June 2024

OfficeLink Updates™

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

HIGHLIGHTS IN THIS ISSUE

Availity: Check authorization without submitting a request

Start your Authorization Add request as you normally would and find out whether the service needs authorization. We'll also tell you when a different entity handles the authorization and how to contact them.

FEHB program contraceptive coverage

Under the ACA, coverage of certain preventive services, including contraceptives, must be provided at no cost. If you believe that a non-formulary contraceptive is medically necessary, you may request an exception.

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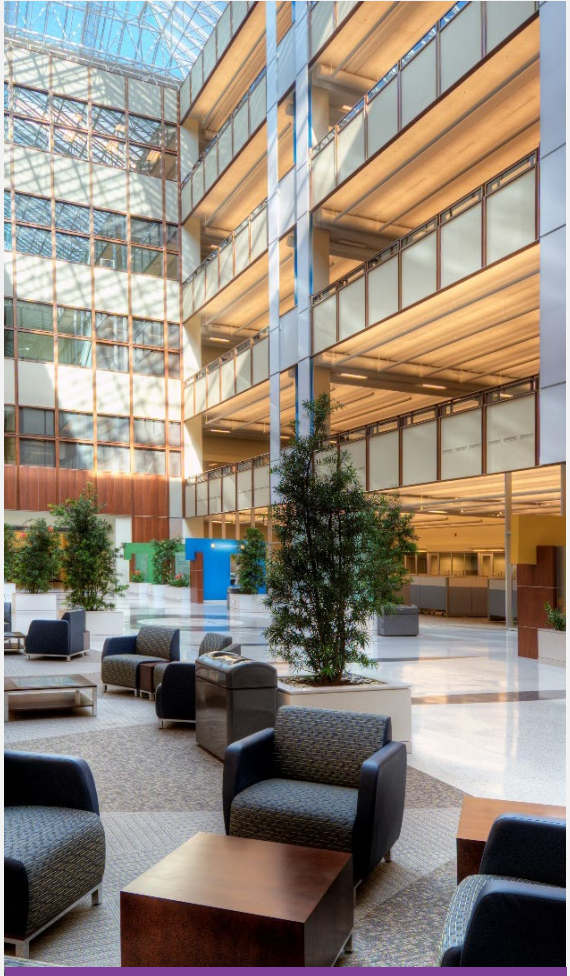

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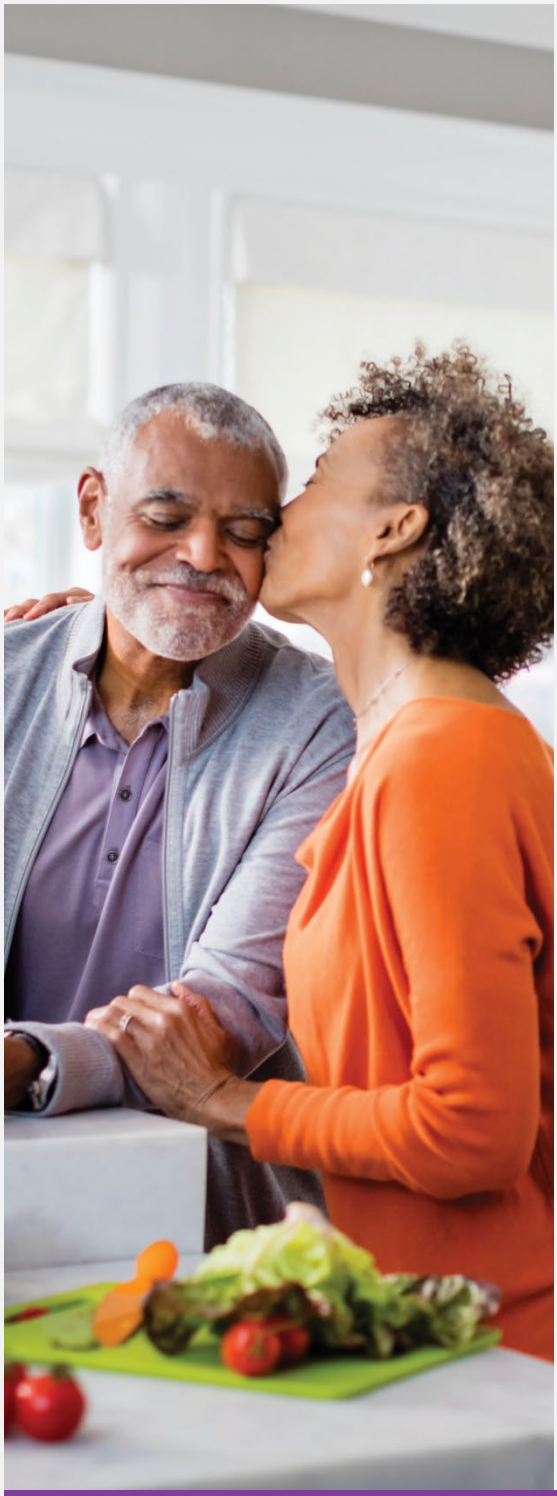

