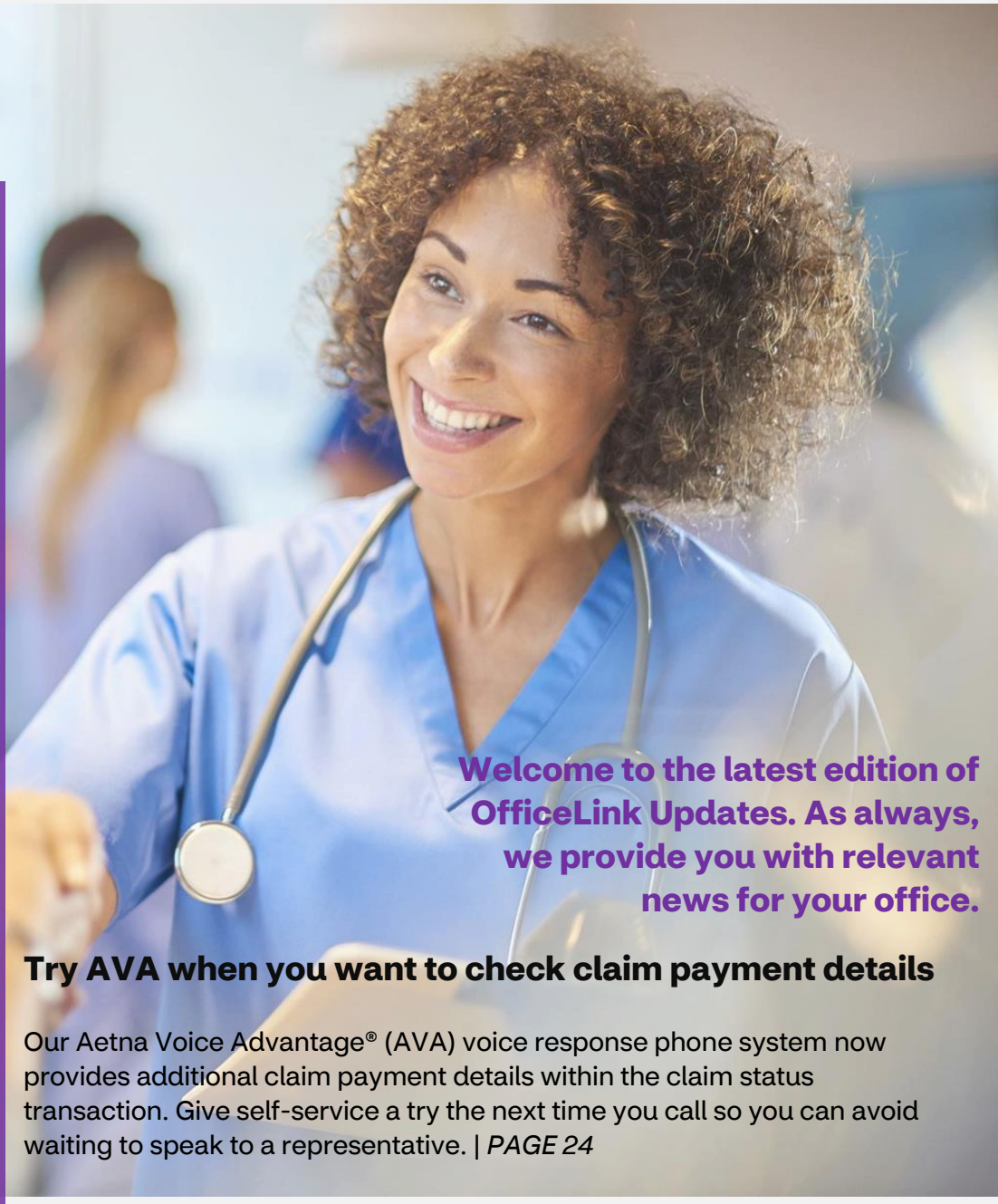
December 2022

OfficeLink Updates™



IN THIS ISSUE

90-day notices

Read about the latest policy changes, amendments and material changes to contracts.

Important reminders

Falling behind on updates? We've got you covered.

News for you

Here's what happening in the medical industry and how it could affect your practice.

Behavioral health updates

We've brought you the latest behavioral health news and updates to help you stay current.

Pharmacy

Check the latest drug list changes and additions.

Medicare

Get Medicare-related information, reminders and guidelines.

State-specific information

Get important news broken out by state.

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

Try AVA when you want to check claim payment details

Our Aetna Voice Advantage® (AVA) voice response phone system now provides additional claim payment details within the claim status transaction. Give self-service a try the next time you call so you can avoid waiting to speak to a representative. | *PAGE 24*

Podcast: SUD screening and treatment

Two Aetna® medical directors offer a hopeful message about managing a challenging clinical scenario: screening for and treatment of substance use disorder.

Dr. Alan Schneider and Dr. Pam Sheffield talk about identifying addiction. *PAGE 27*

LISTEN TO THE PODCAST

90-day notices

We regularly adjust our clinical, payment and coding policy positions as part of our ongoing policy review processes. Our standard payment policies identify services that may be incidental to other services and, therefore, ineligible for payment. We're required to notify you of any change that could affect you either financially or administratively at least 90 days before the effective date of the change. This change may not be considered a material change in all states. Unless otherwise stated, policy changes apply to both Commercial and Medicare lines of business.

Claim and Code Review Program (CCRP) update

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

Beginning March 1, 2023, you may see new claim edits. These are part of our CCRP. These edits support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. You can view these edits on our **Availity provider portal**.*

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

With the exception of Student Health, you'll also have access to our code edit lookup tools. To find out if our new claim edits will apply to your claim, log in to our **Availity provider portal**. You'll need to know your Aetna® provider ID number (PIN) to access our code edit lookup tools.

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

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

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

Changes to commercial drug lists begin on April 1

On April 1, 2023, we'll update our pharmacy drug lists. Changes may affect all drug lists, precertification, step therapy and quantity limit programs.

You'll be able to view the changes as early as February 1. They'll be on our **Formularies & Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug prior authorization

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

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

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

Important pharmacy updates

Medicare

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

Visit our **Medicare Part B Step Therapy** page to view the most current Preferred Drug Lists for Medicare Advantage (MA) and Medicare Advantage with prescription drug coverage (MAPD) members. These lists update regularly throughout the plan year.

Commercial — notice of changes to prior authorization requirements

Visit our **Formularies and Pharmacy Clinical Policy Bulletins** page to view:

- Commercial pharmacy plan drug guides with new-to-market drugs we add monthly
- Clinical policy bulletins with the most current prior authorization requirements for each drug

Coding update for codes Q5116 to Q5118

Procedure/Revenue codes

Q5116 to Q5118

What's changing

The above codes will be assigned to DEFALLDRUGS, effective March 1, 2023. The codes will remain assigned to the following service groupings:

- ALLDRUGS
- ALLDRUGSWCS
- DIALYSDRUG
- DRUGS
- DRUGCJSQ
- HCDHPALL
- HCDHPALLWCS
- HCDHPCHEMCS
- HCDHPCHEMO
- OPCHEMODRUG

If the contract contains a DEFALLDRUGS or one of the service groupings noted above, the applicable service grouping rate will be applied.

If the contract contains none of these provisions, the relevant terms of the contract will rule.

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

Coding update for code Q2055

Procedure/Revenue code

Q2055

What's changing

The above code will be assigned to the following service groupings effective March 1, 2023:

- ALLDRUGS
- ALLDRUGSWCS
- DEFALLDRUGS
- DRUGS
- DRUGCJSQ
- HCDHPALL
- HCDHPALLOTH
- HCDHPALLWCS
- HCDHPCHEMCS
- HCDHPCHEMO
- OPCHEMODRUG

If the contract contains one of the service groupings noted above, the applicable service grouping rate will be applied.

If the contract contains none of these provisions, the relevant terms of the contract will rule.

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

Service codes update

Changes to an individual provider's compensation depends on the presence or absence of specific service groupings in their contract. We are assigning or reassigning individual service codes within contract service groups. These changes are shown below.

Unless noted, all updates become effective on March 1, 2023.

