June 2022

OfficeLink Updates™

IN THIS ISSUE

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

How do Medicare members view your office profile?

Visit the **Find Aetna Medicare Health Care Professionals** page to view your office as it appears to your Medicare patients and others on our public provider search tool. Make certain that current and future patients can find you when they need care. | *PAGE 32*

New onboarding webinar

New to Aetna®? Attend our new provider onboarding webinar — **"**Doing business with Aetna" — for a tour through the provider onboarding welcome page.

You'll discover tools and resources that'll make your day-to-day tasks with us simple and quick. | *PAGE 17*

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.

Changes to our National Precertification List (NPL)

Effective September 1, 2022, the following medical precertification changes apply to commercial and Medicare.

Please note that the following medications are usually self-administered and therefore will be excluded from the medical benefit unless an exception is granted. For Medicare, coverage determinations will still follow all Centers for Medicare & Medicaid Services (CMS) National and Local Coverage Determinations. Precertification may still be required through the **pharmacy benefit for commercial plans** and the **Part D drug benefit for Medicare plans**.

We will no longer require medical precertification for the following drugs. Precertification may still be required through pharmacy plans.

Cardiovascular PCSK9 inhibitors

- Praluent® (alirocumab)
- Repatha® (evolocumab)

Growth hormones

- Genotropin® (somatropin)
- Humatrope® (somatropin)
- Increlex® (mecasermin)
- Norditropin®(somatropin)

- Omnitrope® (somatropin)
- Saizen® (somatropin)
- Serostim® (somatropin)
- Zomacton® (somatropin [rDNA origin])
- Zorbtive® (somatropin)

Immunologic agents

- Enbrel® (etanercept)
- Humira® (adalimumab)
- Kevzara® (sarilumab)
- Kineret® (anakinra)
- Siliq® (brodalumab)
- Simponi® (golimumab)
- Taltz® (ixekizumab)

Multiple sclerosis (MS) drugs

- Betaseron® (interferon beta-1b)
- Copaxone® (glatiramer acetate)
- Extavia® (interferon beta-1b)
- Glatopa® (glatiramer acetate injection)
- Plegridy® (peginterferon beta-1a)
- Rebif® (interferon beta-1a)

Osteoporosis drugs

- Tymlos® (abaloparatide)

Other drugs

- Dupixent® (dupilumab)

Effective September 1, 2022, the following medications will no longer require medical precertification for commercial plans. Medical precertification will still be required for the drugs listed below for Medicare plans.

Growth hormones

- Skytrofa™ (lonapegsomatropin-tcgd)
- Sogroya® (somapacitan-beco)

Immunologic agents

- Actemra® SC (tocilizumab)
- Cimzia® (certolizumab pegol)
- Cosentyx® (secukinumab)
- Enspryng® (satralizumab)
- Ilumya® (tildrakizumab)
- Orencia SQ® (abatacept)
- Skyrizi® (risankizumab-rzaa)
- Stelara® (ustekinumab)
- Tremfya® (guselkumab)

Multiple sclerosis (MS) drugs

- Avonex® (interferon beta-1a)
- Kesimpta® (ofatumumab)

Osteoporosis drugs

- Bonsity™ (teriparatide)
- Evenity® (romosozumab-aqqg)
- Forteo® (teriparatide)
- Miacalcin® (calcitonin)
- Prolia® (denosumab)

Submitting precertification requests

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

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

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

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

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

Third Party Claim and Code Review Program

Beginning September 1, 2022, you may see new claims edits. These are part of our Third Party Claim and Code Review Program.* These edits support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. You can view these edits on the **Availity provider portal**.**

For coding changes, go to:

1. Aetna Payer Space
2. Resources
3. Expanded Claim Edits

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

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

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

*The information in this article applies to our commercial and Medicare members.

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

Mid-level practitioners policy — E&M services

Effective September 1, 2022, we will no longer pay codes G0402, G0438 and G0439 at 100% when billed with E&M Current Procedural Terminology® (CPT®)* codes by nurse practitioners, physician assistants, certified nurse midwives and clinical nurse specialists.**

To find the policy, log in to **Availity***** and follow these steps:

1. Click on Payer Spaces > Aetna.
2. In the search box, type “mid-level practitioners” and click Search.
3. Choose “Mid-level Practitioners and Other Qualified Health Care Professionals — Resource.”