90-day notices and related reminders

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

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

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

Claim and Code Review Program (CCRP) update

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

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

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

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

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

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

Prompt medical chart submission, when requested, will result in timely claim processing.

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

Note to Texas providers: Changes described in this article will be implemented for fully insured plans written in the state of Texas only if such changes are in accordance with

applicable regulatory requirements. Changes for all other plans will be as outlined in this article.

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

Lactation consultants coding update

This update applies to our commercial members only.

Effective September 1, 2024, we will no longer allow evaluation and management services (99202–99205, 99212–99215 or 99415–99417) when billed by lactation consultants. Modifier 25 will not override this denial.

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

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

Modifier SH and SJ coding update

This update applies to our commercial and Medicare members.

Effective September 1, 2024, we will begin editing on modifier SH and SJ. Modifier SH and SJ are appropriately billed with infusion therapy codes.

- If modifier SH is reported, the allowable will be reduced by 25% of the contracted rate.
- If modifier SJ is reported, the allowable will be reduced by 50% of the contracted rate.

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

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

Missing modifier 54 expansion to place of service 20 and 49

This update applies to our commercial and Medicare members.

Beginning September 1, 2024, we will expand our modifier 54 policy to include place of service 20 (urgent care) and 49 (independent clinic). We will pay for surgical procedures performed in these places of service billed with or without modifier 54 (surgical care only) at 75% of the contracted surgery rate. In addition, beginning September 1, 2024, when services are rendered in the ER, we will reduce payment for surgical procedures when billed by nurse practitioners or physician assistants with or without modifier 54.

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

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

Assistant surgeon services update

This update applies to our commercial and Medicare members.

Starting September 1, 2024, we will not allow an assistant surgeon for procedure code 61880 for commercial and participating Medicare Advantage claims. The code is for revision or removal of intracranial neurostimulator electrodes.

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

Service code updates

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

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

Codes	Provider types affected	What's changing
92921, 92925, 92929, 92934, 92938, 92944, C9601	Facilities, including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Coventry Enhanced Grouper: Category 1 • If contract contains an Ambulatory Surgery — Coventry Enhanced Grouper: Category 1 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.

Changes to our National Precertification List (NPL)

Effective September 1, 2024, we'll require precertification for the following procedures (Medicare and commercial plans):

- Hyperthermic intraperitoneal chemotherapy (HIPEC) (96547, 96548)
- Zepzelca (lurbinectedin) (J9223)
- Microprocessor-controlled leg prosthesis (L5926, L5973)
- Neurostimulator implantation (64553, 64555, 64561, 64568, 64569, 64575, 64580, 64581, 64582, 64583, 64584, 64585, 64590, 64595)

Effective September 1, 2024, we'll require precertification for the following procedures (commercial plans only):

- Anterior thoracic vertebral body tethering (22836, 22837)
- Anterior lumbar or thoracolumbar vertebral body tethering (0656T, 0657T)
- Revision, replacement or removal of thoracic vertebral body tethering (22838)
- Revision, replacement or removal of thoracolumbar or lumbar vertebral body tethering (0790T)

Effective September 1, 2024, the **Site of Care for Specialty Drug Administration policy** applies to the following drug (commercial plans only):

- Lanreotide (J1932)

Effective September 1, 2024, we'll require precertification for the following procedure (Medicare plans only):

- Knee arthroscopy with meniscus repair (29882, 29883)

Submitting precertification requests

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

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

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

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

We will cover Intrauterine Insemination (IUI) as a standard medical benefit

Read about who is covered and whether we require precertification.