Codes	Provider types affected	What's changing
66982, 66983, 66984	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be reassigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 5 (AEG5) Code will remain assigned to Ambulatory Surgery: Default Rate. • If the contract contains an Ambulatory Surgery — Aetna Enhanced Grouper: Category 5 rate, it will be applied. If not, then the Ambulatory Surgery: Default Rate will be applied.
66982, 66983, 66984	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be reassigned to Coventry Enhanced Grouper: Category 5 • If contract contains an Ambulatory Surgery — Coventry Enhanced Grouper: Category 5 rate, it will be applied; if not, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.
66987, 66988, 66989, 66991	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be reassigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 6 (AEG6) Code will remain assigned to Ambulatory Surgery: Default Rate. • If the contract contains an Ambulatory Surgery — Aetna Enhanced Grouper: Category 6 rate, it will be applied. If not, then the Ambulatory Surgery: Default Rate will be applied.

66987, 66988, 66989, 66991	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be reassigned to Coventry Enhanced Grouper: Category 6 • If contract contains an Ambulatory Surgery — Coventry Enhanced Grouper: Category 6 rate, it will be applied; if not, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.

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

New filing requirement for Texas starting May 1

Effective May 1, 2023, the days allotted for timely filing will change to align with the Texas requirement of 95 days. All claims must be sent within 95 days of the date of service(s), unless you are legally unable to notify us.

This policy update does not apply to provider contracts with specific filing requirements.

Questions?

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

The Dallas/Fort Worth Referral Pilot Program ends on March 1

Effective March 1, 2023, if a member's plan requires a referral, an electronic referral will be required when patient care is directed by the primary care physician (PCP) for all in-network specialist visits, including visits in a hospital clinic.

As you see patients in these plans, keep the following in mind when you request referrals.

- Referrals are only electronic; there are no paper referral forms.
- Referrals need to be requested by the patient's primary care physician (PCP).
- Referrals are not required for direct access services, like routine eye care and obstetric/gynecologic (OB/GYN) services. Refer to the Health Care Professional Toolkit for other direct-access specialties in your area.

- Referrals are not a substitute for services requiring precertification.
- Referrals are authorized immediately and expire after one year.
- For health maintenance organization (HMO) plans, the first visit from a referral must be used within 30 days to keep it active.
- Referrals do not permit specialists to refer members to another specialist for care. If this is necessary, patients must get a new referral from their primary care physician to see another specialist.
- Referrals should not be retroactive. We may adjust or deny payment for retroactive referrals.
- Referrals may be issued to an individual specialist using their national provider identifier (NPI) or to a specialty using the taxonomy code:

  Use our **provider referral directory** to find a specialist's NPI.

  You can find a list of taxonomy codes on the same website you use for other electronic transactions. Don't use any website? **Sign up to use our provider website**.

  For taxonomy referrals, remind the patient to see a specialist in their network. Patients can find a participating specialist on their secure member website.

- Please remember to direct patients to in-network providers. Directing patients to nonparticipating providers will require prior authorization from Aetna® in order to be covered on an in-network basis. Failure to pre-authorize services, including out-of-network care, could result in a denial of payment or a reduction in the benefit payable in addition to increased costs for your patients.
- Diagnosis and procedure codes are not required. But a referral without a procedure code defaults to a consultation only.
- Use 99499 for consult and treat; it allows the specialist to examine and treat the patient, and it covers automatic studies.

More information

For more information on electronic referrals, see our **Office Manual for Health Care Professionals**. Refer to our **Precertification and Referral guide** to see if a service requires precertification.

Important reminders

Use NPPES to correct your data and improve provider directory accuracy

The Centers for Medicare & Medicaid Services (CMS) suggests using the National Plan and Provider Enumeration System (NPPES) to review, update and attest to your NPPES data. We join with CMS to remind providers to keep their data up to date.

Accurate provider directories help Medicare beneficiaries identify and locate providers and make health plan choices.

Refer to CMS's **frequently asked questions document (PDF)** for more information.

How to contact us about utilization management issues

Our staff members, including medical directors, are available 24 hours a day for specific utilization management issues. You can call us during and after business hours via toll-free numbers.

Contact us by:

- Visiting **our website** and clicking "Contact Us"
- Calling the Provider Contact Center at **1-888 MD AETNA (1-888-632-3862) (TTY: 711)**
- Calling Provider Services at **1-800-624-0756 (TTY: 711)**

- Calling the patient management and precertification staff using the Member Services number on the member's ID card

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.

Cultural competency can help your practice

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

Our commitment

We're committed to meeting the National Committee for Quality Assurance (NCQA) standards to ensure that members' cultural and language needs are met. In addition, each year, we measure our members' perspectives via a health plan survey. The responses help us to monitor and track network providers' ability to meet our members' needs, including their cultural, language, racial or ethnic preferences.

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

- The U.S. Department of Health & Human Services, Office of Minority Health, offers free **continuing education e-learning programs** (Culturally and Linguistically Appropriate Services in Maternal Health Care, Behavioral Health, Oral Health) to help health care professionals provide culturally competent care.
- Consult the Johns Hopkins University of Medicine, Office of Diversity, Inclusion and Health Equity: Unconscious Bias Collection (via LinkedIn Learning).
- Our **Racial and Ethnic Equity page** can show you how to reduce health care disparities.

Want to learn more?

Please review **Aetna's cultural competency training video** to learn more.

Our office manual keeps you informed

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

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

What's in the manual

The manual contains information on the following:

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

How to reach us

Contact us by visiting our website, calling the Provider Contact Center at **1-888 MD AETNA (1-888-632-3862) (TTY: 711)** and selecting the "precertification" phone prompt, or calling patient management and precertification staff using the Member Services number on the member's ID card. Our medical directors are available 24 hours a day for specific utilization management issues.

More information

Visit us online for information on how our quality management program can help you and your patients. We integrate quality management and metrics into all that we do, and we encourage you to take a look at the program goals.

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

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

As a Medicare Advantage provider, you may be in our DSNP network (DSNPs are offered in select counties/states), since DSNPs are **Medicare Advantage plans**.* Providers must complete their annual **Model of Care (MOC) (PDF)** training and attestation by December 31, 2022. Delegated providers/entities are required to attest based on contracted plans.

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

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

Our training materials include:

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

Where to get more information

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

*For more information about our Medicare Advantage plans and where they are offered, visit our **Medicare page** and scroll down to the topic “Medicare and Dual Special Needs Plans expansion information and resources.”

Use our existing resources to check if we require prior authorization

Prior to requesting prior authorization (PA), we encourage you to check one of our existing resources to see if we require PA. You can check our National Precertification List or enter procedure codes into our search tool. You can find both on our **precertification lists** page.

Don't submit a request to check if we require PA for a service

We discourage submitting a PA request using your preferred electronic solution just to check if we require PA on a particular service. When you submit those requests, we must contact you (multiple times, in some cases) to request clinical information for a request you didn't intend to use. And if your patient won't use it, that means we must void it.

If you're a non-participating provider checking on a member's PPO out-of-network benefits, we suggest using the Eligibility and Benefits Inquiry transaction to see what benefits the member has. When you submit your claim, we'll process it in accordance with plan provisions. So there's no need to submit requests just to check a member's benefits. And that saves time in everyone's day.

California: DSNP Notice of Non-Discrimination and language taglines

The requirement*

Starting July 6, 2022, plans/providers are subject to federal requirements contained in the Americans with Disabilities Act (ADA), including standards for communicating effectively with people with disabilities to ensure they benefit equally from government programs.

Plans/Providers must:

- Comply with all nondiscrimination requirements set forth under federal and state law
- Post a nondiscrimination notice that informs members, potential enrollees, and the public about nondiscrimination, protected characteristics, and accessibility requirements, and that conveys how the plan complies with the requirements

Plans/Providers must start using the approved taglines from the California Department of Health Care Services (DHCS) no later than July 6, 2022.

Details about how to comply

Please review the DHCS website for more information and required notices (links below).