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

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

**These changes apply to our commercial and Medicare members.

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

Changes to commercial drug lists

On October 1, 2022, 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 August 1. They'll be on our **Formularies and Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug prior authorization

- Submit your completed request form through our **Availity provider portal**.*
- For requests for non-specialty drugs, call **1-855-240-0535 (TTY: 711)**. Or fax your **authorization request form (PDF)** to **1-877-269-9916**.
- For requests for drugs on the Aetna Specialty Drug List, call **1-866-752-7021 (TTY: 711)** or go to our **Forms for Health Care Professionals** page and scroll down to the Specialty Pharmacy Precertification (Commercial) drop-down menu. If the specific form you need is not there, scroll to the end of the list and use the generic Specialty Medication Precertification request form. Once you fill out the relevant form, fax it to **1-888-267-3277**.

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

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

Visit our **Medicare Part B step therapy** page to view the most current preferred drug lists for Medicare Advantage (MA) and Medicare Advantage with prescription drug coverage (MAPD) members. These lists are updated regularly throughout the plan year.

Commercial — notice of changes to prior authorization requirements

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

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

Expanded code set for site of service for outpatient surgical procedures policy

Effective October 1, 2022, we will expand our listing of procedure codes that apply to our site of service for outpatient surgical procedures policy.

This policy applies to our fully insured, commercial members.

View the **procedure code listing**.

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

Service codes update

We are assigning or reassigning individual service codes within contract service groups. Changes to a provider's compensation depends on the presence of specific service groupings in their contract. You'll find the changes below.

Unless noted, all updates take effect on September 1, 2022.

Codes

90619

Provider types affected

Facilities, including Acute Short-Term Hospitals, Ambulatory Surgery Centers, and Skilled Nursing Facilities, and Physician Contracts

What's changing

The code will be added to the Immunization/Vaccination (IMMVAC) contract service group.

If the contract contains an Immunization/Vaccination rate, then it will be applied; if not, we will apply the "all other outpatient" rate.

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

Important reminders

Check to see if you participate in the Aetna CVS Health™ Affordable Care Act (ACA) insurance plan now offered on the individual exchange

Note that this article applies to Arizona, Florida, Georgia, Missouri, Nevada, North Carolina, Texas and Virginia.

The December 2021 issue of the OfficeLink Updates™ (OLU) newsletter contained articles about Aetna® entering the ACA market with the Aetna CVS Health™ insurance plan or other ACA insurance products. These plans are now offered in certain areas in Arizona, Florida, Georgia, Missouri, Nevada, North Carolina, Texas and Virginia.

If you practice in any of those eight states, you could be participating in the new plans.

How to check whether you participate

- If you practice in **Florida, Georgia, Missouri, Nevada, North Carolina and Texas**, go to the **Aetna CVS Health provider referral directory** to check your status.
- If you practice in **Arizona (Maricopa, Pima and Pinal counties)**, 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 referral 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, you can **refer to our FAQs** or call **1-888-MD AETNA (1-888-632-3862) (TTY: 711)**.

Thank you for helping us get our members the care they need.

Check your Aetna Premier Care Network status

Now is a good time to check our **online provider directory** to see if you're participating in our Aetna Premier Care Network (APCN)/Aetna Premier Care Network Plus (APCN Plus) programs for 2022.

For 2022, we did not perform a designation review of provider performance; however, in some markets we have changed the underlying network configuration — for example, converting a broad network to an Aetna Whole Health® arrangement.

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

Notable 2022 changes

- Cleveland, Ohio: Cleveland Clinic Aetna Whole Health℠
- Toledo and Cincinnati, Ohio: Broad Network
- Fort Meyers and Tampa, Florida: Southwest Florida Aetna Whole Health℠
- El Paso, Texas: Tenet Healthcare Aetna Whole Health℠
- Rio Grande, Texas: Baptist Valley Aetna Whole Health℠
- Boise, Idaho: Broad Network
- Iowa, Southern Illinois, Rock Island/Henry, Illinois: Unity Point Aetna Whole Health℠

Overview of APCN/APCN Plus

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

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

New address for Aetna Medicare Advantage participating providers' post-service appeals

What's changed

Effective January 1, 2022, you need to use a new, Medicare-specific form for your post-service appeals.

You can find this form, which is called the Medicare Provider Complaint and Appeal Request Form, by going to the **forms for health care professionals page** and scrolling to the "Dispute and appeals" drop-down menu.

