot pay such claims.

Medicare Advantage plan member billing, private contracts and claims

CMS reviews and approves all Medicare Advantage (MA) benefits packages. The statutes, regulations, policy guidelines and requirements in the Medicare Managed Care Manual and other CMS instructions are the basis for these reviews and approvals. To comply, MA organizations must be sure that their MA plans do not discriminate in the delivery of health care services, including source of payment.

The rules regarding collection of Medicare beneficiary cost-share amounts applicable in traditional Medicare apply to Aetna Medicare Advantage as well. Therefore, providers must collect all applicable cost-share amounts from Aetna Medicare Advantage plan members. To waive the cost share is a direct violation of federal laws and regulations. This action puts Aetna and your compliance at risk.

Services received under private contract

As specified by Medicare laws, rules and regulations, physicians may "opt out" of participating in the Medicare program and enter into private contracts with Medicare beneficiaries. If a physician chooses to opt out of Medicare due to private contracting, no payment can be made to that physician directly or on a capitated basis for Medicare-covered services. The physician cannot choose to opt out of Medicare for some Medicare beneficiaries but not others, or for some services but not others.

The MAO is not allowed to make payment for services rendered to MA members to any physician or health care professional who has opted out of Medicare due to private contracting, unless the beneficiary was provided with urgent or emergent care.

Claims and billing requirements

Physicians and other health care professionals must use the current revision of the International Classification of Diseases, Clinical Modification (ICD-10-CM) codes and adhere to all conventions and guidelines specified in the ICD-10-CM Official Guidelines for Coding and Reporting. Complete, accurately use both the CMS Healthcare Common Procedure Coding System (HCPCS Level II) and the required procedural codes of the American Medical Association's (AMA's) Current Procedural Terminology (CPT), current edition.

Hospitals and physicians using the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, (DSMV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk-Adjustment Processing System.

- The ICD-10 CM codes must be to the highest level of specificity: A code is invalid if it does not contain the full number of required characters detailed in the tabular list. Valid codes may contain three to seven characters.
- Report all secondary diagnoses that impact clinical evaluation, management and/or treatment.
- Report all status codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Again, failure to use current coding guidelines may result in a delay in payment and/or rejection of a claim.

Submitting Medicare claims and encounter data for risk adjustment

Risk adjustment is used to fairly and accurately adjust payments made to MAOs by CMS based on the health status and demographic characteristics of an enrollee. CMS requires MAOs to submit diagnosis data regarding physician, inpatient and outpatient hospital encounters on a quarterly basis, at minimum.

CMS uses the Hierarchical Condition Category payment model referred to as CMS-HCC model. This model uses the ICD-10 CM as the official diagnosis code set in determining the risk-adjustment factors for each member. The risk factors based on HCCs are additive and are based on predicted expenditures for each disease category. For risk-adjustment purposes, CMS classifies the ICD-10 CM codes by disease groups known as HCCs.

Providers are required to submit accurate, complete and truthful risk-adjustment data to the MAO. Failure to submit complete and accurate risk-adjustment data to CMS may affect payments made to the MAO and payments made by the MAO to the physician or health care professional organizations delegated for claims processing.

Ambulance services

Ambulance services, including fixed-wing and rotary-wing ambulance services, are covered only if they are furnished to a member whose medical condition is such that other means of transportation

are contraindicated. The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Note that air ambulance services are covered only if the member's medical condition is such that transportation by ground ambulance is not appropriate.

The member must be transported to the nearest facility (hospital, critical access hospital or rural emergency hospital) with the available type of physician or physician specialist needed to treat the beneficiary's condition.

Nonemergency, scheduled and repetitive ambulance services may be covered if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a physician certification statement dated no earlier than 60 days before the date the service is furnished indicating that these services are medically necessary.

Providers of hospice-related services

Aetna Medicare Advantage members may elect to use the hospice benefit in the Original Medicare program instead of their MA HMO and PPO coverage. Prior to initiating hospice care, the member or their representative must sign the "Election of Benefits" waiver. When this election is documented, the enrollee should be referred to the Original Medicare hospice provider.

Original Medicare will assume financial responsibility on the date the waiver is signed, and reimbursement will be made by Original Medicare directly to the agency.

Durable medical equipment (DME) will be the responsibility of the hospice provider. The MA plan remains responsible for payment of those medical services not related to the terminal illness and additional benefits not covered by Medicare. An example of an additional benefit is the eyeglasses reimbursement.

For services not related to the terminal illness, inpatient services should be billed to the Medicare Fiscal Intermediary using the condition code "07." For physician services and ancillary services not related to the terminal illness, the physician or other health care professional should bill the Medicare carrier (as is done for Medicare FFS patients) and use the modifier "GW."

Attending physician services are billed to the Medicare carrier with the "GV" modifier, provided these services were not furnished under a payment arrangement with the hospice. If another physician covers for the designated attending physician, the services of the substituting physician are billed by the designated attending physician under the reciprocal or *locum tenens* billing instructions. In such instances, the attending physician bills using the "GV" modifier in conjunction with either a "Q5" or "Q6" modifier.

Access to facilities and records

Medicare laws, rules and regulations require that contracted providers retain and make available all records pertaining to any aspect of services furnished to MA plan members or their contract with the MAO for inspection, evaluation and audit. Providers are required to hold these records for whichever of the following time periods is longest:

- A period of 10 years from the end of the contract period of any Aetna Medicare contract
- The date the Department of Health and Human Services or the Comptroller General or their designees complete an audit
- The period required under applicable laws, rules and regulations

Obligation to respond to requests for records

We are required to ask our network providers to give us clinical documentation to help make coverage decisions for pharmacy or medical services. Under our contract with you, you're obligated to provide this information to us promptly upon request. Our clinical staff will contact your office by phone or fax when we need documentation.

The timelines for making coverage decisions are short and highly regulated, so it is critical that you provide us with the requested clinical information on a timely basis. If you don't, it could adversely impact your patients' access to care and result in unnecessary coverage denials. Please make sure your staff knows they must respond quickly to medical record requests. Failure to respond may impact your future participation status.

Confidentiality and accuracy of member records

Contracted providers must safeguard the privacy and confidentiality of, and ensure the accuracy of, any information that identifies an MA plan member. Original medical records must be released only in accordance with federal and state laws, court orders or subpoenas.

We expect our contracted providers to:

- Maintain accurate medical records and other health information
- Help ensure timely access by members to their medical records and other health information
- Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information and member information
- Provide staff with periodic training in member information confidentiality

Refer to the **Privacy Practices** section of this manual for further information.

Risk adjustment medical record validation

CMS conducts medical record reviews to validate the accuracy of the risk-adjustment data submitted by the MAO. Medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient and physician diagnoses submitted by the provider to the MAO. In addition, Medicare Advantage regulations require that providers submit samples of medical records for validation of risk-adjustment data and the diagnoses reported by Aetna to CMS, as required by CMS.

Therefore, providers must give access to and maintain medical records in accordance with Medicare laws, rules and regulations. (Refer to the **Access to Facilities and Records** section). CMS may adjust payments to the MAO based on the outcome of the medical record review.

Advance directives

Our contracted providers must document in a prominent place in an MA plan member's medical record whether the member has executed an advance directive. Refer to the Member Rights and Responsibilities policy for more information on advance directives.

Physician-member communications policy

Our contracts with participating providers do not contain "gag clauses." Nothing about the contract prevents the physicians or other health care professionals from discussing issues openly with their patients. We include language in our contracts to promote open physician-member communication.

Our objective is to give members the comfort of knowing that their physicians and other health care professionals have the right and the obligation to speak freely with them.

We encourage providers to discuss with their patients:

- Pertinent details regarding the diagnosis of their conditions
- The nature and purpose of any recommended procedure
- The potential risks and benefits of any recommended procedure or treatment
- Any reasonable alternatives to such recommended treatment

The "effective communication" baseline rule

As an Aetna provider, you are obligated to do both of the following:

- Ensure all communications with the deaf and hard of hearing are as effective as those with other persons.
- Provide appropriate auxiliary supports and services to the deaf and hard of hearing, whenever necessary, to afford them an equal opportunity to benefit from their services.
- Ensure the ability to assist members in a variety of languages, per federal law requirements.
- When deciding whether a particular aid should be provided, keep in mind that the general goal is to ensure all communications with individuals are effective.

Individuals qualifying for auxiliary supports and services

Individuals qualify for auxiliary supports and services if either of the following apply:

- They are deaf or hard of hearing
- They are in one of the classes of people covered by the regulations

The term "deaf" includes individuals who do not hear well enough to rely on their hearing to process speech and language. The term "hard-of-hearing" includes individuals with conditions that affect the

frequency or intensity of their hearing. A deaf or hard-of-hearing person would be covered by **ACA Section 1557** if they are substantially limited in hearing or substantially limited in some other major life activity because of hearing loss.