The informational notices include the following:

- Documents intended for the public, such as outreach, education and marketing materials
- Notices requiring a response from an individual
- Notices to an individual, such as those pertaining to rights or benefits

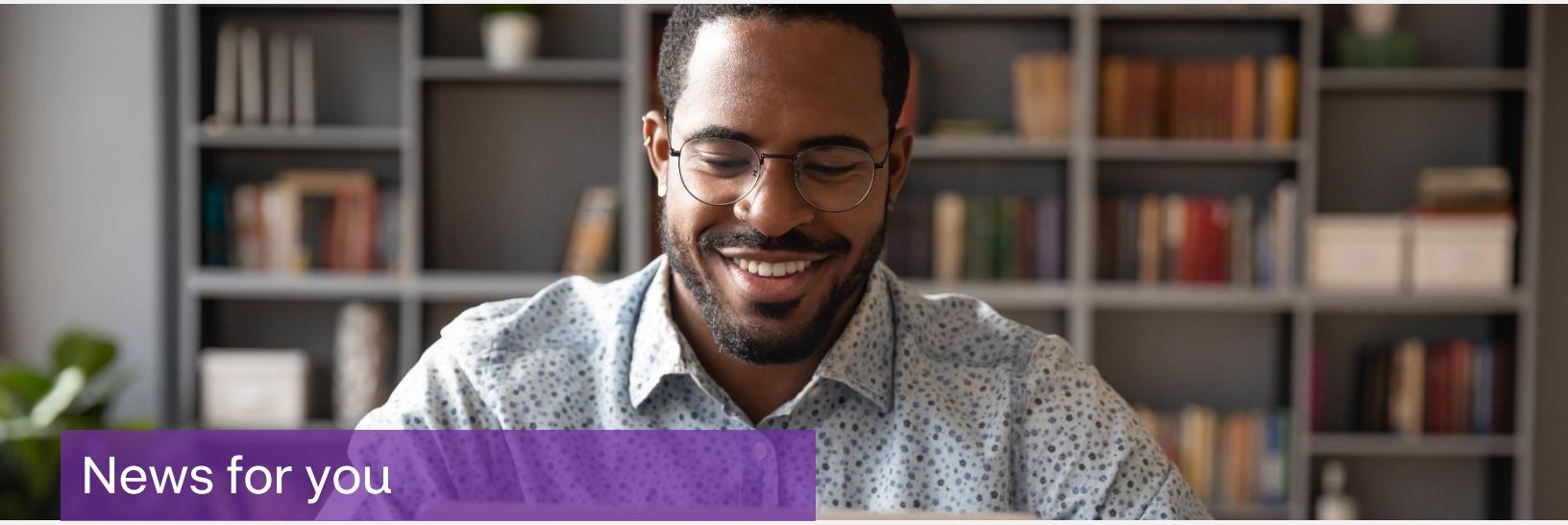
The nondiscrimination notice must:

- Be posted in at least a 12-point font in conspicuous physical locations where the plans/providers interact with the public
- Be posted on the plan/providers website in a location that allows any visitor to the website to easily locate the information
- Include all legally required elements as well as information on how to file for discrimination

California DHCS resources

- **Threshold and Concentration Languages for All Counties (PDF)**
- **Notice of Nondiscrimination Template (PDF)**
- **Taglines template**
- **Statement of Nondiscrimination template for small-sized notices**
- **CA policies (also called All Plan Letters, or APLs) by year**

*Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services Policy # APL 21-004 re-issued 5/6/2022) (Supersedes APL 17-011 and Policy Letters 99-003 and 99-004)



News for you

Help your practice by providing more detailed demographic information

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

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

Updating is easy

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

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

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

Updating your information is easy. Simply log in to our **Availity provider portal**.* Navigate to My Providers and then to Provider Data Management.

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

If you need further help, you can go to the **Learn about Provider Data Management** page. You'll find short demos about how to enter, update, validate and attest to demographic data in the Availity PDM application.

Soon you can voluntarily provide ethnicity and additional race information

We're updating our database so that you can voluntarily provide your ethnicity and more specific details about your race. Watch for information about this via Availity in early 2023.

You'll be able to select from the following enhanced demographic identifiers:

- Ethnicity (choose only one value)

  I choose not to respond
  I am Hispanic, Latino/a or of Spanish origin
  I am not Hispanic, Latino/a or of Spanish origin

- Race (choose multiple values)

  I choose not to respond
  Arab, Middle Eastern, or North African
  Asian
  Native Hawaiian or Pacific Islander
  Black or African American
  White
  Native American or Alaska Native
  Some other race
  I only identify as Hispanic

New LGBTQ Champion identifier

We will also be adding identifiers for providers who are LGBTQ Champions. Selecting the LGBTQ Champion identifier means you are a provider who participates in and actively supports provider care to the LGBTQ+ community. Provided care may include gender-affirming care.

- LGBTQ Champion (select one)

  I choose not to respond
  Yes
  No

How we use demographic details

We share demographic details in our online provider directory. Patients can refer to them when searching for care. Our customer service representatives might provide these demographic details if a plan member requests them.

Giving us your racial and ethnic information is voluntary. You can request that this information be removed from your profile at any time.

More information

Find out more about how CVS Health® is working to make **meaningful health equity gains**.

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

[1]Takeshita J, Wang S, Loren A, et al. **Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings**. JAMA Network Open. November 9, 2020; 3(11). Accessed September 15, 2022.

Coming soon: Check authorization status using the power of your voice

We're excited to let you know about a new way to check authorization status for commercial patients. In late December, we'll introduce our new virtual assistant. Here's what you can look forward to:

- Status details that are more robust (approved, pending, cancelled, or denied — including reasons when applicable) than the ones you get through our automated system today
- Access to our virtual assistant using any telephone number you already use for Provider Services or Precertification
- More time in your day because you can check authorization status on your schedule instead of waiting on hold to speak to a representative

Our virtual assistant is easy to use and will replace what you use today. Once you validate your patient's information, say "precert" then "precert status." Use the authorization number to get the status. You can check authorization status for multiple members during the same call.

We'll let you know when our new virtual assistant is ready.

We've moved overpayments management online for Availity® users

The new tool on our Availity* provider portal:

- Keeps you current with overpayment requests
- Allows you to inquire, resolve or dispute an overpayment
- Offers status updates and case history maintenance
- Gives you the ability to upload supporting documentation

Important: Over the next several months, most overpayment letters you receive via USPS will be transitioning online and will only be available for viewing within the Overpayments tool.

Make sure you have the Claim Status role. If you don't have access, contact the Availity administrator for your office to decide if you need this role.

More information

Learn more about Overpayments with an Availity Essentials webinar. Within Availity, go to Help & Training > Get Trained and then search Aetna Overpayments.

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

How to speed up the credentialing process

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

Recently, some of you asked about getting added more quickly to the network.

What to do before requesting to join the network

Please make sure the following information is up to date in Council for Affordable Quality Healthcare (CAQH) to ensure timely completion of credentialing:

- CAQH ProView application is in "Re-attestation" or "Initial Application Complete" status
- Aetna is listed as an authorized health plan
- CAQH ProView includes current provider Professional Liability Insurance policy information
- CAQH ProView has all active service locations listed for the state for which the practitioner is requesting participation

- CAQH ProView includes an active/current DEA and an active/current state license for every state in which the practitioner has active service locations

The credentialing timeline

Providers interested in participating start at **Aetna.com** and click on **Join the network**. After that, they proceed through the following schedule:

	Welcome to Aetna.com	Contracting	Credentialing	Contracting
Approximate time frame	1 to 30 days	30 to 60 days	60 to 90 days	90 to 120 days
What to expect	Complete the request for participation. Providers will be notified via email if we intend to pursue a contract or if we are unable to accept you into our networks.	The local network operations team will reach out to you to begin the contracting process, if required. The contract is an electronic document that must be signed through the AdobeSign process. Please sign and return the contract through AdobeSign.	Once Network receives your signed contract, they'll request that the credentialing process get started. For most states, we use CAQH to obtain your credentialing application. Make sure all data is up to date.	Once you have been approved in the credentialing process, Aetna will countersign and return your final contract via email through AdobeSign. Aetna systems will reflect your participation effective date, and Aetna members will be able to see your information in the directory. You can now submit claims.

Aetna Smart Compare™ designation program changes

What is Aetna Smart Compare?

Aetna Smart Compare is a tool members can use to find high-quality, effective providers. We use an industry standard methodology to give members personalized recommendations that they can easily access through our secure member portals.

How does Aetna Smart Compare work?

We identify up to two designations per physician practice: one for effectiveness and one for clinical quality. We publish these designations for the following commercial specialties: primary care, obstetrics and gynecology, orthopedic hip and knee, orthopedic and neurosurgeon spine, and cardiology. The program will include endocrinology and pulmonary physicians in Q1 2023.