You will also need to send this form to a new, dedicated mailbox and fax number:

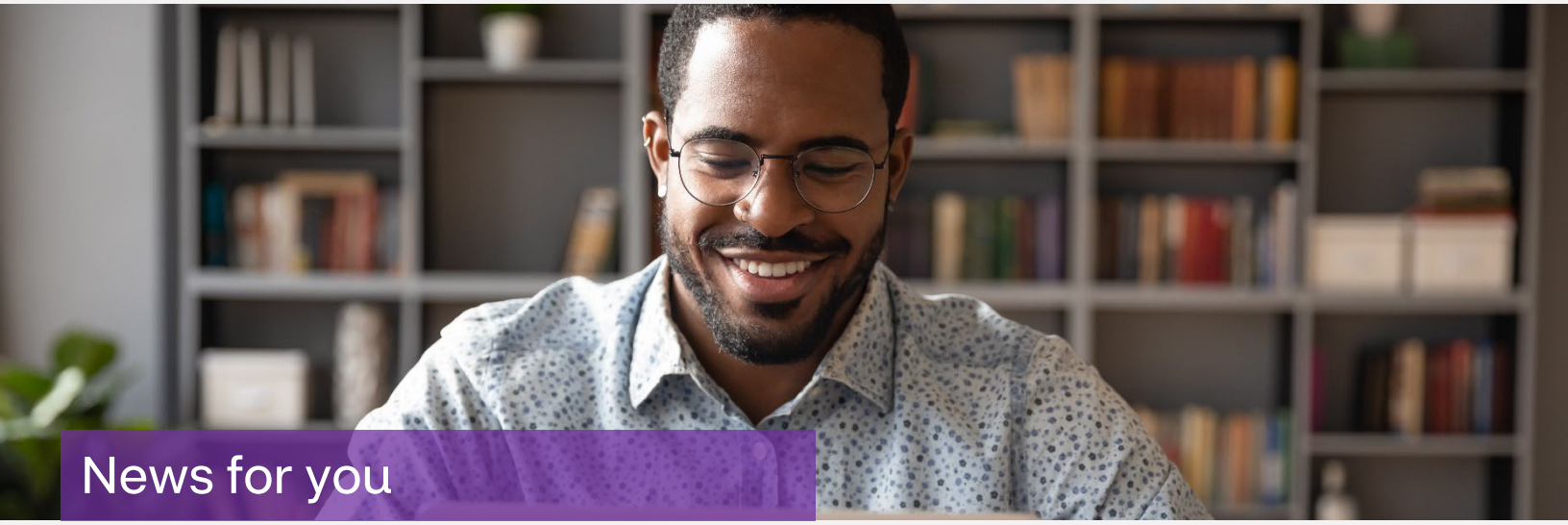
Medicare Provider Appeals
PO Box 14835
Lexington, KY 40512
Fax: 1-860-900-7995

Please immediately discontinue using the old mailbox and fax number:

Provider Resolution Team
PO Box 14020
Lexington, KY 40512
Fax: 1-800-624-0756

What hasn't changed

Continue to use the existing address for **commercial appeals**. Also know that the **reconsideration process** is not changing.



News for you

Our office manual keeps you informed

Visit us online to view a copy of your **Office Manual for Healthcare Professionals (PDF)**. This Aetna® office manual also 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

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

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.

Help improve communication between treating providers

Based on the results of a recent survey, we know that primary care physicians (PCPs) are concerned about how they don't get regular reports about their patients' ongoing evaluation and care from other treating providers.*

This breakdown in communication can pose a threat to quality patient care. We understand that coordinating care with many physicians, facilities and behavioral health care professionals can be a challenge.

Use our tools to share information

Comprehensive patient care includes communicating with your patients' other treating health care professionals. To promote collaboration and comprehensive care, it's critical that PCPs and specialists talk openly with each other.

You can use **our tools** to help. Here are a few to get you started:

- **Behavioral Health Sample Initial Evaluation Form (PDF)**
- **Dilated Retinal Eye Examination Report Form (PDF)**
- **Physician Communication Form (PDF)**
- **Physician Communication Post-Fragility Fracture Care Form (PDF)**
- **Specialist Consultation Report (PDF)**

Thank you for your efforts to improve how you communicate with other providers.

*Each year, we survey primary care practices contracted for all Aetna® products. The surveys assess the practices' attitudes and perceptions on key interactions with us. We use the Center for the Studies of Services, a third-party vendor, to administer the surveys. It

performs the surveys at market levels accredited by the National Committee for Quality Assurance (NCQA).

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 and ethnic preferences.

Practitioner training on equity, cultural 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 watch **Aetna's cultural competency training video**.

Request prior authorizations on Availity®

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

- Shoulder arthroplasty
- Inpatient electroencephalographic (EEG) video monitoring
- Endoscopic nasal balloon dilation
- Hip surgery to repair impingement syndrome

- Functional endoscopic sinus surgery (FESS)
- Excessive skin excision

Just use our **Availity provider portal**.

How to request an authorization

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

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

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

Advantages of using Availity

Completing the questionnaire on Availity:

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

How to register for Availity

It's easy to **register for Availity**. Once your account is ready, you can start submitting authorization requests right away.

Get trained

Sign up for our "Authorizations on Availity" webinar. You'll learn how to use the authorization transaction and questionnaire on Availity.