An individual may be considered deaf or hard of hearing even if their hearing loss is eased by the use of a hearing aid or cochlear implant.

Auxiliary support and service options

The regulations include a long, but non-exhaustive list of auxiliary supports and services that may be provided in a particular instance. The list includes (among other possibilities):

- Qualified interpreters, who can provide services in person and on-site or remotely through technology, such as video remote interpreting (VRI)
- Use of written materials and exchange of written notes
- Voice-, text- and video-based telecommunications products, such as video relay service (VRS)
- Text telephones, called "teletypewriters" (TTYs)

There are many other options, but all must be provided free of charge. Any special technology such as VRI or VRS must meet technical and operational standards and users must be properly trained. The appropriate aid to use will depend on the individual in need of the aid, the type of communication and the context. When deciding which aid to provide, primary consideration should be given to the person with a disability who is requesting the service. Aids should also be provided in a timely manner and in such a way that protects the privacy and independence of the individual.

Persons qualified to act as interpreters

Interpreters used by covered entities (whether interpreting in-person or via VRI) should be qualified. A qualified interpreter may use one of several methodologies, but must:

- Adhere to generally accepted interpreter ethics principles, including client confidentiality
- Be able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology

You must not require a person to bring someone with him or her to interpret, nor should you rely on an adult companion or child to interpret, unless:

- There is an emergency involving an imminent threat to the safety or welfare of the individual or the public and no other interpreter is available
- The person requests interpretation from their companion and reliance on the companion is determined to be appropriate

For more from the Office of Civil Rights on effective communications, go to the U.S. Department of Health and Human Services website, **www.hhs.gov**.

Annual notice of change

Medicare plan benefits are subject to change annually. Members are provided with written notice regarding the annual changes by the date specified by CMS. The CMS Annual Election Period typically runs from October 15 through December 7 for the upcoming calendar year for beneficiaries enrolled in individual MA-only, MAPD and PDP plans. Elections made during the Annual Election Period are effective January 1 of each year. Providers can access the Aetna Medicare website for information on the individual plans and benefits that will be available within their service area for the following calendar year.

Access to services

We have established programs and procedures to:

- Identify members with complex or serious medical conditions
- Work in conjunction with the member's physician, who is responsible for directing and managing their patients' care, assessing those conditions, and using medical procedures to diagnose and monitor patients on an ongoing basis
- Grant members an adequate number of direct-access visits to specialists (that is, no prior authorization required) to implement the treatment plan

In addition, as provided in applicable laws, rules and regulations, contracted providers are prohibited from discriminating against any Medicare member based on health status. Therefore, providers contracted with us are required to make services available in a culturally competent manner to all MA plan members. This includes those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities. In turn, we maintain procedures to inform members with specific health care needs of follow-up care and provide training in self-care, as necessary.

Direct access to in-network women's health specialists

Without a referral, MA plan members have direct access to mammography screening services at a contracted radiology facility. They also have direct access to in-network women's health specialists for routine and preventive services.

Direct-access immunizations

Without a referral, MA members may receive influenza, hepatitis B and pneumococcal vaccines from any network provider. There is no cost to the member if any of these vaccinations are the only service provided at that visit. A PCP copayment will apply for all other immunizations that are medically necessary, in addition to the cost of the drug.

Beginning January 1, 2023, Part D-covered adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), including the shingles and tetanus-diphtheria-whooping cough vaccines, will be available with no deductible and no cost-sharing to people with Medicare prescription drug coverage.

Emergency services

Refer to the Your Rights section of the Aetna website for more information on emergency services for your patients.

Health-risk assessment

We offer all members the opportunity to complete a health-risk assessment within 90 days of their enrollment in an Aetna MA plan.

The information obtained through the assessment is sent to the member's primary care physician if we have one on file.

Provider-initiated permissible activities

Provider-initiated activities are activities conducted by a provider at the request of the patient, or as a matter of a course of treatment, and occur when meeting with the patient as part of the professional relationship between the provider and patient.

Permissible activities include:

- Distributing unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" (from **Medicare.gov**), including in areas where care is delivered
- Providing the names of MA organizations with which they contract or participate or both
- Answering questions or discussing the merits of a MA plan or plans, including cost sharing and benefit information, including in areas where care is delivered
- Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Offices, CMS' website at **Medicare.gov**, or **1-800-MEDICARE**
- Referring patients to MA plan marketing materials available in common areas
- Providing information and assistance in applying for the Low-Income Subsidy (LIS)
- Announcing new or continuing affiliations with MA organizations, once a contractual agreement is signed. Announcements may be made through any means of distribution

What contracted providers may do:

- Make available, distribute, and display communications materials, including in areas where care is being delivered
- Provide or make available marketing materials and enrollment forms in common areas

Medicare Outpatient Observation Notice (MOON) requirement

All participating hospitals and critical access hospitals (CAHs) must adhere to the provisions of the MOON Notice Act developed by CMS. Under this act, hospitals and CAHs must deliver a MOON to any member, including Medicare Advantage members, who receives observation services as an outpatient for more than 24 hours. The MOON must be provided to members no later than 36 hours after services begin. Go to **https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-moon** to find the notice and the accompanying instructions.

Medicare Medical Loss Ratio (MLR) requirements

Congress, under the Affordable Care Act, amended the MA program provisions in the Social Security Act to require MAOs to achieve an 85% MLR, beginning with contract year 2014. CMS issued regulations to implement these MLR requirements that include maintenance and access to records obligations.

These requirements apply to any provider who:

- Is contracted with an MAO to participate in their Medicare network
- Retains medical/drug cost data that the MAO uses to calculate Medicare MLRs for which the MAO does not have independent access

MA organizations and Part D sponsors are required to maintain evidence of amounts reported to CMS and to validate all data necessary to calculate MLRs in accordance with the requirements in §§ 422.2480 and 423.2480. See also 42 CFR §§ 422.503(d), 422.504(d)–(e), 422.2480, 423.504(d), 423.505(d), and 423.2480.

Additionally, the MAO must require any third-party vendor supplying drug or medical cost contracting and claim adjudication services to provide the MAO with all underlying data associated with MLR reporting, regardless of current contractual limitations. If this MA regulation is applicable to a participating provider, the provider is required to do both of the following:

- Ensure that they are retaining such data for the requisite time period (11 years from the CMS MLR reporting date, not the termination of the CMS contract, as referenced in existing MA regulations)
- Preserve the MAO's and government's ability to obtain data and records, as necessary, to satisfy any government information request during the 11-year period

MA Organization Determination (OD) process

Medicare beneficiaries enrolled in MA plans are entitled to request an OD, which is a decision or determination concerning the rights of the member with regard to item, service or drug covered by Medicare and/or Aetna, and any decision/determination concerning the following items:

- Reimbursement for coverage of emergency or urgently needed services or post-stabilization care
- Payment for any other health services furnished by a provider or supplier other than the organization that the member believes are Medicare covered (or, if not covered by Original Medicare, should have been furnished, arranged for or reimbursed by the organization)
- Denial of coverage of an item or service the member has not received but believes should be covered
- Discontinuation of coverage of a service, if the member disagrees with the determination that the coverage is no longer medically necessary

Members can request an expedited or standard organization determination decision. We will review and process the request in accordance with the CMS requirements and time frames. If the member's request is denied, the member may exercise his or her appeal rights.

Ban of Advance Beneficiary Notice of Noncoverage (ABN) for Medicare Advantage (MA)

Provider organizations should be aware that an ABN is not a valid form of denial notification for a Medicare Advantage member. ABNs, sometimes referred to as "waivers," are used in the Original Medicare program. CMS prohibits use of ABNs for members enrolled in a Medicare Advantage plan. Therefore, ABNs cannot be used for patients enrolled in Aetna Medicare Advantage plans, such as Aetna.

As a provider who has elected to participate in the Medicare program, you should understand which services are covered by Original Medicare and which are not. Aetna Medicare Advantage plans are required to cover all benefits that Original Medicare covers and, in some instances, may provide coverage that is more generous or otherwise goes beyond what is covered under Original Medicare. If you believe an item, service or Part B drug may not be covered, you must advise the member to request prior approval from Aetna or you may request prior approval on the member's behalf. If you believe an item, service or Part B drug may not be covered for a member, or could be covered only under specific conditions, the appropriate process is for the member or provider to request a pre-service organization determination from the plan.

CMS mandates that providers who are contracted with a Medicare Advantage plan, such as Aetna, are not permitted to hold a Medicare Advantage member financially responsible for payment of a service not covered under the member's Medicare Advantage plan.