We will also publish Aetna Smart Compare Medicare PCP designations nationally in 2023.

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

Designation notification

Physician practices received a letter in November 2022 regarding their designation. We exclude physicians who see few or no Aetna® members. (Physician designations will not display for Maryland physician practices.)

In California and Texas, Aetna Smart Compare designations for commercial plans are only for self-insured plans.

More information

Visit our **Aetna Smart Compare** page, where you can find guides for the designation measures. Email **Aetna Smart Compare** if you have questions or want to provide feedback.

Patients should use preferred labs for genetic testing and services

Worldwide, 263 to 446 million people are affected by rare diseases.[1] Determining who would benefit from testing and the most appropriate test to order can be a challenge in this rapidly evolving space.

Our Nationally Preferred Labs (Quest Diagnostics®, Labcorp, BioReference) offer comprehensive genetic and molecular testing across the lifespan, and the testing is not limited to one method, disease focus or specialty.

Genetic testing and services include:

- Predictive genetic testing: Identifies asymptomatic individuals who are at a higher risk of developing genetic conditions (hereditary cancer, for example) and could benefit from increased surveillance or modified clinical management
- Diagnostic genetic testing: Provides a diagnosis for symptomatic patients
- Prenatal screening: Screens pregnancies to assess risk for aneuploidy or other birth defects
- Prenatal testing: Diagnoses a fetus at risk for a genetic condition
- Genetic carrier screening: Identifies individuals who may be at risk of passing an autosomal recessive or X-linked condition to their child
- Pharmacogenetic testing: Provides insight into a patient's response to a medication
- Somatic tumor testing: Characterizes the genetic makeup of a tumor that can potentially inform prognosis and/or treatment

Consult your lab for the availability of genetic counselors who are available to provide consultation on test selection and interpretation of results.

Remember that Aetna® members who receive care from out-of-network providers typically pay substantially more for those services. Helping members stay in network can save them money. Please consider this when referring your Aetna patients for laboratory services.

[1]Nguengang Wakap S, Lambert DM, Olry A, et al. **Estimating cumulative point prevalence of rare diseases: analysis of the Orphanet database**. European Journal of Human Genetics. 2020; 28: 165–173. Accessed September 9, 2022.

New onboarding webinar for providers and their staff

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

We'll show you how to:

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

Register today

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

Questions?

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

We'd like your opinion on your prior authorization experience with us

We'd like your opinion on your prior authorization experience with us to see where we can make improvements. We'd like to know your opinion on the entire process, starting with

initiating your PA request on your preferred electronic solution all the way to receiving our decision. We're especially interested in speaking to you if you submit documentation (like medical records) to support your request, whether you upload them through **our Availity provider portal*** or via our clinical questionnaire.

How to get in touch with us

If you're interested in sharing your opinion, **send us an email message**. Include your practice or facility name, taxpayer identification number (TIN), name, email address, telephone number and time zone. Someone will contact you to schedule an interview.

Limitations

We're interested in speaking only with health care professionals who initiate PA requests using their preferred electronic method. We're unable to interview health care professionals who initiate their requests by telephone.

We look forward to speaking with you!

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

We've added new clinical questionnaires

In a previous article, we suggested using **our Availity provider portal*** to request prior authorizations. For certain procedures, we may ask you to complete a clinical questionnaire to submit requested clinical information. **See the updated list** of procedures we may ask you to complete a clinical questionnaire for. You can also see the list at **AetnaClinicalQuestionnaire.com**. We suggest checking the page regularly.

See how the clinical questionnaire works during a live webinar

Join us for a live webinar to see how the clinical questionnaire works. Go to **AetnaWebinars.com** for a schedule and to register for our "Authorizations on Availity" webinar. Ask your questions and get answers on the spot.

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

Use electronic prior authorization (ePA) to process prescriptions

How ePA works

ePA is a fully electronic solution that processes prior authorizations (PAs), formulary exceptions and quantity limit exceptions using the most up-to-date criteria. It processes PAs up to 30 times faster, resulting in a response time of hours — or even minutes. And it's available at no cost.

Why use ePA?

- It works for most plans and medications,* including specialty drugs.
- You'll receive clinical questions electronically, which reduces faxing and calling.
- You can include chart notes, supporting statements and other attachments.
- Near real-time decisions mean your patients can start therapy sooner.

Getting started is easy

You can access ePA through a web-based portal or your electronic health record (EHR).

- Secure online portal

  CoverMyMeds
  Surescripts

- Through your EHR

  CoverMyMeds
  Surescripts

*ePA may not be an option based on some criteria.

Moda Health Plan, Inc., is a new Aetna Signature Administrators® (ASA) third-party administrator (TPA) partner

Beginning October 1, 2022, Moda Health Plan, Inc., members started to use the ASA preferred provider organization program and medical network outside of Oregon, Alaska, Idaho, and Clark and Cowlitz counties in southwestern Washington.

How to check eligibility and get additional support

To check eligibility or verify benefits for Moda Health Plan members, refer to the Moda Health Customer Service phone number on the member's ID card.

Send claims to Moda Health Plan

Our TPA partners handle all claims processing and claims questions. Send claims electronically to Moda Health Plan, payer ID #13350.

Or send paper claims to:

Moda Health Plan — Medical Claims
P.O. Box 40384
Portland, OR 97240

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

Neither Aetna® nor ASA can verify eligibility or process claims.

To learn more, see our **ASA flyer**.

How to get claim status information faster

We hear you. We want you to know that Aetna® is committed to reviewing your feedback and providing information to make it easier to get claim status information.

We've enhanced our Aetna Voice Advantage® (AVA) automated interactive voice response phone system. Now, it provides additional claim payment details within the claim status transaction. You can access the following information:

- Amount of the Electronic Funds Transfer (EFT)
- EFT number, issue date and settlement date
- Check amount, number, issue date and cashed date

- Check mailing address

Give self-service a try the next time you call so you can avoid waiting to speak to a representative. Want to avoid being on the phone altogether? Go to our **Availity provider portal**, where you will find a comprehensive suite of self-service options.

Provider and facility participation criteria updates

We'll be making some important criteria changes in the new year.

Primary Care Provider (PCP) section

We are modernizing this section to reflect current standards of evidence-based practice. All PCPs, regardless of how they deliver care (that is, in person, via telehealth or a hybrid model), must:

- Have access to a means for assessing and monitoring clinically indicated vital signs
- Conduct physical examinations either in person or, if clinically appropriate, via telehealth audio visual (AV)
- Have access to a means for administering immunizations
- Have a process for referring members to a participating lab for testing

It is acceptable for PCPs to provide these services via an established relationship with other participating providers.

If a PCP meets the updated criteria and is a virtual-only provider, that PCP may serve as a PCP for adult Aetna® members. We understand that this is a substantial change given that the current criteria do not allow virtual-only providers to be available for member PCP selection or to provide anything other than supplemental primary care services unless granted written permission.

We are pleased to open this capability to our providers and enable greater access to primary care services for our members.

Note that the Telehealth section continues to apply to providers offering virtual services. Aetna will reimburse only for virtual services as described in the Telemedicine Reimbursement Policy, which is available to providers through our **Availity provider portal**.*

Family planning services

Given the evolving legislative landscape, Aetna emphasizes the importance of following state laws governing abortion services.

Home office requirements

We will be updating our provider home office requirements.

More information

For further details about all of these updates, refer to the **participation criteria (PDF)**.

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

Behavioral health updates

Behavioral health Access to Care standards

We want to ensure that our members have timely access to behavioral health care. To that end, we maintain appointment timeliness standards.

Access to Care standards*

Service	Time frame
Non-life-threatening emergency needs	Within 6 hours of request
Urgent needs	Within 48 hours of request
Routine office visits	Initial visit within 10 business days of request. Follow-up visits should be available within 5 weeks for behavioral health practitioners who prescribe medications, and within 3 weeks for behavioral health practitioners who don't prescribe medications.
Following emergency department visit for behavioral health condition or alcohol or other drug abuse or dependence	Within 7 days of emergency department visit
Following hospital discharge for a behavioral health condition	Within 7 days of the inpatient discharge date

After-hours and emergency care	Each behavioral health practitioner must have a reliable 24 hours a day, 7 days a week live answering service or voicemail message. MDs must have a notification system or designated practitioner backup. Non-MDs, at a minimum, must have a message system that provides 24-hour access to a licensed professional.