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

Diagnosing tick-borne disease using Quest, Labcorp and BioReference laboratories

When diagnosing tick-borne disease, timing is everything.

Lyme disease and other tick-borne illnesses can vary in severity and symptom type across different patients and in different geographic regions. Diagnosing tick-borne illnesses is not always easy since other conditions have similar symptoms.

Diagnosis is further complicated when patients delay seeking treatment because they are unfamiliar with, or do not recognize, the symptoms of a tick-borne illness.

Types of testing available

With both molecular and serologic testing available, Quest Diagnostics®, Labcorp and BioReference can give you the insights you need to make a timely, differential diagnosis — helping you and your patients make informed decisions about the appropriate treatment path.

Additional information

Keep in mind that coverage for testing is subject to health plan policies. Please check the appropriate clinical policy for coverage and coding.

Member access to care

We measure member access to care every year. We do this in many ways. For example, we review:

- Member satisfaction survey results
- Complaint data
- Phone surveys we conduct (the phone surveys include a random sampling of primary care and specialty care providers)

Access standards include appointment availability time frames for routine care, urgent matters and after-hours care. State requirements supersede these access standards and can be found in the Regional Office Manual Supplements.

Read more about the **access standards we measure**.

Thank you for taking part in these phone surveys. We do all this to comply with the National Committee for Quality Assurance (NCQA) accreditation standards and with various state regulations.

New provider 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" — for a tour through the provider onboarding welcome page. You'll discover tools 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.

A new way to access our payer partner Marpai (formerly Continental Benefits)

Aetna Signature Administrators' payer partner recently changed their name from Continental Benefits to Marpai.

To verify eligibility for patients whose card shows the Marpai logo, please visit Marpai's **provider portal** or call the customer service number on the back of the member's ID card.

When submitting claims, send them to the address on the back of the member's ID card. Or, for faster processing, send them electronically to payer ID 35245.

Keep your demographic information current

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

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

It's easy

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

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

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

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

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

*Availity is available only to 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 April 5, 2022.

Behavioral health coverage decisions and clinical criteria

Who makes coverage decisions

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

Coverage criteria

Patient management staff members use evidence-based clinical guidelines from nationally recognized authorities to guide utilization management decisions involving precertification, inpatient review, discharge planning and retrospective review.

Staff members use criteria found in the sources below to help make coverage determinations. The criteria are based on information about the specific member's clinical condition.

- **Aetna Clinical Policy Bulletins**
- **Guidelines for coverage determination**
- Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, Local Coverage Determinations, and the Medicare Benefit Policy Manual
- Milliman Care Guidelines® (MCG)

- 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** for information on how to purchase it.)
- Applied Behavior Analysis (ABA) Medical Necessity Guide
- Level of Care Utilization System (LOCUS®) and the Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS/CASII®)
- Other state-mandated criteria or guidelines

How to get hard copies

Need a hard copy of a source above in order to make a specific determination? We're here to help. Just call our Provider Contact Center at **1-888-632-3862 (TTY: 711)**.

Follow-up care for ADHD

Managing attention-deficit/hyperactivity disorder (ADHD) doesn't end with medication and a treatment plan. Talk with your patients about the importance of follow-up care.

This article offers some tips. You can find additional recommendations from the **American Academy of Pediatrics (PDF)**.

Medication follow-up

The most recent **Clinical Practice Guideline** from the American Academy of Pediatrics recommends that physicians who prescribe medication for ADHD:

- Schedule an in-person follow-up visit with the patient 30 days after the initial prescription to assess for side effects and improvements
- Schedule monthly visits, if needed, until a good routine is in place, then every three months for the first year
- Recognize that ADHD is a chronic condition and therefore requires ongoing treatment
- Collaborate with other medical providers and the school personnel for behavior therapy

Collaborate and track progress

Treatment plans for ADHD often involve medication in conjunction with behavior therapy and classroom interventions. Using a mix of these actions can promote calmer relationships with family members, better study habits and more independence. Collaboration between the prescribing physician, therapist and the school are important for success.

Parents can track their child's progress with **report cards (PDF)**. There are also **several apps** that may help.

Support for patients and parents

You may want to encourage your patients and their parents to seek more help from:

- **A support group**
- **A parent training program**
- Counseling
- The local school district

How to increase adherence to antidepressants

Depression responds well to antidepressant therapy.[1] Those who adhere to therapy early and continue to take medication as prescribed are more likely to recover from depression and avoid future relapse.[2] The most recent HEDIS® (Healthcare Effectiveness Data and Information Set) data available show that 79.45% of Aetna® members comply with their antidepressant medication plan during the first 12 weeks of treatment and that 65.53% of members remain compliant 6 months or more.