As an Aetna Medicare Advantage contracted provider, if you believe an item, service or Part B drug may not be covered, you must advise the member to request prior approval from Aetna, or you may request prior approval on the member's behalf.

- If the member does not have a pre-service OD notice of denial from Aetna on file, you must hold the member harmless for the noncovered services. You cannot charge the member any amount beyond the normal cost-sharing amounts (such as copayments, coinsurance and/or deductibles).
- As a contracted provider, if you furnish a service or refer the member for a service that a member reasonably believes is a plan-covered service, the member cannot be financially liable for more than the applicable cost-sharing for that service. If you believe an item or service may not be covered for a member, or could be covered only under specific conditions, the appropriate process is for the member or provider to request a pre-service organization determination from the plan.
- However, if a service is never covered under Original Medicare or is listed as a clear exclusion in the member's plan materials, you can hold the member financially liable without a pre-service OD. However, you cannot hold a member financially liable for services or supplies that are only covered when medically necessary unless you go through the OD process. Members cannot be expected to know when a service is medically necessary and when it is not.

Providers and members can initiate pre-service ODs. You must go through this process to determine if the requested or ordered service is covered prior to a member receiving it, or prior to scheduling a service such as a lab test, diagnostic test or procedure. The procedure to request a pre-service OD is similar to the procedure to request a prior authorization. Call the number on the member's ID card and ask for a pre-service OD to determine if the service will be covered for the member.

Once we make a determination, the member will be notified of the decision. You will only be able to charge the member for the service if the member has already received the decision from us and the service(s) in question have not been rendered.

Aetna Behavioral Health

Aetna Behavioral Health refers to an internal business unit of Aetna. On **Aetna.com**, you'll find:

- Archived issues of our **Office Links Updates** newsletter with information for participating behavioral health professionals
- **Aetna Behavioral Health Programs** overview
- **Utilization Management** and how we determine coverage

Our guiding principles

Our behavioral health programs support our belief in the following:

- Enhancing our members' — your patients' — clinical experiences
- Adhering to the importance of the mind-body principle and connection
- Providing a treatment approach that is evidence-based, goal-directed, and consistent with accepted standards of care, all Aetna Clinical Policy Bulletins, and Aetna clinical practice guidelines
- Providing treatment that is medically necessary
- Educating members about the risks and benefits of available treatment options
- Developing a strong relationship with you, informing you about resources, and concentrating on continuity of care among all, for the benefit of you and your patients
- Integrating behavioral health care across our product spectrum

Access to care

Members may access behavioral health care in three ways:

- Through direct access to the behavioral health provider
- Through a recommendation from the primary care physician or other treatment provider
- Through a referral from an employee assistance or student assistance program provider

Aetna Behavioral Health Participation Criteria and accessibility standards

Providers are required to comply with Aetna participation requirements, which are available in our **Participation Criteria (PDF)**.

We have standards for member access to behavioral health services, which are listed in our Participation Criteria, along with other PCP criteria.

Clinical management and delivery

How we determine coverage

Our medical directors make all coverage decisions that involve clinical issues. Only licensed medical directors, psychiatrists/psychologists and pharmacists make denial decisions for reasons related to medical necessity. (Licensed pharmacists and psychologists review coverage requests, as permitted by state regulations.)

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

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

To ensure Aetna members receive the highest quality of care, a comprehensive diagnostic evaluation prior to the initiation of treatment is expected. Diagnoses submitted on claims must be current and consistent with the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. Collecting complete and accurate clinical data is critical to successfully completing the authorization process. Treatment approach is expected to be evidence-based, goal directed, and consistent with accepted standards of care, Aetna Clinical Policy Bulletins and Aetna clinical practice guidelines. It is also expected that treatment provided is **medically necessary**.

In addition to reviewing clinical information to determine coverage, our utilization management clinician will discuss treatment alternatives, the appropriate level of care and explore discharge planning opportunities. If Aetna case management is involved, we will request that the member's family, physician(s), and other health care professionals be involved in the treatment plan and activities. We recommend that you discuss the available benefits for outpatient care with your patient, so that treatment can be planned accordingly.

Note: *For these purposes, "coverage" means either the determination of (i) whether or not the particular service or treatment is a covered benefit under the terms of the particular member's benefits plan, or (ii) where a physician or health care professional is required to comply with the Aetna patient management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement.*

Utilization management coverage determinations

We use evidence-based clinical guidelines from nationally recognized authorities to make utilization management (UM) decisions. We base decisions on the appropriateness of care and service. We review coverage requests to determine if the requested service is a covered benefit under the terms of the member's plan and is being delivered consistently with established guidelines.

Aetna offers providers an opportunity to present additional information and discuss their cases with a peer-to-peer reviewer as part of the utilization review coverage determination process. The timing of the review incorporates state, federal, Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) requirements.

If we deny a request for coverage, the member (or a physician acting on the member's behalf) may appeal this decision through the complaint and appeal process. Depending on the specific circumstances, the appeal may be made to a government agency, the plan sponsor, or an external utilization review organization that uses independent physician reviewers, as applicable.

We don't reward physicians or other individuals who conduct utilization reviews in order to issue denials of coverage or create barriers to care or service. Financial incentives for utilization management decision makers don't encourage denials of coverage or service. Rather, we encourage the delivery of appropriate health care services. In addition, we train utilization review staff to focus on the risks of underutilization and overutilization of services. We don't encourage utilization-related decisions that result in underutilization.

Level of Care Utilization System

The **Level of Care Utilization System** for Psychiatric and Addiction Services, or LOCUS, is a nationally recognized level of care tool used to help determine the resource intensity needs of individuals who receive adult mental health services. It is used for patients 18 years and older who are in need of placement in specialized psychiatric or mental health facilities or units. This person-centered approach aims to find the best fit between individual needs and behavioral health services. For more information about LOCUS, visit the American Association of Community Psychiatry (AACP) website at **CommunityPsychiatry.org**.

The Child and Adolescent Level of Care/Service Intensity Utilization System and Child and Adolescent Service Intensity Instrument, or CALOCUS-CASII, are nationally recognized tools used to determine the appropriate level of care placement for a child or adolescent. These tools are used for children and adolescents from 6 to 17 years of age. For more information about these tools, visit the American Academy of Child and Adolescent Psychiatry (AACAP) website at **AACAP.org**.

Note: *The LOCUS and CALOCUS/CASII are instruments that an Aetna clinician uses to aid in the decision-making process. They help determine the level of care appropriate for effective treatment for a mental health patient. "Aetna clinician" may mean a Licensed Behavioral Health Clinician or RN, an independent physician reviewer working on our behalf or an Aetna medical director. LOCUS and CALOCUS/CASII guidelines don't constitute medical advice. Treating providers are solely responsible for medical advice and treatment of members.*

The ASAM Criteria: Treatment Criteria for Addictive Substance-related and Co-occurring Conditions

This is a nationally recognized criteria set that helps determine appropriate levels and types of care for patients in need of evaluation and treatment for chemical dependency and substance use conditions and diagnoses. The third edition is compliant with the DSM-5 and also applies for patients who are in need of placement in specialized chemical dependency detoxification or rehabilitation facilities or units.

State-specific guidelines

Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) is used for chemical dependency treatment that takes place in New York.

Some states have specific requirements or laws in place for practitioners and facilities. For more information on state-specific requirements, see our **Provider Manual State Supplement**.

Aetna's Applied Behavior Analysis (ABA) Medical Necessity Guide

The ABA Medical Necessity Guide is a clinical behavioral health patient-management instrument used to guide and track treatment decisions for our members in need of ABA. For practitioners treating autism spectrum disorders using ABA, either national certification is needed from the Behavior Analyst Certification Board (BACB), or the practitioner must be licensed as a behavior analyst in the state in which they practice.

Aetna Clinical Policy Bulletins (CPBs)

These are based on evidence in peer-reviewed, published medical literature; technology assessments and structured evidence reviews; evidence-based consensus statements; expert opinions of health care providers; and evidence-based guidelines from nationally recognized professional health care organizations and government public health agencies. CPBs are detailed technical documents that explain how we make coverage decisions for members under our health benefits plans. They spell out what medical, dental, pharmacy and behavioral health technologies and services may, or may not, be covered.

Both new and revised CPB drafts undergo a comprehensive review process that includes review by our Clinical Policy Council. Our chief medical officer (or designee) approves CPBs. The Aetna Clinical Policy Council evaluates the safety, effectiveness, and appropriateness of medical technologies (that is, drugs, devices, medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided) that are covered under our medical plans, or that may be eligible for coverage under our medical plans.