*Some states have more stringent access to care requirements, and those requirements supersede Aetna® national standards.

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

We know it's often challenging to ensure timely care for your patients, and we thank you for your efforts to take care of our members as quickly as possible.

Provider surveys are important for quality improvement

We appreciate your responses to our annual behavioral health provider experience surveys. These surveys are sent via email, so if you have not received them previously, please **update your contact information**. Your feedback is essential for helping us improve services.

Our annual survey

We send this survey to monitor our members' access to and availability of services. We also use it to make sure you are aware of all the resources available to you and our members. Survey results, along with data from complaints, appeals, and out of-network-claims, help us measure compliance with National Committee for Quality Assurance (NCQA) standards. Survey results also help us identify areas for improvement.

The 2022 survey results

We received responses from 11% of providers surveyed. Specific state surveys requiring additional questions had much lower response rates. We ask that you please make your voice heard by completing these surveys in 2023.

Based on the responses we received, we want to remind you that:

- Aetna® reimburses for coordination-of-care communications with other providers (less than 8% of providers reported knowing about this reimbursement opportunity)
- Aetna urges practitioners to refer members with acute, complex behavioral health care needs for case management (only 6% of providers reported knowing about this service)

Please take advantage of these opportunities to provide additional support to your patients.

How to identify addiction: A conversation about substance use disorder screening and treatment

Two Aetna® medical directors offer a hopeful message about managing a challenging clinical scenario: screening for and treatment of substance use disorder.

Responding to the issue

Primary care providers are on the front lines of the substance use disorder crisis in this country. In addition to addressing what brought the patient into the office, they have to assess whether the patient might have an occult substance use disorder. Challenges include:

- How to approach patients who have complex psychological needs with a sense of hopefulness and efficacy
- How to make time to manage the presenting health problem and also screen for and begin the process of substance use disorder treatment or referral
- Understanding that a patient's primary care doctor might be the one who manages initial treatment

Listen to the podcast

Dr. Alan Schneider and Dr. Pam Sheffield talk about identifying addiction. **Listen to the podcast**.

Pharmacy

Changes to commercial drug lists begin on April 1

On April 1, 2023, we'll update our pharmacy drug lists. Changes may affect all drug lists, precertification, step therapy and quantity limit programs.

You'll be able to view the changes as early as February 1. They'll be on our **Formularies & Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug prior authorization

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

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

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

Important pharmacy updates

Medicare

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

Visit our **Medicare Part B Step Therapy** page to view the most current Preferred Drug Lists for Medicare Advantage (MA) and Medicare Advantage with prescription drug coverage (MAPD) members. These lists update regularly throughout the plan year.

Commercial — notice of changes to prior authorization requirements

Visit our **Formularies and Pharmacy Clinical Policy Bulletins** page to view:

- Commercial pharmacy plan drug guides with new-to-market drugs we add monthly
- Clinical policy bulletins with the most current prior authorization requirements for each drug

Medicare

Aetna Individual Medicare Advantage (MA) plan expansion

We're expanding our Individual MA plans to 141 new counties for 2023. Depending on your contract, you may be listed as a participating provider in our MA networks.*

What are the new counties?

On **Aetna.com**, you can view our **2023 MA Individual expansion counties (PDF)**.

2023 Annual Enrollment Period

The Annual Enrollment Period (AEP) for Medicare is from October 15, 2022, through December 7, 2022.

More about our MA products

- View our **Aetna Medicare Advantage plans quick reference guide (PDF)**.
- Visit our Health Care Professionals page on **Aetna.com** to view the **At a Glance reference guide (PDF)**.
- Find out how to **verify your patients' eligibility**.

How to get contracted for MA plans

If you're not currently contracted for our MA plans, please call our Provider Service Center at **1-800-624-0756 (TTY: 711)**.

*Not all plans are offered in all service areas.

Use NPPES to correct your data and improve provider directory accuracy

The Centers for Medicare & Medicaid Services (CMS) suggests using the National Plan and Provider Enumeration System (NPPES) to review, update and attest to your NPPES data. We join with CMS to remind providers to keep their data up to date.

Accurate provider directories help Medicare beneficiaries identify and locate providers and make health plan choices.

Refer to CMS's **frequently asked questions document (PDF)** for more information.

Help your practice by providing more detailed demographic information

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

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

Updating is easy

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

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

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

Updating your information is easy. Simply log in to our **Availity provider portal**.* Navigate to My Providers and then to Provider Data Management.

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

If you need further help, you can go to the **Learn about Provider Data Management** page. You'll find short demos about how to enter, update, validate and attest to demographic data in the Availity PDM application.

Soon you can voluntarily provide ethnicity and additional race information

We're updating our database so that you can voluntarily provide your ethnicity and more specific details about your race. Watch for information about this via Availity in early 2023.

You'll be able to select from the following enhanced demographic identifiers:

- Ethnicity (choose only one value)

  I choose not to respond
  I am Hispanic, Latino/a or of Spanish origin
  I am not Hispanic, Latino/a or of Spanish origin

- Race (choose multiple values)

  I choose not to respond
  Arab, Middle Eastern, or North African
  Asian
  Native Hawaiian or Pacific Islander
  Black or African American
  White
  Native American or Alaska Native
  Some other race
  I only identify as Hispanic

New LGBTQ Champion identifier

We will also be adding identifiers for providers who are LGBTQ Champions. Selecting the LGBTQ Champion identifier means you are a provider who participates in and actively supports provider care to the LGBTQ+ community. Provided care may include gender-affirming care.

- LGBTQ Champion (select one)

  I choose not to respond
  Yes
  No

How we use demographic details

We share demographic details in our online provider directory. Patients can refer to them when searching for care. Our customer service representatives might provide these demographic details if a plan member requests them.

Giving us your racial and ethnic information is voluntary. You can request that this information be removed from your profile at any time.

More information

Find out more about how CVS Health® is working to make **meaningful health equity gains**.

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

[1]Takeshita J, Wang S, Loren A, et al. **Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings**. JAMA Network Open. November 9, 2020; 3(11). Accessed September 15, 2022.

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

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

As a Medicare Advantage provider, you may be in our DSNP network (DSNPs are offered in select counties/states), since DSNPs are **Medicare Advantage plans**.* Providers must complete the annual **Model of Care (MOC) (PDF)** training and attestation by December 31, 2022. Delegated providers/entities are required to attest based on contracted plans.

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

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

Our training materials include:

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

Where to get more information

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

*For more information about our Medicare Advantage plans and where they are offered, visit our **Medicare page** and scroll down to the topic "Medicare and Dual Special Needs Plans expansion information and resources."

2023 Dual Eligible Special Needs Plan (DSNP) information

We're expanding our DSNP program into more markets for 2023.

What is a DSNP?

A DSNP is a special type of Aetna® Medicare Advantage Prescription Drug (MAPD) plan. It provides benefits to members who qualify for Medicare and who receive full Medicaid benefits and/or assistance with Medicare premiums or Medicare Parts A & B cost sharing through one of the Medicare Savings Program (MSP) categories. Members must reside in a county where Aetna Medicare offers a DSNP.

Am I in the DSNP network?

The DSNP network is in limited counties. Check your participation status by using the **provider search tool**. If you are in Virginia, check your status by going to the **Aetna Better Health of Virginia provider search page**. If you are in New Jersey, check your status by going to the **Aetna Assure Premier Plus provider search page**.

Required Centers for Medicare & Medicaid Services (CMS) training

All DSNP plans are required to have an approved Model of Care. CMS requires providers to take the **Model of Care training course (PDF)**.

Member eligibility and benefits

Note the following:

- Members should show their DSNP member ID card and their state-issued Medicaid card.
- NJ FIDE-SNP members will have one member ID card for both Medicare and Medicaid.
- Members must select a primary care physician.

- There are no out-of-network benefits unless the member follows the approval process by contacting Member Services directly.

Claims processing

Depending on MSP eligibility, the member may have a cost-share responsibility. Providers may not balance bill members who do not have cost-share responsibility (including QMB-only).

Visit our **Medicare page** for more DSNP resources, including cost-share information.

How to reach us

If you have questions, visit our **Contact Aetna page**.