You can help improve adherence

Using the **Mayo Clinic depression medication decision choice aid** can help you work with your patients to select the medication that's right for them. Using the tool can improve the decision-making process and may lead to an increase in medication adherence and improve quality outcomes for your patients.[3]

Failure to adhere to medication can lead to high-risk outcomes, such as poor quality of life, comorbidity-related death and suicide attempts.[4] This can affect patients who:

- Don't take their medicine during the first six weeks of therapy
- Have chronic conditions such as chronic obstructive pulmonary disease, diabetes, heart disease or myocardial infarction

Questions?

To learn more, review the American Psychological Association **clinical practice guidelines for the treatment of depression.**

[1]Cipriani A, Furukawa T, Salanti G, et al. **Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder:**

a systematic review and network meta-analysis. The Lancet. April 7, 2018; 91: 1357–1366. Accessed March 11, 2022.

[2]Rush AJ, Thase ME. **Improving depression outcome by patient-centered medical management**. Focus: The Journal of Lifelong Learning in Psychiatry. Spring 2020; 18(2): 244–254. Accessed March 11, 2022.

[3]LeBlanc A, Herrin J, Williams MD, et al. **Shared decision making for antidepressants in primary care: a cluster randomized trial.** JAMA Internal Medicine. 2015; 175(11): 1761–1770. Accessed March 11, 2022.

[4]Ho SW, Jacob SA, Tangiisuran B. **Barriers and facilitators of adherence to antidepressants among outpatients with major depressive disorder: a qualitative study.** PLoS One. June 14, 2017; 12(6): 1–14. Accessed March 11, 2022.

Applied behavior analysis (ABA) treatment and claims

We have been working hard to provide additional education and support to our claims processing and benefits staff to ensure accurate claims handling. Please use the resources provided in this article to guide your treatment and claims decisions.

Precertification requests

ABA is on the Aetna® **precertification list** for behavioral health services. To get these services precertified, you can call the number on the back of the member's ID card and speak to a customer service representative. You may also use the **ABA Treatment Request form (PDF)** when applicable.

Benefits and claims questions

You can go to our **Contact Aetna** page or just call the number on the member's ID card.

Procedure codes

Aetna continues to use the American Medical Association (AMA) CPT® (Current Procedural Terminology®) codes for adaptive behavior treatment. The AMA made the following code revisions effective January 1, 2019:

- Eight new Category I codes for adaptive behavior assessments (97151 and 97152) and adaptive behavior treatments (97153–97158) were added.
- Fourteen associated Category III codes (0359T, 0360T, 0361T, 0363T–0372T and 0374T) were deleted.
- Two Category III codes (0362T and 0373T) were revised and maintained.

Autism treatment and ABA

You can refer to our **Autism Spectrum Disorders** clinical policy bulletin and our **Applied Behavior Analysis** clinical policy bulletin for more information.

ABA medical necessity guidelines

See the **Applied Behavior Analysis Medical Necessity Guide**.

Becoming an Aetna provider

We welcome new providers. Find out how to **join the Aetna network**.

Working together to solve the teen mental health crisis

We're dedicated to working with you to resolve the teen mental health crisis. We're here with resources you need to best support your young patients.

Partnering with Psych Hub

Our behavioral health providers can have a meaningful impact on our members. That's why we're partnering with **Psych Hub**, the world's largest online platform for mental health education. Psych Hub offers access to **best-in-class behavioral health resources** on evidence-based interventions, built with the provider and their patients in mind.

What you'll receive

You'll get free access to a series of courses you can take to earn an **eLearning certification in suicide prevention (video)**, developed by leading experts at Columbia University, the University of Pennsylvania and Harvard University.

Course titles and descriptions

"CBT Adaptations for Adolescents"

Learners will build on their knowledge of CBT foundations and acquire the skills to summarize developmental factors related to adolescents, create strategies to help young clients engage and stay motivated to continue therapy, and develop a rapport with adolescent clients' parents or guardians and include them in treatment as appropriate.

“DBT Foundations”

Learners will find out how to identify the stage of treatment the client is currently in, understand the client’s Life Worth Living goals, target an initial focus of treatment, and collaboratively define the highest priority goal of treatment.

“DBT Skills — for Clinicians”

These four modules cover the four main guiding practices and skills of DBT for providers to learn and reinforce implementation specifically with adolescent clients.

The courses include:

- Expert instruction and role play
- Scenario-based activities
- Engaging animated videos
- Resources and homework tools for your patients

You can earn national Continuing Education (CE) credits and Continuing Medical Education (CME) credits for these courses.

When you can start

This offering is now available to commercial behavioral health providers. **Sign up for suicide prevention courses**.