In making this determination, the Clinical Policy Council reviews and evaluates evidence in the peer-reviewed, published medical literature; information from the U.S. Food and Drug Administration and other federal public health agencies; evidence-based guidelines from national medical professional organizations; and evidence-based evaluations by consensus panels and technology evaluation bodies.

Custodial Care Guidelines

When care is deemed to fall under custodial care, the care is no longer eligible for coverage. Based on the information provided the Member has reached the maximum achievable level of mental function with the current treatment at the current level of care; and/or the services are given mainly to maintain, rather than improve, a level of mental function, and/or provide a surrounding free from environmental conditions that can worsen the person's physical or mental state.

You can learn more about these guidelines on the **utilization management page on Aetna.com**.

More information

The criteria noted above are only guidelines. Their use doesn't preclude the requirement that trained, licensed, credentialed and experienced behavioral health professionals must exercise their independent professional judgment when providing behavioral health care services to our members.

Referrals for evaluation and/or treatment of chemical dependency and mental health issues will be reviewed by a psychiatrist or licensed clinician to determine the appropriate level of care.

If you need hard copies of any of Aetna Behavioral Health UM criteria or CPBs, call us at:

- Provider Service Center: **1-800-624-0756 (TTY: 711)**
- HMO and Aetna Medicare Advantage plans: **1-800-624-0756 (TTY: 711)**
- All other plans: **1-888-MDAetna (TTY: 711)** or **1-888-632-3862 (TTY: 711)**

For current information on our medical necessity criteria or Clinical Policy Bulletins, visit **Aetna.com/health_care-professionals/clinical-policy-bulletins.html** for our Clinical Policy Bulletins page.

Precertification

Precertification is the process of determining the eligibility for coverage of the proposed level of care and place of service. Precertification occurs before inpatient admissions and select ambulatory procedures and services. Use our online tools to help you determine if precertification is required for a particular procedure. You can submit a precertification request the following ways:

- Through **Availity.com** (our provider portal)
- Through one of our vendors — go to **Aetna.com/health-care-professionals/claims-payment-reimbursement/electronic-transaction-vendors.html** to see our list
- By calling our Provider Service Center at **1-800-624-0756 (TTY: 711)**
- By calling the toll-free behavioral health/precertification telephone number on the member's ID card

To request precertification, use our provider portal at **Availity.com** or any other website that allows you to send precertification requests electronically.

Visit our website for a general list of services that require precertification and concurrent review, and to learn more about **precertification**.

Note: *The term "precertification" (used here and throughout the office manual) refers to the utilization review process used to determine if a requested service, procedure, prescription drug or medical device meets our clinical criteria for coverage. It does not mean precertification as defined by Texas law. Texas law defines precertification as a reliable representation of payment of care or services to fully insured health maintenance organization (HMO) and preferred provider organization (PPO) members.*

Outpatient care

It's important to note that outpatient care that isn't consistent with evidence-based, goal-directed practices, Aetna Clinical Policy Bulletins and Aetna clinical practice guidelines may be subject to quality-of-care and utilization reviews.

Also note that outpatient care inconsistent with such a treatment approach may be subject to a concurrent review.

Assessing for comorbidity

It's expected that facility diagnostic evaluations assess for either comorbid chemical dependency or comorbid psychiatric conditions that could be impacting current presentation.

Stepping down care

Stepping down to a less restrictive level of care within the same facility (for example, a step down from inpatient detoxification to inpatient rehabilitation), even within the same unit of the same facility, requires precertification.

Out-of-network referrals

A member may sometimes seek treatment outside of our network (for example, a nonparticipating referral for routine outpatient behavioral health services). This is a written or oral request that we review. Reasons that a nonparticipating referral may be approved include:

- When a specific health care professional preferred by the member isn't available in network (and the member's plan provides coverage for out-of-network services)
- When the member is continuing, or returning to, treatment with a nonparticipating health care professional, in certain circumstances
- When the primary care practitioner identifies a local or known nonparticipating health care professional with expertise in the treatment of the member's condition (and the member's plan provides coverage for out-of-network services)

Precertification for ABA

Applied behavior analysis (ABA) services require precertification. To get ABA services precertified, call the number on the member's Aetna ID card and speak to a Member Services representative.

See our **medical necessity guidelines for ABA**.

We've used the American Medical Association Category I CPT codes (97151–97158) for Adaptive Behavior Treatment as of January 1, 2019, and Category III CPT codes (0362T and 0373T).

Exceptions

The precertification process applies to all Aetna plans with the exception of behavioral health benefits that we administer but do not control and self-funded plans with plan sponsors that have expressly purchased specific precertification requirements.

Clinical practice guidelines (CPGs)

Consult behavioral health CPGs as you care for patients

Evidence-based clinical practice and preventive services guidelines from nationally recognized sources promote consistent application of evidence-based treatment methodologies. Guidelines are chosen based on the review of scientific literature, professional sources, our current clinical quality improvement activities and collaboration with our provider network through the National Quality Advisory Committee.

Once implemented, we review each guideline at least annually for continued applicability and update them as needed. We report guideline changes through our online newsletter, OfficeLinks Updates, posted on the **newsletters page** of our public website.

Our adopted guidelines are intended to support, not replace, sound clinical judgment. We welcome your feedback and will consider all suggestions and recommendations in our next review. You can contact our Quality Management department at **QualityImprovement2@Aetna.com**.

Clinical Practice Guidelines – links

Our current Behavioral Health clinical practice guidelines are linked below:

- **American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents (2019)**
- **American Society of Addiction Medicine (ASAM) Clinical Practice Guideline on Alcohol Withdrawal Management (2020)**
- **American Psychiatric Association (APA) Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder (2018)**
- **VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder (MDD) (2022)(PDF)**
- **American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder (2020)**
- **American Society of Addiction Medicine (ASAM) Clinical Considerations: Buprenorphine Treatment of Opioid Use Disorder for Individuals Using High-potency Synthetic Opioids (2023)**
- **American Society of Addiction Medicine (ASAM) and American Academy of Addiction Psychiatry (AAAP) Clinical Practice Guideline on the Management of Stimulant Use Disorder (2024)**

There are several other behavioral health guidelines to help support your patient care decisions on the **APA website**.

For a copy of a specific CPG, log into **Availity** and see the Clinical Resources and Clinical Medical Management sections.

Coordination of care

We appreciate the importance of the therapeutic relationship and strongly encourage continuity, collaboration and coordination of care. Whenever a transition-of-care plan is required, whether the transition is to a less intensive level of care or to another outpatient provider, the transition is designed to allow the member's treatment to continue without disruption whenever possible.

We also believe that collaboration and communication among providers who are participating in a member's health care are essential for the delivery of integrated, quality care. There are several ways to ensure continuity, collaboration and coordination of care, including:

- **Ambulatory follow-up:** Members being discharged from an inpatient stay should have a follow-up appointment scheduled before discharge. The appointment should occur within seven days of discharge.
- **Emergency department follow-up:** Members seen in an emergency department setting for a behavioral health condition or for alcohol or other drug abuse or dependence should have a follow-up appointment within 7 days of discharge. Emergency department staff should assist with appointment setup if possible. Behavioral health care professionals should have available appointments within 7 days for members recently treated in an emergency department.
- **Timely and confidential exchange of information:** With written authorization from the member, it's important that you communicate key clinical information in a timely manner to all other health care providers participating in a member's care, including the member's primary care practitioner.
- **Timely access and follow-up for medication evaluation and management:** Members should receive timely access and regular follow-up for medication management.