Annual Wellness Visit (AWV) documentation and coding

A Medicare Annual Wellness Visit (AWV) is not a typical physical exam. Rather, it's an opportunity to promote quality, proactive, cost-effective care. AWVs help you engage with your patients and increase revenue.

A physician, PA, NP, certified clinical nurse specialist or a medical professional under the direct supervision of a physician (including health educators, registered dietitians and other licensed practitioners) can perform AWVs.

AWV documentation

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

AWV coding

An ICD-10 Z code is the first diagnosis code to list for wellness exams to ensure that member financial responsibility is $0.

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

The two CPT® codes used to report AWV services are:*

- G0438 — initial visit**
- G0439 — subsequent visit (no lifetime limits)

Additional services (lab, X-rays, etc.) ordered during an AWV may be applied toward the patient's deductible and/or be subject to coinsurance. Before performing additional services, discuss them with the patient to verify that the patient understands their financial responsibilities.

More information

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

*CPT® is a registered trademark of the American Medical Association.

**Code G0438 is for the first AWV only. The submission of G0438 for a beneficiary for which a claim code of G0438 has already been paid will result in a denial.

The Connecticut State Retiree Health Plan will automatically transition from UnitedHealthcare® to an Aetna Medicare℠ Plan (PPO)

Your Connecticut Medicare patients have a new plan for 2023

Starting January 1, 2023, all retirees enrolled in the Connecticut State Retiree Health Plan will automatically transition from UnitedHealthcare to an Aetna Medicare℠ Plan (PPO).

We'll help you help them during their transition.

Aetna Medicare Advantage PPO plan benefit highlights

You can help your patients better understand their plan. Here's a summary of key benefits:

	Your patients' responsibility when visiting either a network or out-of-network provider
Member coinsurance	**0%**
Deductible	**$0**
Annual out-of-pocket maximum This amount includes deductibles, copayments and coinsurance	**$2,000**
Primary care physician visits	Retired prior to July 1999: **$5** Retired after July 1999/Partnership retirees: **$15**
Specialist visits	Retired prior to July 1999: **$5**

	Retired after July 1999/Partnership retirees: **$15**
Urgent care/walk-in clinic visits	Retired prior to July 1999: **$5** Retired after July 1999/Partnership retirees: **$15**
Diagnostic testing, X-rays, lab work, complex radiology, radiation therapy, dialysis, therapy (PT, OT, ST), cardiac and pulmonary rehab, home health, DME, oxygen and equipment	**$0**

Support your Aetna Medicare Advantage PPO patients

You can't be there for them 24/7, but you can still give them extra support. With the Aetna Medicare Advantage PPO plan, members get added benefits at no additional cost. These programs are meant to complement the care you provide to your patients.

Our programs can help your patients:

- **Manage a chronic condition, such as diabetes or high blood pressure**

  Let your patients know we offer personalized nurse support to help them. Our nurses can ensure that your patients are taking their medications as prescribed, help them make healthy lifestyle choices and answer questions they may have about their condition. In some cases, patients may benefit from having a case manager assigned to help coordinate their care.

- **Find resources in their communities**

  A Resources For Living® life consultant can refer members to services in their area that make life easier and more enjoyable. We can help with home care, social and recreational activities, caregiver support, and more. The referral service is offered at no extra cost, but members do have to pay the cost of any services they decide to use.

- **Check for health, wellness and safety concerns in their homes**

  Patients can sign up for a Healthy Home Visit. A licensed doctor or nurse will come to their home to review their health needs, do a home safety assessment, review medications, and ask about their medical and family history. The visit is offered at no extra cost, but Aetna® services may be recommended to help support their health journey.

- **Treat depression and anxiety**

  Help your patients get fast, affordable and convenient access to virtual behavioral health services. Patients can confidentially meet with an MDLIVE® licensed therapist or board-certified psychiatrist by phone or video appointment. MDLIVE providers are specially trained in common issues such as anxiety, depression, grief and loss, stress management, and more.

- **Get answers to health questions**

  The 24-Hour Nurse Line offers 24-hour access to nurses who can help answer members' health questions. It doesn't replace care from their regular doctor, but it can help them get the information they need after hours.

  Members can visit the **State of Connecticut retirees** page for more information about the programs available to them.

Sample ID card

Here's a sample ID card:

Helpful resources

If you have questions about a patient's medical plan, just call our Provider Contact Center at 1-800-624-0756, Monday through Friday, 8 AM to 5 PM local time.

You can also visit our **Availity provider portal** for access to electronic transactions, online resources, patient care programs and more.* Use of the Availity® provider portal does not cost extra, but you will need to register.

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

Your State of Illinois Medicare Advantage patients have a new plan for 2023

Your office may see patients that are State of Illinois retirees and their dependents. The State of Illinois offers health care benefits to more than 150,000 retirees.

Starting January 1, 2023, many of these retirees will have a new Aetna Medicare Advantage plan with prescription drug coverage. It's called Aetna Medicare℠ Plan (PPO) with Extended Service Area (ESA). It is also known as the Aetna MAPD PPO. The plan coverage depends on which State of Illinois retiree group your patient is a member of:

- College Insurance Program (CIP)
- State Employees Group Insurance Program (SEGIP)
- Teachers' Retirement Insurance Program (TRIP)

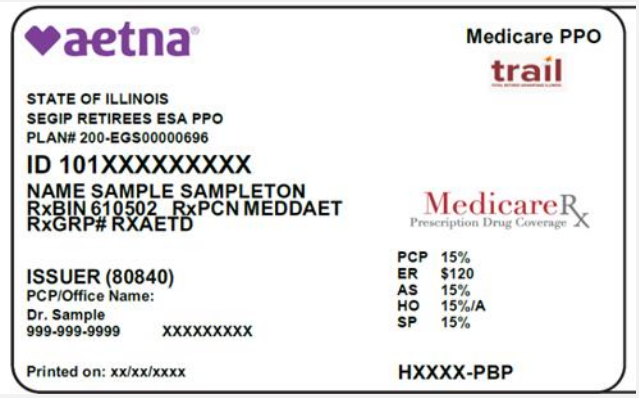
Plan highlights: Aetna MAPD PPO

You can help your State of Illinois patients better understand their Aetna MAPD PPO plan. Here's an outline of the plan benefits:

	SEGIP retirees	**CIP and TRIP retirees**
	Network and out-of-network providers	
Annual medical deductible	$110	$250
Annual medical maximum out-of-pocket amount	$1,300	$1,100
Primary care physician visits	15% coinsurance after deductible	20% coinsurance after deductible
Physician specialist visits	15% coinsurance after deductible	20% coinsurance after deductible
Diagnostic procedures (X-rays, MRIs)	15% coinsurance after deductible	20% coinsurance after deductible
Inpatient hospital stay	15% coinsurance after deductible	20% coinsurance after deductible
	Network pharmacies	
Annual prescription drug deductible	$125	$0
Tier 1: Generic prescription drugs	$9 at Preferred network pharmacies $10 at Standard network pharmacies	$9 at Preferred network pharmacies $10 at Standard network pharmacies

ID cards

Here's what the ID cards for these patients look like:

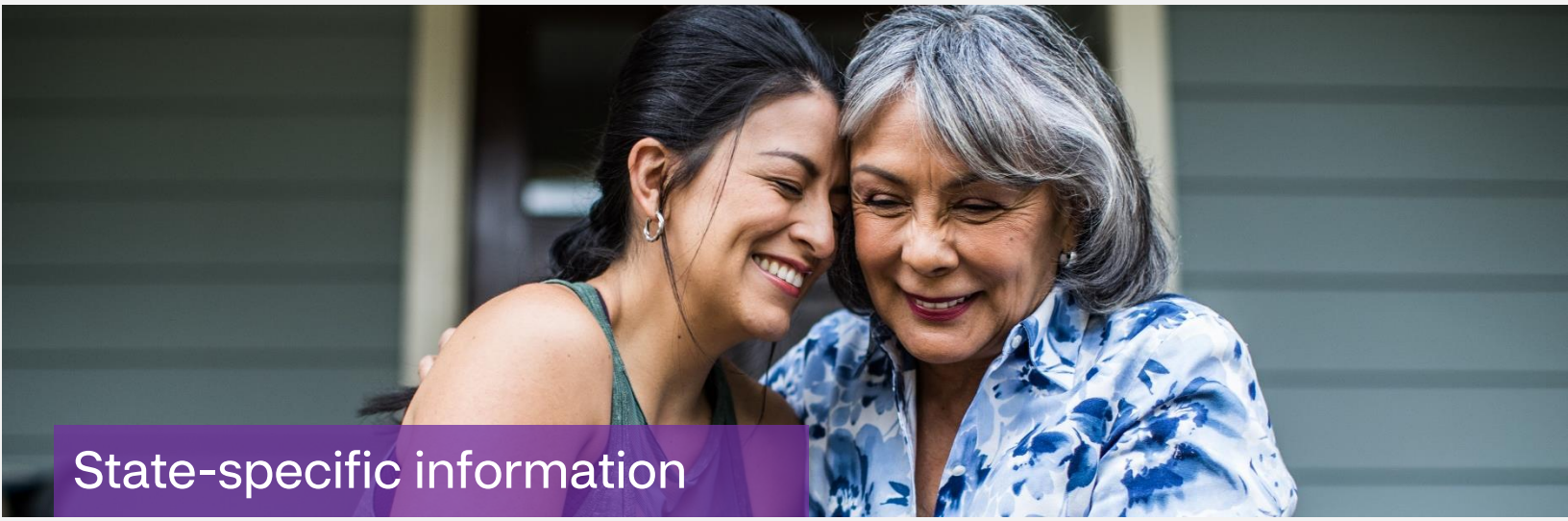


About the Extended Service Area (ESA)

The Aetna MAPD PPO plan with ESA for State of Illinois retirees allows Aetna members to use doctors and hospitals in or out of the Aetna Medicare network. Providers need to be licensed, accept Medicare and accept the Aetna plan.

More information

If you have questions about your patient's plan, just call our Provider Contact Center at **1-800-624-0756**, Monday through Friday, 8 AM to 5 PM, in all time zones.



State-specific information

Alabama, Louisiana and Mississippi: Aetna® Medicare offers chiropractic care through WholeHealth Living®, a Tivity Health Company

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

Services included with this benefit:

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

You can find out whether you participate in the DSNP plans by visiting **AetnaMedicare.com** > Find a doctor.

More information

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

*In addition to this supplemental chiropractic benefit, Aetna has contracted with WholeHealth Living to administer core chiropractic benefits for the 2023 program year.

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

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

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

Welcome our new members by checking your participation status

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

Questions?

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

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

California: 2023 Dual Eligible Special Needs Plans (DSNPs) to launch in San Diego County

We're rolling out a new, exclusively aligned DSNP in San Diego County in 2023.

Visit our **Medicare page** for more DSNP resources, including cost-share information. If you have more questions, visit our **Contact Aetna** page.

California: COVID-19 therapeutics do not require prior authorization

Aetna® covers COVID-19 therapeutics without prior authorization. In accordance with guidance from the U.S. Department of Health and Human Services (HHS), the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC), COVID-19 therapeutics are effective within five to seven days of when symptoms start.

In accordance with guidance issued by the California Department of Managed Health Care (DMHC), appointments for COVID-19 therapeutics must be provided within 48 hours of the request.

What you need to do

If you are unable to provide an appointment for a request for a COVID-19 therapeutic, please contact us and we can direct the member to a provider who has an available time slot.

For more information, please refer to the California Department of Public Health's **COVID-19 Test-to-Treat Playbook** for additional information.

Colorado: Patient cost-share for certain pain treatments in place of opioids

This law applies to covered patients with fully insured plans.

When the member's physician orders physical therapy, occupational therapy, chiropractic or acupuncture services for a patient with a pain diagnosis in place of prescribing opioids, the patient pays the same cost-share amount as they would for a primary care visit. The patient can receive up to six visits of one or more of these services at this cost-share amount per plan year.

We will identify any claims that may be subject to the law above on your Explanation of Benefits (EOB) statement.

To notify us when a fully insured Aetna® member is receiving therapy instead of opioids for a pain diagnosis, or if the member paid more than the cost-share amount, you can send correspondence via our **Availity provider portal**; fax to **1-859-455-8650**; or mail to PO Box 981106, El Paso, TX 79998-1106. Or you can call the Provider Contact Center at **1-888 MD AETNA (1-888-632-3862) (TTY: 711)**.

Colorado: Complete your anti-bias training, provider directory updates and a survey

The anti-bias-training requirement

To offer a culturally competent network, the Colorado Division of Insurance requires that providers and front office staff who participate in Individual and Small Group ACA plans complete anti-bias, cultural competency, or similar training annually to assist patients who experience higher rates of health disparities or inequities.

Providers and their front office staff must have this training no later than January 1, 2023. Providers are responsible for coordinating their own training.

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

The directory update requirement

The provider directory must indicate whether providers are multilingual, have extended hours and are accessible for people who have disabilities.

The mandatory survey

Complete one **survey** per office/facility. Please take it by January 20, 2023.

Colorado providers — notice of material change to contract

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

Florida: Memorial Healthcare System in Florida members can use the Aetna Signature Administrators® (ASA) solution

ASA's new third-party administrator (TPA) partner: Community Care Plan (CCP)

On January 1, 2022, CCP became a TPA partner with ASA. This new partnership gives Memorial Healthcare System in Florida members access to the ASA preferred provider organization program and medical network.

How to check eligibility and get additional support

To check eligibility or verify benefits for Memorial Healthcare System in Florida members, call their payer, CCP, at **954-622-3499**. You'll also find the phone number on the member's ID card.

Send claims to CCP

CCP handles all claims processing and claims questions for Memorial Healthcare System in Florida. Send all claims electronically to CCP's payer ID, #59064, which is listed on the member's ID card.

Or send paper claims to:

Community Care Plan
P.O. Box 849029
Pembroke Pines, FL 33804

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

Neither Aetna® nor ASA will be able to verify eligibility or process claims.

To learn more, see our **ASA flyer**.

Idaho, Washington and Oregon: American Specialty Health provides Aetna® with an Individual MA supplemental benefits program

American Specialty Health (ASH) is providing Aetna with an Individual Medicare Advantage (MA) supplemental benefits program option (some Individual MA plans are excluded) with a benefit for chiropractic, acupuncture, naturopathy and therapeutic massage.

Chiropractic and acupuncture

The supplemental benefits option provides routine services and benefits as well as Centers for Medicare & Medicaid Services' required benefit for chiropractic (subluxation) and the newly defined, CMS-required acupuncture benefit (chronic low back pain). The supplemental benefits program options go beyond CMS required benefits for chiropractic and acupuncture and provide members with a broader range of covered services for a broader range of conditions.

Naturopathy and therapeutic massage

ASH provides a supplemental benefits option for naturopathy and therapeutic massage even though these services are not currently required/covered by CMS.

Claims

This program is fully delegated (credentialing, claims and patient management) for all administrative and claims costs for in-network and out-of-network (if applicable) benefits. Under this program, ASH provides a credentialed/contracted practitioner network that submits claims through ASH for program services.

More information

Providers interested in joining the ASH network or who have questions about Aetna program participation can call ASH at **1-888-511-2743**.

State-specific county and supplemental benefits offerings

- Idaho

  For non-Medicare members, Aetna uses Network Management Group's network to provide acupuncture, chiropractic, massage therapy and naturopathy services (when covered). Providers contracted with NMG for Medicare may also provide CMS-required benefits only to Medicare members. Providers interested in joining the NMG network can call NMG at **1-801-747-3228**.

  See the chart below for alternative benefits offerings administered by American Specialty Health Specialties.

Plan name	Plan type	Counties	2023 supplemental benefit
Elite Plan	HMO-POS	Ada, Canyon, Elmore, Gem, Owyhee, Payette, Washington	Acupuncture
Choice Plan	PPO	Ada, Canyon, Elmore, Gem, Owyhee, Payette, Washington	Therapeutic massage Acupuncture
Eagle Plan	PPO- MA Only	Ada, Bonner, Canyon, Elmore, Gem, Kootenai, Owyhee, Payette, Shoshone, Washington	Acupuncture
Choice Plan	PPO	Bonner, Kootenai, Shoshone	Therapeutic massage Naturopathy

- Washington

For non-Medicare members, Aetna uses Tivity Health, Healthway's Whole Health Network (HWHN) (in WA and Kootenai County, ID) to provide acupuncture, chiropractic, massage therapy and naturopathy services (when covered). Providers contracted with HWHN Medicare may also provide CMS-required benefits only to Medicare members. Providers interested in joining the HWHN network can call HWHN at **1-800-274-7526**.