Pharmacy

Changes to commercial drug lists

On October 1, 2022, 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 August 1. They'll be on our **Formularies and Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug prior authorization

- Submit your completed request form through our **Availity provider portal**.*
- For requests for non-specialty drugs, call **1-855-240-0535 (TTY: 711)**. Or fax your **authorization request form (PDF)** to **1-877-269-9916**.
- For requests for drugs on the Aetna Specialty Drug List, call **1-866-752-7021 (TTY: 711)** or go to our **Forms for Health Care Professionals** page and scroll down to the Specialty Pharmacy Precertification (Commercial) drop-down menu. If the specific form you need is not there, scroll to the end of the list and use the generic Specialty Medication Precertification request form. Once you fill out the relevant form, fax it to **1-888-267-3277**.

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

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

Important pharmacy updates

Medicare

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

Visit our **Medicare Part B step therapy page** to view the most current preferred drug lists for Medicare Advantage (MA) and Medicare Advantage with prescription drug coverage (MAPD) members. These lists are updated regularly throughout the plan year.

Commercial — notice of changes to prior authorization requirements

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

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

Pennsylvania and West Virginia: Expanded Aetna Medicare Advantage program starting July 1, 2022

Our Aetna Medicare Advantage program works with **myNEXUS**, a technology-enabled care management company, to manage the network, claims payment and precertification/prior authorization program for home health services.

This program initially began in Texas on March 1, 2020; expanded to Georgia, Oklahoma and Virginia on August 1, 2021; expanded into Kentucky, Ohio and Missouri effective January 1, 2022; and is now expanding into Pennsylvania and West Virginia effective July 1, 2022.

We have also made important changes regarding pre-approval and claims payments.

Pre-approval changes

Starting July 1, 2022, myNEXUS will require advance approval for all home-health-related requests for in-home skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social work. Aetna Medicare Advantage members who are in Pennsylvania or West Virginia and who need to receive services administered in a home or residence will need pre-approval from myNEXUS for those services before they can begin.

View the **Aetna home health care pre-approval list**.

Claims payment changes

Starting July 1, 2022, myNEXUS will pay all claims (participating and nonparticipating) for covered home health services, including those filed with an authorization issued on or after July 1, 2022, for Pennsylvania and West Virginia Medicare Advantage members under the rates and terms of their myNEXUS contracted providers.

This change applies only to home health care services for:

- Aetna Medicare Advantage members
- Members residing in the state of Pennsylvania
- Aetna Medicare DSNP members in Pennsylvania
- Members residing in the state of West Virginia
- Aetna Medicare DSNP members in West Virginia

This change does not apply to any other plans or members, including, but not limited to:

- Medicare members residing outside of the state of Pennsylvania and West Virginia
- Aetna and Coventry commercial fully insured HMO/POS/PPO plans
- Aetna administrative services only (ASO) self-funded HMO/POS/PPO plans
- Aetna Student Health℠
- Aetna Global Business
- Coventry Workers' Compensation
- Cofinity®
- First Health®, Meritain® Health, Traditional Choice®
- Aetna Signature Administrators®

Pre-approval requests

- Visit the **myNEXUS portal** (registration required) to get started.
- Fax the **authorization request form** to **1-866-996-0077**.

If you have questions, call myNEXUS Intake (Monday through Friday, 8 AM to 8 PM ET) at **1-833-585-6262**.

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

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

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

How to complete your Medicare compliance FDR or FDR/DSNP attestation

In the summer of 2022, we will post training materials on our **Medicare page**.

Our training materials include:

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

Where to get more information

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

The Aetna Smart Compare™ designation program for Medicare

We are piloting the Aetna Smart Compare primary care physician (PCP) designation program for Medicare in 2022. You may be familiar with our commercial program, which launched in 2021. Aetna® members enrolled in our Medicare plans will be able to access similar designations for clinical quality and cost effectiveness.

Aetna Smart Compare has designations for the following commercial specialties:

- Primary care physicians (PCPs)
- Orthopedics who treat hip and knee
- Obstetricians and gynecologists (Ob/Gyn)
- Cardiologists
- Spine surgeons

The Aetna Smart Compare designation has two measurement categories:

- Clinical quality
- Effectiveness

All measures are based on recognized industry standards and are relevant to the specialty evaluated.

Designation results

Providers who meet the evaluation criteria for each designation will receive a letter. The designation is valid through 2022.

How we'll use the designation results

We'll use the designations in two ways:

- To help our members choose a physician through our digital search tools
- To identify care options for members who use other channels, like a member call center

These designations are one way to help members choose a physician through Aetna digital tools and other channels. But it should not be the sole basis for their choice.

These designations do not impact your network status or your reimbursement. Nor do they affect a member's benefit level.

Questions?

The **Aetna Smart Compare page** has complete program information. There, you'll find an overview of the designation measures.