Behavioral health care professional responsibilities for all levels of care

- Explain to the member the purpose and importance of communicating clinical information and coordinating care with other relevant health care providers treating the same patient.
- Obtain written authorization from the member to communicate significant clinical information to other relevant providers.
- Obtain, at the initial treatment session, the names and addresses of all relevant health care providers involved in the member's care.
- Subject to applicable law, include the following in the Authorization to Disclose document signed by the member in both outpatient office and higher-levels-of care settings:
  - A specific description of the information to be disclosed
  - Name of the individual(s) or entity authorized to make the disclosure
  - Name of the individual(s) or entity to whom the information may be disclosed
  - An expiration date for the authorization
  - A statement of the member's right to revoke the authorization, any exceptions to the right to revoke and instructions on how the member may revoke the authorization
  - A disclaimer that the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected
  - A signature and date line for the member
  - If the authorization is signed by the member's authorized representative, a description of the representative's authority to act for the member.
- Contact the member's primary care practitioner when a member enters care and promptly when there is an emergency or, with member consent, under circumstances such as the following:
  - Medical comorbidities and/or medication interactions are a possibility
  - Clinical information needs to be exchanged to aid in diagnosis and/or treatment
  - Primary care practitioner or specialist support for a treatment plan would enhance member compliance and/or treatment outcome
  - Primary care practitioner or specialist has requested immediate feedback
- Upon obtaining appropriate authorization, communicate in writing to the primary care practitioner or other appropriate specialist, at a minimum, at the following points in treatment:
  - Initial evaluation or assessment
  - Significant changes in diagnosis, treatment plan or clinical status
  - When medications are initiated, discontinued or significantly altered
  - Termination of treatment

Note: *It's recommended that communication occur within two weeks of the above situations— if needed, the* ***Behavioral Health/Medical Provider Physician Communication Form*** *is located at* ***Aetna.com*** *in the "Provider forms" section under the Resources tab.*

- Work with medical practitioners to support the appropriate use of psychotropic drugs.
- Collaborate with our Patient Management staff to develop and implement discharge plans before the member is discharged from an inpatient setting.
- Cooperate with follow-up verification activities and provide verification of kept appointments when requested, subject to applicable federal, state, and local confidentiality laws.
- Work with us to establish discharge plans that include a post-discharge scheduled appointment within seven days of discharge from an inpatient stay or an emergency department visit.
- Notify us immediately if a member misses a post-discharge appointment.
- Promptly complete and submit a claim for services rendered, confirming that the member kept the after-care appointment.
- Provide suggestions to us on how we can continue to improve the collaboration-of-care process.

Helpful tips

- There is a difference between how behavioral health practitioners share information with medical providers and how medical providers share information among themselves.
- For behavioral health information such as general progress reporting and sharing of details like medication lists, a signed release may be required by relevant federal or state law. This release may be required even if the medical provider seeking the information is also the one that referred the member to the behavioral health provider. State and/or other laws may apply.
- Learn more about **mental health HIPAA requirements** and **substance use disorder requirements**.
- **Psychotherapy notes** that contain the content of conversations are not covered under a general release.
- Psychotherapy notes require a separate release of information.
- Confidentiality laws govern what and how information can be shared, and they vary by state. We encourage both behavioral health and medical providers to find out about and **follow their state regulations**.
- To enhance coordination of care, obtaining a release of information from your patient is one way to facilitate information sharing with other providers and practitioners.

Discharge review and planning

Discharge planning includes all of the following components:

- If a patient needs to be admitted to a different level of care, discharge information will be provided to the health care professional/facility at the time of referral for admission.
- Facilities will designate a clinical staff member to be responsible for coordinating discharge planning activity.
- A written discharge plan must exist for each member, and discharge planning should begin at the time of admission.
- Where required, the inpatient facility, partial hospital program, intensive outpatient program or other involved health care professional will obtain a release of information from the member that meets all state and federal confidentiality regulations for the purpose of coordinating care with the current treating providers. If a release is obtained, the provider will facilitate coordination of care and collaboration with the primary care practitioner and/or other appropriate health care specialist.
- Facilities should arrange for follow-up appointments within seven days for each member discharged from an inpatient stay. We also ask that health care professionals to schedule such appointments within seven days.

Transition and continuity of care

We may allow members to continue care for a specified period of time with a behavioral health care professional who has left the network. This will ensure that the member's course of treatment isn't interrupted.

The length of time may vary and depends on regulatory requirements, company policies, and the health care professional's willingness to continue to treat the member. Company policy states that participating providers leaving the network will work with us to transition the member to a participating provider when network benefits are requested, and the care will exceed the 90-day transition period. A health care professional may not continue to care for a member under the network benefit if we determine that a quality-of-care issue may negatively impact the member's care.

Inpatient level of care

Members who, at the time of enrollment, are being treated at an inpatient level of care should complete their single, uninterrupted course of care under the benefits plan or policy that's active at the time of admission.

All other levels of care

Patients who have met certain requirements are allowed to continue an "active course of treatment" with a nonparticipating practitioner. They can continue for up to 90 days without penalty, within the benefits limitations, at the new or preferred plan benefits level as outlined in the provider contract. In some states, regulatory requirements may mandate that we continue coverage beyond 90 days.

Telehealth services

Aetna Behavioral Health offers telehealth services to all commercial fully insured members and to all commercial self-insured plan sponsors, unless those self- insured plan sponsors opt out of telehealth services. Providers must act within the scope of their license and ensure that they have the proper licensure based on state requirements.

Aetna Behavioral Health Quality Program

Overview

Participating behavioral health care professionals are required to support and cooperate with our Aetna Behavioral Health Quality program, be familiar with our guidelines and standards, and apply them in their clinical work.

We're committed to a continuous quality improvement program and encourage your involvement. The Aetna Behavioral Health Quality program includes:

- A utilization management program
- Quality improvement activities
- Screening programs
- Condition management programs
- Member and provider experience surveys
- Provider treatment record review studies (completed for specific states where mandated by law)
- Oversight of availability and access to care
- Member safety
- Complaint, non-authorization and appeal processes
- Medical necessity criteria
- Clinical practice guidelines
- Investigations of potential facility and practitioner quality-of-care concerns

Quality program guidelines

Specifically, behavioral health care professionals are expected to:

- Adhere to all Aetna policies and procedures, including those outlined in this manual
- Cooperate with quality improvement activities
- Communicate with the member's primary care physician and any specialists (after obtaining a signed release)
- Adhere to **Aetna Behavioral Health treatment record review standards and best practices**, as outlined in this manual
- Respond in a timely manner to inquiries by our behavioral health staff
- Cooperate with our behavioral health complaint process
- Adhere to continuity-of-care and transition-of-care standards when the member's benefits are exhausted or if they leave the network
- Cooperate with onsite audits or requests for treatment records
- Return completed annual provider surveys when requested
- Participate in treatment plan reviews or send in necessary requests for treatment records in a timely fashion
- Submit claims with all requested information completed
- Adhere to patient safety principles
- Comply with state and federal laws, including confidentiality standards, by maintaining the confidentiality of member information and records

Quality program results

Annual quality program information and program evaluation results are detailed on the Quality Management & Improvement Efforts page on our website. If you want a hard copy of our quality program evaluation and don't have Internet access, you can give us a call at:

- HMO and Aetna Medicare Advantage plans: **1-800-624-0756 (TTY: 711)**
- All other plans: **1-888-MDAetna (TTY: 711)** or **1-888-632-3862 (TTY: 711)**

Adverse incident reporting

We investigate reports of potential quality-of-care concerns, which include any adverse incident that takes place while a member is in care. Examples of potential quality-of-care concerns include, but aren't limited to any completed suicide, serious suicide attempt, or homicide that takes place within 30 days of discharge from care; violent member behavior; or adverse outcomes requiring hospitalization from psychotropic medication. Behavioral health care professionals and facilities are required to inform us (using the phone number listed on the member ID card) as soon as they become aware of a potential quality-of-care concern for any member in their care.

Aetna Behavioral Health treatment record review criteria and best practices

Each year, our quality management program randomly selects Aetna Behavioral Health network practitioners, in states where it is required, to participate in our outpatient treatment record review. This audit procedure is a key part of our quality program. It's important for the network to comply with standards set by Aetna Behavioral Health, our customers, and external agencies.

Your Aetna Behavioral Health Agreement requires that you participate in our quality management program.

Contact us at **QualityImprovement2@Aetna.com** for a copy.

Aetna Behavioral Health screening programs

Opioid overdose risk screening program

In an effort to address the rising opioid epidemic, we've implemented a screening program to identify members at risk for opioid overdose. When our clinicians assess a case involving opioid dependence, they discuss the potential benefits of adding naloxone (common brands include NARCAN® and EVZIO®) to the member's treatment plan as an intervention, in the event of relapse and future overdose.

Naloxone reverses the effects of an opioid overdose. Providing naloxone rescue kits to laypeople reduces overdose deaths, is safe, and is cost effective.* Other elements supporting this potentially life-saving intervention include telling patients and their family and support network about signs of overdose and about administering naloxone.

Coverage of naloxone rescue kits varies by individual plans and can be verified by calling the number on the member ID card. When it is covered, we waive copays for the naloxone rescue medication NARCAN for fully insured commercial members.

Resources for you and your patients

- **Aetna opioid resources**
- **CVS Health opioid response**
- **U.S. Department of Health and Human Services: Naloxone: The Opioid Reversal Drug that Saves Lives (PDF)**
- **U.S. Substance Use and Mental Health Services Administration (SAMHSA) Opioid Overdose Prevention Toolkit**

Aetna Depression in Primary Care Program

Depression often coexists with other serious medical illnesses, such as heart disease, stroke, cancer, HIV/ AIDS, diabetes and Parkinson's disease. Most people do not seek treatment due to the perceived stigma associated with depression. Many of those treated don't receive appropriate or continued treatment.