See the chart below for alternative benefits offerings administered by American Specialty Health Specialties.

Plan name	**Plan type**	**Counties**	**2023 supplemental benefit**
Value Plan	HMO-POS	Clark, Cowlitz	Therapeutic massage Chiropractic Naturopathy
Elite Plan	HMO-POS	Clark, Cowlitz	Therapeutic massage Chiropractic Naturopathy
Value Plan	HMO-POS	Spokane, Stevens	Therapeutic massage Naturopathy
Elite Plan	HMO-POS	Spokane, Stevens	Therapeutic massage Naturopathy
Value Plus Plan	HMO-POS	King, Kitsap, Lewis, Pierce, Snohomish, Thurston	Therapeutic massage Chiropractic Naturopathy Acupuncture
Platinum Plus Plan	HMO-POS	King, Kitsap, Lewis, Pierce, Snohomish, Thurston	Therapeutic massage Chiropractic Naturopathy Acupuncture
Elite Plan	HMO-POS	King, Kitsap, Lewis, Pierce, Snohomish, Thurston	Therapeutic massage Chiropractic Naturopathy Acupuncture
Value Plus Plan	HMO-POS	Benton, Franklin, Walla Walla, Yakima	Therapeutic massage Chiropractic Acupuncture
Value Plan	HMO-POS	Mason	Therapeutic massage Chiropractic
Platinum Plan	HMO-POS	Mason	Therapeutic massage Chiropractic
Prime Plan	HMO-POS	Pierce	Therapeutic massage Chiropractic

			Naturopathy Acupuncture
Choice Plan	PPO	Clark, Cowlitz, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston	Therapeutic massage Chiropractic Naturopathy Acupuncture
Select Plan	PPO	King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston	Therapeutic massage Chiropractic Naturopathy Acupuncture
Eagle Plan	PPO- MA Only	Benton, Clark, Cowlitz, Franklin, King, Kitsap, Lewis, Mason, Pierce, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Yakima	Therapeutic massage Chiropractic Naturopathy Acupuncture
Choice Plan	PPO- MA Only	Benton, Franklin, Walla Walla, Yakima	Therapeutic massage Chiropractic Acupuncture
Preferred Plan	PPO	King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Spokane, Thurston	Therapeutic massage Chiropractic Naturopathy Acupuncture
Choice Plan	PPO	Mason	Therapeutic massage Chiropractic

- Oregon

See the chart below for alternative benefits offerings administered by American Specialty Health Specialties.

Plan name	**Plan type**	**Counties**	**2023 supplemental benefit**
Elite Plan	HMO-POS	Clackamas, Columbia, Marion, Multnomah, Polk, Washington, Yamhill	Therapeutic massage Chiropractic Naturopathy Acupuncture
Value Plan	HMO-POS	Clackamas, Columbia, Marion, Multnomah, Polk, Washington, Yamhill	Chiropractic Naturopathy
Eagle Plan	PPO- MA Only	Clackamas, Columbia, Jackson, Josephine, Marion, Multnomah, Polk, Washington, Yamhill	Therapeutic massage
Choice Plan	PPO	Clackamas, Columbia, Marion, Multnomah, Polk, Washington,	Therapeutic massage Chiropractic

		Yamhill	Naturopathy Acupuncture
Elite Plan	HMO-POS	Jackson, Josephine	Chiropractic
Choice Plan	PPO	Jackson, Josephine	Chiropractic

New Jersey and New York: Life Time®, Inc., covered employees can access Aetna® through the Aetna Signature Administrators® (ASA) solution

As Life Time, Inc., expands in New York City, its covered employees can use the ASA preferred provider organization program and medical network.

How to recognize a Life Time member

The Life Time member ID card has two logos:

- HealthEZ (the payer's logo)

- The Aetna logo

Also, the card will refer to Aetna Signature Administrators.

How to check eligibility and get additional support

To check eligibility or verify benefits, simply call the HealthEZ exclusive provider line at **1-844-449-5553**. You'll also find the phone number on the member's ID card.

Send claims to HealthEZ

Our third-party administrator (TPA) partner, HealthEZ, will handle all claims processing and claims questions for Life Time. Send claims electronically to HealthEZ, payer ID #141178.

Or send paper claims to:

HealthEZ
P.O.Box 211186
Eagan, MN 55121

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

Neither Aetna® nor ASA will be able to verify eligibility or process claims.

To learn more, see our **ASA flyer**.

Pennsylvania: New Institutional Special Needs Plan (ISNP)

We're rolling out a new ISNP in certain counties in Pennsylvania in 2023.

What is an ISNP?

ISNPs are for people living in a long-term care facility. ISNPs offer benefits tailored to the unique medical, social, and emotional needs of members who are long-term residents (90 days or longer) in one of the following:

- A long-term care skilled nursing facility
- A long-term care nursing facility
- A skilled nursing facility/nursing facility
- An intermediate care facility for with intellectual disabilities
- An inpatient psychiatric facility

How to know if you participate in our ISNP

Our ISNP is being implemented in a limited area. If you practice in one of the following counties, you are automatically in our ISNP network: Allegheny, Berks, Bucks, Butler, Chester, Delaware, Lackawanna, Luzerne, Mercer, Montgomery, Philadelphia, Washington and Westmoreland.

Required Centers for Medicare & Medicaid Services (CMS) training

All ISNP plans are required to have an approved Model of Care. CMS requires providers to take the **Model of Care training course (PDF)**.

How to reach us

If you have questions, visit our **Contact Aetna** page.

South Dakota: New 2023 Dual Eligible Special Needs Plan (DSNP)

We're rolling out a DSNP in certain counties in southeastern South Dakota in 2023. Beneficiaries must reside in one of the following counties: Brookings, Clay, Davison, Hanson, Lake, Lincoln, McCook, Miner, Minnehaha, Moody, Sanborn, Turner, Union and Yankton.

Plan information

A DSNP is a Medicare Advantage (MA) Preferred Provider Organization (PPO) plan. You will be able to see DSNP members through your current MA agreement with us. We will pay you your current Aetna® MA rates.

A DSNP offers rich resources to complement the care you provide to your patients. Every DSNP member has access to a dedicated Interdisciplinary Care Team that includes a Registered Nurse and other clinical and non-clinical professionals as needed. The plan covers all Medicare benefits as well as dental, vision, hearing, transportation and quarterly allowances to help pay for healthy food and over-the-counter pharmacy items.

Required Centers for Medicare & Medicaid Services (CMS) training

All DSNP plans are required to have an approved Model of Care. CMS requires providers to take the **Model of Care training course (PDF)**. The training takes about ten minutes to complete.

Additional information

Visit our **Medicare page** for more DSNP resources, including cost-share information. If you have more questions, visit our **Contact Aetna** page.

Texas: New filing requirement

Effective April 1, 2023, the days allotted for timely filing will change to align with the Texas requirement of 95 days. All claims must be sent within 95 days of the date of service(s), unless you are legally unable to notify us.

This policy update does not apply to provider contracts with specific filing requirements.

Questions?

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

Texas: Texas Schools Health Benefits Program (TSHBP) members can now access Aetna® through the Aetna Signature Administrators® (ASA) solution

Starting September 1, 2022, Texas Schools Health Benefits Program (TSHBP) members were able to use the ASA preferred provider organization program and medical network.

How to recognize an ASA and TSHBP member

Look for the key identifiers on the TSHBP member ID card:

- The group's logo

- The Aetna logo

Also, the card will refer to Aetna Signature Administrators.

Note: There may be additional logos when the member lives in a rental network area or a rural network area.

How to check eligibility and get additional support

Direct all TSHBP eligibility and claims questions to the payer, 90 Degree Benefits, at **1-888-803-0081**. You'll also find the phone number on the member's ID card.

Send claims to 90 Degree Benefits

90 Degree Benefits handles all claims processing for TSHBP. Send all claims electronically to 90 Degree Benefits' payer ID, CAPHP, which is also listed on the member's ID card.

Or send paper claims to:

90 Degree Benefits
P.O. Box 21548
Eagan, MN 55121-2747

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

Neither Aetna® nor ASA will be able to verify eligibility or process claims.

To learn more, see our **ASA flyer**.

1378385-01-01