If you have questions or feedback about the program, **send us an email message**.

Connecticut: Starting July 1, you must use Anna™ for the SNF concurrent review process

Aetna® has partnered with Post-Acute Analytics (PAA) to automate the concurrent review process by using their Anna™ software platform.

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

What's changing?

Starting July 1, 2022, all skilled nursing facilities (SNFs) in Connecticut that admit Aetna Medicare Advantage members who reside in and receive care in those states will be required to work with PAA and use Anna to:

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

The precertification and concurrent management process

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

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

How to start using Anna

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

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

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

- Send a message to **PAA Provider Relations**
- Call Tammy Starr at **1-469-312-1030**

Sending "continued stay" documentation

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

How to reach us

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

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

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

Want to know how your patients view your practice?

Visit the **Find Aetna Medicare Health Care Professionals** page to view your office as it appears to your patients and others on our public provider search tool. Make certain that current and future patients can find you when they need care.

Review your information

- Address and phone number
- Email and fax numbers
- Hospital and group affiliations
- Gender and languages spoken
- Whether you are accepting new patients
- Telemedicine indicator
- Add a new service location to an existing contract
- Tax Identification Number (TIN)

Choose how to update your information

- Via our **Availity provider portal**,* which is our preferred site for changes
- Via our **Request Changes to Provider Data** page

Note that if you are a delegated, custom, NAP, rental, dental or EyeMed provider, please submit your change request to your contracted group's administrator.

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

We've submitted 2022 HEDIS® Medical Record Collection Project results

Annually, we collect HEDIS (Healthcare Effectiveness Data and Information Set)* data from claims, encounters, administrative data and medical records. We support a consumer-obsessed culture — one that enhances member health and quality of life, expands provider relationships to support an enhanced patient experience, and closes data and care gaps.

We submitted our data for 2021 according to National Committee for Quality Assurance (NCQA) reporting requirements.

We want to thank the offices and staff that have provided medical records in support of our HEDIS efforts.

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

Update to the telehealth Place of Service (POS) code

Telehealth continues to be an integral part of providing safe and convenient health care visits for Medicare Advantage beneficiaries.

As of January 1, 2022, a new POS code has been approved to report more specifically where services were provided.*

POS code

10

POS code name

Telehealth Provided in Patient's Home

POS code description

The POS code indicates the location where health services and health-related services are provided or received, through telecommunication technology. It applies to patients located in their home (defined as a location other than a hospital or other facility and is where the patient receives care in a private residence) when receiving health services or health-related services through telecommunication technology.

When completing a telehealth visit, please review the tips below:

- It must be performed in real time, using both audio and visual.
- You should document the visit properly.
    - Indicate the mode of the visit (for video conferencing).
    - Document the date and duration of the visit.
    - Complete documentation as you would for an in-person visit.

Our nurse educator plays an important role to ensure that providers have access to the most updated information. For additional information, contact us at **RiskAdjustment@aetna.com**.

*Prior to January 1, 2022, the authorized POS code for telehealth was POS 02.

New address for Aetna Medicare Advantage participating providers' post-service appeals

What's changed

Effective January 1, 2022, you need to use a new, Medicare-specific form for your post-service appeals.

You can find this form, which is called the Medicare Provider Complaint and Appeal Request Form, by going to the **forms for health care professionals page** and scrolling to the "Dispute and appeals" drop-down menu.

You will also need to send this form to a new, dedicated mailbox and fax number:

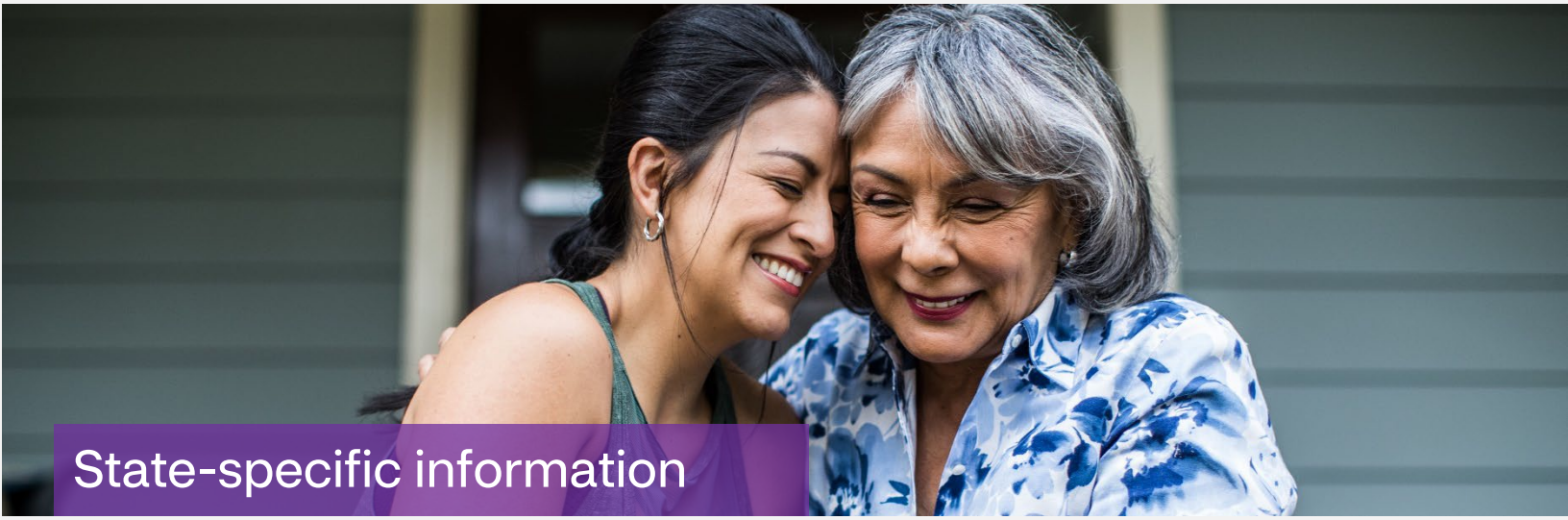
Medicare Provider Appeals
PO Box 14835
Lexington, KY 40512
Fax: 1-860-900-7995

Please immediately discontinue using the old mailbox and fax number:

Provider Resolution Team
PO Box 14020
Lexington, KY 40512
Fax: 1-800-624-0756

What hasn't changed

Continue to use the existing address for **commercial appeals**. Also know that the **reconsideration process** is not changing.



State-specific information

Check to see if you participate in the Aetna CVS Health™ Affordable Care Act (ACA) insurance plan now offered on the individual exchange

The December 2021 issue of the OfficeLink Updates™ (OLU) newsletter contained articles about Aetna® entering the ACA market with the Aetna CVS Health™ insurance plan or other ACA insurance products. These plans are now offered in certain areas in **Arizona, Florida, Georgia, Missouri, Nevada, North Carolina, Texas and Virginia**.

If you practice in any those eight states, you could be participating in the new plans.

How can you check whether you participate?

- If you practice in **Florida, Georgia, Missouri, Nevada, North Carolina and Texas**, go to this **provider referral directory** to check your status.
- If you practice in **Arizona (Maricopa, Pima and Pinal counties)**, 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 this **provider referral directory** to check your status. If you are an Innovation Health provider in **Northern Virginia**, you can check this **provider directory**.

Questions?

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

Thank you for helping us get our members the care they need.

California: Make member grievance forms available at your office

California regulations require providers to make **member grievance forms** for health plans available at all office or facility locations.

You can download the California HMO and California DMO grievance forms, which include information about member rights and responsibilities, in English or Spanish.

California: Use our interpretation service at no extra cost

Need help giving care to non-English-speaking Aetna® members? Just use our Language Assistance Program (LAP). There is no charge for this interpretation service.

You can call **1-800-525-3148 (TTY: 711)** to reach a qualified interpreter directly.

Members can also request interpretation services from our LAP by calling the number on their ID card. They can contact our LAP for general questions, to file a grievance or to get a grievance form.

Questions?

Get help from your state. Just call the:

- California Department of Insurance Hotline at **1-800-927-4357** for traditional plans
- California Department of Managed Health Care Help Center at **1-888-466-2219 (TDD: 1-877-688-9891**) for HMO and DMO plans

You can reach the **California Department of Managed Care Help Center** 24/7. It provides written translation of independent medical review and complaint forms in Spanish, Chinese and other languages. You can get copies of the forms by submitting a written request to:

Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725

California access standards

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

Appointment type	**Time frame**
Urgent care (primary care physicians)	48 hours from request
Urgent care (specialists, non-physician mental health)	96 hours from request
Non-urgent doctor appointment (primary care physician)	10 business days
Non-urgent doctor appointment (specialty physician)	15 business days
Non-urgent mental health appointment (non-physician)	10 business days
Non-urgent appointment (ancillary provider)	15 business days
As of July 1, 2022: non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider	10 business days for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition

Exceptions to the above appointment time frames

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

Rescheduling appointments

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

Aetna® does not delegate monitoring and assessment of these standards to any of our contracted provider groups. We will assess our contracted provider network against these standards by conducting an annual provider survey to assess appointment availability and a provider satisfaction survey to solicit concerns and perspectives.

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.

Connecticut: Starting July 1, you must use Anna™ for the SNF concurrent review process

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