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

Our program offers your primary care practice:

- Recommended tools to screen for depression as well as monitor response to treatment
- Reimbursement for depression screening and follow-up monitoring

To participate, you just need to be a participating primary care provider, use a recommended screening tool to screen your patients and submit claims with the following billing combination (select the most appropriate): CPT code(s) "96127" (brief emotional/behavioral assessment), "96160" (patient-focused health risk assessment) or "96161" (caregiver-focused health risk assessment) in conjunction with diagnosis code(s) "Z13.31"

*FOR NALOXONE SOURCE: Wheeler E, Jones S, Gilbert MK, et al. Opioid overdose prevention programs providing naloxone to laypersons — United States, 2014. Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR). June 19, 2015. Available at: **CDC.gov/mmwr/preview/mmwrhtml/mm6423a2.htm**. Accessed January 8, 2025.

(screening for depression), "Z13.32" (screening for maternal depression), or "Z13.39" (screening for other mental/ behavioral health disorders). To learn more, visit the **Aetna Depression in Primary Care Program page**.

Depression screening program for pregnant and postpartum patients

We work with our medical management team to help identify depression and behavioral health factors for pregnant members. The **Aetna Maternity Program** gives educational support to members and providers. We help them reach their goal of a healthy, full-term delivery.

Program elements

- The clinical case management process focuses on members holistically. This includes behavioral health and comorbidity assessment, case formulation, care planning, and focused follow-ups.
- The Aetna Maternity Program refers members with positive depression or general behavioral health screens to behavioral health condition management if they have the benefit and meet the program criteria. We assess members who have enrolled for any need, including depression. We case manage members with a history of any behavioral health issues, as well as a positive depression screening. We make postpartum calls to screen for depression. Then, we refer members to their behavioral health benefit and providers as appropriate, based on our assessment and screening.
- Behavioral health specialists support the Aetna Maternity Program team. They help enhance effective engagement and identify members with behavioral health concerns.
- Aetna Maternity Program nurses reach out to members who have lost their babies to offer condolences and behavioral health resources.

California Assembly Bill 2193 requires maternal mental health screening

As of July 1, 2019, California Assembly Bill (AB) 2193 requires all licensed health care practitioners who provide prenatal or postpartum care to a patient to screen or offer to screen mothers for maternal mental health conditions.

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

Practitioners serving Aetna members can use the following screening tools:

- The **Pfizer Patient Health Questionnaire-9 (PHQ-9) (PDF)** is appropriate for prenatal screening. This is available for download at no cost.
- The **Edinburgh Postnatal Depression Scale (PDF)** is for postnatal screening. This is available at no cost.

Scoring references are included for each, and recommendations are made below. However, the final determination for referral to treatment resources belongs to the screening/treating professional.

For prenatal screening with the PHQ-9, any score under 4 requires no immediate action. For a score of 5 to 14, it is recommended to refer the member to a behavioral health counselor via the Member Services number on the member ID card (ask for Aetna Behavioral Health customer service). And for a score of 15 or over, refer directly to Aetna Behavioral Health condition management services by calling **1-800-424-4660 (TTY: 711)**.

For postnatal screening with the Edinburgh Scale, any score from 7 to 13 warrants a referral to Aetna Behavioral Health, which can then make referrals to behavioral health providers. Any score of 14 or above suggests a referral directly to Aetna Behavioral Health condition management services by calling **1-800-424-4660 (TTY: 711)**.

Note: *Scores of 1 or higher on question #10 (self-harm) should be referred to Aetna Behavioral Health condition management services immediately for follow-up.*

These screening services are reimbursable. Submit your claim with the following billing combination: CPT codes 96127 or G0444 (brief emotional and behavioral assessment) in conjunction with diagnosis code Z13.31 (screening for depression).

How to contact us

Members and providers can call **1-800-272-3531 (TTY: 711)** to verify eligibility or register for the program. Members can complete enrollment with a representative, and you can also refer members by calling this number. This includes members who are pregnant, as well as members who have experienced a loss. Members can also enroll online through their member website.

Visit our website to learn more about the **Aetna Maternity Program**.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The Institute of Medicine encourages use of the SBIRT model, which calls for community-based screening for health risk behaviors, including substance use.

We'll reimburse you for screening patients for alcohol and substance use disorder, providing brief intervention, and referring them to treatment. You can help increase the adoption of the SBIRT process in your practice. The patient must be nine (9) years of age or older and have Aetna medical benefits to be eligible.

The SBIRT practice supports health care professionals in all health care settings. Overall, our goal is to improve both the quality of care for patients with alcohol and substance use disorders conditions, as well as outcomes for patients, families and communities. You can visit our **Screening, Brief Intervention and Referral to Treatment page** to get started.

Helpful app screens for abuse

The **SBIRT app** is available as a free download.

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

D-SNPs screening for coexisting behavioral health and substance use disorders

Do you have Medicare-Medicaid Dual Eligible Special Needs Program (D-SNP) members? Our behavioral health clinical team works with D-SNP members to identify those who may have a behavioral health and/or substance use disorder diagnosis.

These members will receive:

- An initial screening for coexisting mental health and substance use disorders using evidenced-based screening tools
- An individualized care plan (if the screening shows the coexisting conditions)
- A behavioral health care manager who, as a part of the care team, will help maintain continuity of care

How to make a referral

Help make sure these members get the quality care they need. Refer them to our **Aetna D-SNP** page.

Resources

- Aetna emotional well-being resources
- U.S. Centers for Medicare & Medicaid Services Roadmap to Behavioral Health U.S.
- Substance Use and Mental Health Services Administration

Behavioral health member support programs and resources

Condition Management and Complex Case Management programs

Refer member to our Condition Management and Complex Case Management programs. All members referred are screened for the presence of co-occurring mental health and substance use disorders. This is applicable for both Commercial and Medicare lines of business. Both case management programs utilize recognized screening instruments to support members in the identification and diagnosis of co-occurring mental health and substance use disorders. These instruments are tools to be used to inform members and care managers in developing the care plan goals and coordinating care or making referrals to the most appropriate providers.

These members will receive:

- An initial screening for coexisting mental health and substance use disorders using evidenced-based screening tools
- A individualized care plan (if the screening shows the co-existing conditions)
- A behavioral health care manager who, as a part of the care team, will help maintain continuity of care

Behavioral Health Condition Management

Behavioral Health Condition Management supports our Commercial members' medical and psychological needs. Our focus is on helping our members make the best use of their benefits by coordinating behavioral health and wellness services. To support the efforts of clinicians, we also closely follow patient progress and treatment recommendation adherence and share it with you.

Through this program, we:

- Work with your practice and other health care professionals on patient progress
- Evaluate patient needs to promote full use of covered services and benefits in support of your treatment plan

- Provide educational materials and decision-support tools, both online and via mail, so patients better understand their illness
- Use case management by phone to support patient adherence to your treatment plan

This program provides additional care options for your eligible Aetna patients.

Complex case management

Complex case management is for Medicare and dual-eligibility special needs (D-SNP) members with complex conditions who need extra help understanding their health care needs and benefits. Our behavioral health clinical team works with members to identify those who may have a coexisting behavioral health and/or substance use disorder diagnosis. We also help them access community services and other resources. The program offers an inclusive process for the member, the caregiver, the providers and Aetna. Available for members with eligible Medicare and Medicare-Medicaid Dual Eligible Special Needs (D-SNP) plans.

Program goals

We want to help produce better health outcomes while managing health care costs. Let's work together to meet these goals. Members who complete this program show significant symptom relief and improvement in overall health.

National principles of care

In November 2017, we were one of 16 major health care payers to commit in writing to the National Principles of Care for Substance Use Treatment. The principles are derived from the **Surgeon General's Report on Alcohol, Drugs, and Health** and are backed by three decades of research.

We support these principles, and our goal for all our members is that they receive these services:

- Universal screening for substance use disorders across medical care settings
- Personalized diagnosis, assessment and treatment planning
- Rapid access to appropriate substance use disorder care
- Engagement in continuing long-term outpatient care with monitoring and adjustments to treatment
- Concurrent, coordinated care for physical and mental illness
- Access to fully trained and accredited behavioral health professionals
- Access to The U.S. Department of Food and Drug Administration (FDA)-approved medications
- Access to non-medical recovery support services

Visit **Shatterproof.org** to learn more about the National Principles of Care.

Who may benefit from our Behavioral Health Member Support programs

- Aetna members (children, adolescents and adults)
  - With co-occurring medical and behavioral health conditions
  - With complex behavioral health conditions who have had inpatient readmissions, extended hospitalization stays, or suicide attempts resulting in medical admissions
  - Who have symptoms of major depression, dysthymia, depression not otherwise specified, or bipolar depression
  - Who are diagnosed with anxiety disorders, such as generalized anxiety, panic disorder or post-traumatic stress syndrome
  - Aetna members ages 18 and older who have a substance use disorder

Program referrals

Know a member who could use extra help? Program referrals are welcome from many sources, including:

- Primary care physicians
- Specialists
- Facility discharge planners
- Family members
- Internal departments
- The member's employer

Help these members get the care they need — make a referral

For Commercial members:

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

For Medicare and Dual Eligible Special Needs Plan (D-SNP) members:

- Call: **866-326-7195**

Resources

- **Aetna emotional well-being resources**
- **Centers for Medicare & Medicaid Services - Behavioral Health Guide**
- **U.S. Substance Use and Mental Health Services Administration**

Aetna Behavioral Health Quality program surveys

Behavioral Health member experience survey

Another aspect of our quality program and the services we provide to our members is the member experience survey. We randomly survey members annually, and the results are analyzed to identify opportunities and implement improvement activities. The effectiveness of the improvement activities is monitored and assessed annually. The survey covers the following areas:

- Accessibility to our staff and our network providers
- Availability of appropriate types of behavioral health practitioners, providers and services
- Acceptability (cultural competence to meet member needs)
- Utilization management process
- Coordination of care

We also annually evaluate member complaints, appeals and denials. We collect data in these categories:

- Quality of care
- Access
- Attitude and service
- Billing and financial issues
- Quality of the practitioner's office site

Behavioral Health practitioner survey

The practitioner experience survey is conducted annually to assess, monitor, and improve the practitioner and member experience and to monitor practitioner compliance with appointment wait times. The survey covers the following topics:

- Utilization management process
- Availability and accessibility (self-report)
- Continuity and coordination of care
- Referral to complex case management program

Health Care Provider Task Force

Along with health care providers and the broader community, we were involved on the task force to implement needed changes to confront the opioid crisis. We continue to partner with providers to help implement these principles, including establishing measurements of the adoption of these eight key principles. We believe that universal screening is important to identification of needs for substance use care. We also believe that medication-assisted treatment is critical in the delivery of high-quality, evidence-based care.

Aetna Behavioral Health treatment record review criteria and best practices

N	Y	N/A	Criteria Number	Criteria Description
A. General record/documentation components				
N	Y		1	Record is legible to someone other than the writer (if record is not legible, all questions are marked "N" and review ends).
N	Y		2	Member's contact and demographic data is documented (examples: address, gender, date of birth, home phone numbers, emergency contact, marital/legal status and guardianship, as applicable).
N	Y		3	Member's name or unique identifier appears on every page.
N	Y		4	All entries in the record are dated and contain the author's signature or electronic identifier with title (if applicable) and credentials/degree.
N	Y		5	There is a signed release form for communication with a primary care practitioner and/or other medical or behavioral health practitioners. If not, there is documentation that the member declined to sign releases or is not currently under the care of other providers.
N	Y		6	There is a signed Consent for Treatment form.
B. Initial assessment and treatment plan				
N	Y		7.1	There is documentation of a presenting problem description, including history, current symptoms and behaviors, problem onset and problem development.
N	Y		7.2	There is documentation of the application of a standard assessment tool(s) (examples include PHQ-9, GAD-7) to evaluate severity of symptoms and/or to evaluate progress toward goals.
N	Y		8.1	There is documentation of a mental status examination (MSE).
N	Y		8.2	As part of the MSE, there is documentation of a risk assessment, including presence or absence of suicidal or homicidal thoughts and history of suicidal actions.
N	Y	N/A	8.3	For members who have a history of suicidal thoughts/actions, there is a safety plan documented which includes member self-management activities and an emergency or crisis response service.
N	Y	N/A	9.1	There is documentation of a substance use assessment, including past and/or current substances used, or documentation that member has no substance use history.
N	Y	N/A	9.2	Substance use history details such as frequency, duration and amounts are documented as applicable.
N	Y		10.1	There is documentation of a behavioral health treatment history, or documentation that member has no treatment history.
N	Y	N/A	10.2	Behavioral health treatment history details, such as type of care (inpatient/outpatient, therapy/medication management), duration and efficacy, are documented as applicable.
N	Y	N/A	11	There is documentation of family, legal, educational, cultural and/or other social variables as they relate to the presenting problem and/or treatment plan.

N	Y		12	There is documentation of a medical history, including medical conditions, medications and allergies, as applicable. Or there is documentation that patient has no history of health problems.
N	Y		13	There is a behavioral health diagnosis(es) documented.
N	Y		14.1	There is documentation of a complete treatment plan, which includes objective and measurable goals and criteria used to evaluate member's readiness for discharge.
N	Y		14.2	Each goal relates to the presenting problem(s)/diagnosis(es) and includes specific steps or activities.
N	Y		14.3	Goals include a time frame for evaluating progress, and there is documentation indicating assessment of progress within those time frames.
N	Y	N/A	15	For children and adolescents: There is documentation of a developmental history (examples are prenatal and perinatal events or physical, psychological, social, intellectual, academic and educational history).
CA members only (autism spectrum disorders) (reference California Code of Regulations Title 28 CCR 1300.67.1(e); 28 CCR 1300.80(b)(4); 28 CCR 1300.80(b)(5)(E); 28 CCR 1300.80 (b)(6)(B); 28 CCR 1374.73); non-CA members score "N/A"				
N	Y	N/A	16	**CA members only:** If member is 0-6 years of age, there is documentation of screening for autism spectrum disorder.
N	Y	N/A	17	**CA members only:** For members with an autism spectrum disorder diagnosis, there is documentation to support this diagnosis.
N	Y	N/A	18	**CA members only:** The treatment plan reflects evidence-based therapies for autism spectrum disorder.
C. Follow-up documentation				
N	Y	N/A	19	For patients with a history of suicidal/homicidal thoughts/actions, or patients who are otherwise at risk: There are risk assessments documented at every session, with interventions (crisis care, facility admission, etc.) documented as indicated.
N	Y		20	There is a progress note documented for every session.
N	Y	N/A	21	If member's permission was granted, there is documentation of continuity and coordination of care with the member's health care practitioner(s) and/or behavioral health practitioner(s), specialist(s) or consultant(s).
CA members only (autism spectrum disorders) (reference California Code of Regulations Title 28 CCR 1300.67.1(e); 28 CCR 1300.80(b)(4); 28 CCR 1300.80(b)(5)(E); 28 CCR 1300.80 (b)(6)(B); 28 CCR 1374.73); non-CA members score "N/A"				
N	Y	N/A	22	**CA members only:** For pediatric members with an autism spectrum disorder diagnosis, there is documentation of collaboration, consultation and/or continuity of care.
CA members only (reference California Code of Regulations Title 28 CCR 1300.67.04(c)(4)(A) and 28 CCR 1300.70); non-CA members score "N/A"				
N	Y	N/A	23	**CA members only:** There is documentation of the patient's preferred language.
N	Y	N/A	24	**CA members only:** If the member's preferred language is not English, there is documentation of an offer of a qualified interpreter.

N	Y	N/A	25	CA members only: If interpretation services were offered, there is documentation that the member accepted or declined the offer of a qualified interpreter.
D. Prescribing practitioner documentation (These questions score as "N/A" for all non-prescribing practitioners.)				
N	Y	N/A	26	**Prescribing practitioners only:** There is documentation of current psychotropic and non-psychotropic medications, dosages and dates of recent medication changes.
N	Y	N/A	27	**Prescribing practitioners only:** There is documentation of past psychotropic medication trials and efficacy of those trials, or documentation that the member has not previously been prescribed psychotropic medication.
N	Y	N/A	28	**Prescribing practitioners only:** There is documentation of member education on the risks and benefits of the prescribed medications, and documentation that the member understands the information. There is also documentation reflecting the member's report of efficacy, side effect(s) and/or concern about taking the medications as prescribed.
N	Y	N/A	29	**Prescribing practitioners only:** If the practitioner is prescribing a controlled substance, there is documentation indicating that the practitioner reviewed the state prescription database to assess the member's past prescriptions for controlled substances.

How to contact us

If a treating provider wants to discuss an individual member's case, they can contact Aetna Behavioral Health staff 24 hours a day, 7 days a week. Our staff identify themselves by name, title and organization when they initiate or return calls about utilization management issues. We also offer TDD/TTY services for deaf, hard-of-hearing, or speech-impaired members, and language assistance for members to discuss these issues.

Contact us by:

- Visiting **our website**
- Calling us at **1-800-624-0756 (TTY: 711)**
- Calling the Member Services number on the member's ID card

Note: *For all continental U.S. time zones; hours of operation may differ based on state regulations. Texas: 6 AM to 6 PM (CT), Monday through Friday, and 9 AM to noon (CT) on weekends and legal holidays. (For all other times, phone recording systems are used.)*

When only a Member Services number is shown on the member's ID card, you'll be directed to the appropriate unit (precertification or utilization management) through either a phone prompt or a Member Services representative.

First Health® and Cofinity® networks

About First Health and Cofinity

Our networks include the First Health Network and Cofinity Network. First Health is one of the nation's largest and most respected preferred provider organizations. Cofinity is a leading regional network in Michigan and Colorado. You will know when your patient is a member. One of our network logos will be on the identification card.

Our relationships with providers are an important part of our success. We are committed to making sure that you receive the latest information, technology and tools available when serving your patients.

First Health serves a wide range of payers, including third-party administrators, carriers, employers, Taft-Hartley trusts and government entities. More than 5.5 million people access the First Health network each year. We serve the needs of student plans, unions and health plans, as well as self-insured employer groups and international payers. Payment policies may differ.

Our provider portal

Our provider portal, **FirstHealth.com**, allows you secure access to claims and pricing sheets for First Health's networks. You can:

- Search for claims by patient or physician
- View and print pricing sheets
- Research and correct misdirected claims

To register, you will need a tax identification number (TIN), health plan name and member's ID number. If you need help registering, please contact Net Support at **1-800-226-5116**.

Eligibility

To get eligibility information, use any of the ways below:

- Phone: Call the payer phone number on the member's ID card
- Website: **FirstHealth.com**

Referrals

- Website: To find a participating specialist, use the "Locate a Provider" button on **FirstHealth.com**
- Phone: Call the payer phone number on the member's ID card
- Phone: If you don't have access to the ID card, call **1-800-937-6824, option 3 (TTY: 711)**

Claims submission

- Email: Send claims electronically to the payer ID email address on the member's ID card
- Mail: Use the address on the member's ID card
- Phone: If you don't have access to the ID card, call **1-800-937-6824, option 3 (TTY: 711)**

Claims status

- Phone: Call the payer phone number on the member's ID card
- Phone: If you don't have access to the ID card, call **1-800-937-6824, option 3 (TTY: 711)**

Claims follow-up

- Phone: Call the payer phone number on the member's ID card
- Website: **FirstHealth.com**
- Phone: If you don't have access to the ID card or website, call **1-800-937-6824, option 3 (TTY: 711)**

Fee schedules

Access **FirstHealth.com** and select the "Request a Fee Schedule" tab for:

- Current or future fee schedules
- Full or sample schedules
- Single procedure code or range
- Changed values (future only)

Provider Services

Call **1-800-937-6824, option 3 (TTY: 711)** for:

- All inquiries about the First Health Network
- Demographic updates
- Credentialing or contract requests
- Provider participation verification

Complaints and grievances

Request a copy of the First Health Complaints and Grievances process.

- Mail: First Health Complaints and Grievances, 3611 Queen Palm Drive, Suite 201, Tampa, FL 33619
- Phone: Provider Services at **1-800-937-6824, option 3 (TTY: 711)**

Questions? Go to **FirstHealth.com** to read the "First Health Network Provider Reference Guide."

Helpful links

Here are the websites to use to access related content and information.

Website	Description
Aetna	Aetna home page.
Aetna for Providers	Aetna web page for professionals
Aetna Individual and Family Plans (link)	Affordable Care Act (ACA)
Provider Onboarding Center	For new and existing providers to request to join our network, update information for an existing participating provider, and more
Availity Provider Portal	Our preferred provider portal for electronic transactions
Electronic transaction vendors	List of vendors with Aetna electronic transactions, including contact information for the vendors/clearinghouses
Meritain Health	Self-funded health care benefits administration for plan sponsors and health plans nationwide
Aetna Signature Administrators (PDF)	Plan solution that enables Aetna to extend our services to additional plan sponsors with PPO plans
First Health and Cofinity	First Health is a national PPO network and Cofinity is a regional PPO network offering network access to various third-party payers. This is an online provider portal to provide access to claims information, and pricing sheets and payer information.
Aetna Women's Health program	Program offering service and support to women — includes mental well-being, reproductive health, healthy aging, and menopause
Aetna Compassionate Care program	Program offering service and support to our members with serious illnesses
EviCore healthcare	Medical benefits management company that works with health plans to improve care and affordability for patients
Council for Affordable Quality Healthcare (CAQH)	Provides data solutions, operating rules, and research to improve health care efficiency
Aetna Medicare Advantage Resources for Providers	Information about Aetna Medicare Advantage plans, regulations, compliance, attestation requirements, training and more
Medication Search Tools	Commercial, Medicare and Medicaid have many formularies
Commercial Formulary Drug List	Select plan year and plan type
Medicare Formulary Drug List	Search by ZIP code or select state, county and plan name
Aetna Better Health	Select state
Provider Referral Directories	Commercial, Medicare and Medicaid have different directories
Commercial and IFP Directory	Search by ZIP code and plan name (optional)
Medicare Directory	Search by ZIP code and plan name (optional)
Medicaid Directory List	Select state

Key contacts

Here are the numbers to call for questions or requests on behalf of your patients.

Department	Contact information
Provider Contact Center Claim inquiries and questions Member eligibility and benefits Patient management Precertification	**1-800-624-0756 (TTY: 711)** for Aetna Medicare Advantage plans and HMO-based plans **1-888-MDAetna (1-888-632-3862) (TTY: 711)** for all other plans
24-Hour Nurse Line	**1-800-556-1555 (TTY: 711)**
Aetna Credentialing Customer Service	**1-800-353-1232 (TTY: 711)**
Aetna Signature Administrators®	Refer to the member ID card.
Aetna Student Health℠ plans	Visit **Aetna Student Health**.
Aetna voluntary plans and the Limited Benefits Insurance Plan (formerly "Aetna Affordable Health Choices")	**1-888-772-9682 (TTY: 711)**
Aetna Maternity Program	**1-800-272-3531 (TTY: 711)**
Behavioral health Member Services	Refer to the member ID card.
Behavioral health Provider Services	**1-888-632-3862 (TTY: 711)**
Breast Health Education Program	**1-888-322-8742 (TTY: 711)**
BRCA Genetic Testing program (genetic testing for breast and ovarian cancers)	**1-877-794-8720 (TTY: 711)**
CVS Caremark® Mail Service Pharmacy	Phone: **1-888-792-3862 (TTY: 711)** Fax: **1-800-378-0323**
CVS Specialty®	Phone: **1-800-237-2767 (TTY: 711)** Visit **CVS Specialty**.
EviCore healthcare	**1-800-420-3471 (TTY: 711)**
Dispute submission Write to the PO box listed on the Explanation of Benefits (EOB) statement or the denial letter related to the issue you're disputing. Include the reason(s) for the disagreement. ***Note:*** *The information is also available on our provider portal on Availity.*	**1-800-624-0756 (TTY: 711)** for Aetna Medicare Advantage plans and HMO-based plans **1-888-MDAetna (1-888-632-3862) (TTY: 711)** for all other plans ***Note:*** *When you call, have the EOB statement and the original claim handy.*

Enhanced clinical review program	EviCore healthcare **1-800-420-3471 (TTY: 711)**
Infertility program	**1-800-575-5999 (TTY: 711)**
Medicare expedited organization determinations (EODs)	Aetna Medicare Advantage plans Standard requests Phone: **1-800-624-0756 (TTY: 711)** Expedited requests Submit the request via electronic data interchange (EDI) Phone: **1-800-624-0756 (TTY: 711)**
National Medical Excellence Program® (transplants)	**1-877-212-8811 (TTY: 711)**
Novologix® prior authorization	**1-844-345-2803 (TTY: 711)**
Pharmacy management precertification	Commercial plans: Phone: **1-855-240-0535 (TTY: 711)** Fax: **1-877-269-9916** Medicare Part D pharmacy management precertification: Phone: **1-800-414-2386 (TTY: 711)** Fax: **1-800-408-2386** Part B precertification: Phone: **1-866-503-0857 (TTY: 711)** Fax: **1-844-268-7263** Website: **Availity.com**
SilverScript® Part D plan	Phone: **1-866-235-5660** Fax: **1-855-633-7673**

Eligible members enrolled in high-deductible plans must meet their deductible. However, such services would be subject to negotiated contract rates. Once the deductible has been met, members will be able to access MinuteClinic services at no cost-share. Members in indemnity plans are not eligible for this benefit. Such members should refer to their benefit plan documents in order to determine coverage and applicable cost-share for walk-in clinic benefits and services, as applicable. This benefit is not available in all states.

Aetna.com

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