Starting on September 1, 2024, we will cover IUI as a standard medical benefit for all individuals regardless of reproductive partner status, including:

- Same-sex couples
- Opposite-sex couples
- Individuals seeking pregnancy

We will cover IUI under the member's benefits plan, with applicable cost-sharing and deductible amounts. Members should consult their plan for more details.

Precertification

We will not require precertification.

Additional information

This update does not include other treatment-level services that might be associated with IUI, such as injectable medication, cycle monitoring, the purchase of gametes (egg or sperm), etc. The policy does not impact other infertility treatment services, including in vitro fertilization.

For more details, visit our **Medical Clinical Policy Bulletins** page. The bulletin number is 327.

Changes to commercial drug lists begin on October 1

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

On October 1, 2024, we'll update our pharmacy drug lists. Changes may affect all drug lists, precertification, step therapy and quantity limit programs.

You'll be able to view the changes as early as August 1, 2024. They'll be on our **Formularies and Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug prior authorization

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

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

More information

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

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

Important pharmacy updates

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

Medicare

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

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

Commercial — notice of changes to prior authorization requirements

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

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

Student Health

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

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

Aetna federal employee plans

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

Enhanced prior authorization reviews for medical specialty drugs

A new program will include review of dose appropriateness.

This update applies to commercial members only.

The program

Beginning September 1, 2024, we're introducing the Novologix® Enhanced Quantity on Authorization (EQOA) program. This is a new prior authorization feature that will include the review of dose appropriateness based on indication, age and weight per FDA dosing guidelines and accepted compendia. To reduce waste, the feature will apply dose optimization by rounding up the requested dose using commonly available package sizes.

Approved drug dose, Healthcare Common Procedure Coding System (HCPCS) units and number of doses will be communicated in decision letters explaining the quantity limits applied upon claims submission.

Future updates

We'll include a subset of drugs initially and then expand the in-scope drug list in phases.

State-specific updates

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

Arizona: Some Radiation Oncology (RO) program services will soon require authorization

Starting July 1, 2024, we will require authorization for certain procedures.

This update applies only to Aetna® and Banner|Aetna commercial fully insured and Individual and Family Plan (IFP) members whose residence state is Arizona.

Services that will require pre-approval

- 77014, 77371, 77372, 77373, 77385, 77386, 77387, 77401, 77402, 77407, 77412, 77423, 77424, 77425, 77520, 77522, 77523, 77525, 77600, 77605, 77610, 77615, 77620, 77750, 77761, 77762, 77763, 77767, 77768, 77770, 77771, 77772, 77778, 79005, 79101, 79403
- A9513, A9543, A9606, A9590
- G0339, G0340, G6001, G6002, G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, G6014, G6015, G6016, G6017
- 0394T, 0395T, 0747T

For a complete list of procedures that need authorization, visit us at **Aetna.com**. From there, navigate to our provider site, where you can find our precertification lists and clinical policy bulletins.

Submitting authorization requests

Before you perform and get paid for services, the CVS Health Solutions® radiation oncology program must review authorization requests for medical necessity.

If a date of service is on or after July 1, 2024, and you haven't already requested precertification, contact CVS Health Solutions to request authorization. There are two ways you can do this:

- Log in to our **provider portal on Availity*** and navigate to Novologix®.
- Call **1-866-231-8569 (TTY: 711)** during normal business hours.

Urgent requests

If a member needs services in less than 48 hours due to medically urgent conditions, please tell the representative that the request is for urgent care.

Tips

- We recommend that ordering physicians get authorizations and share the approval numbers with the facility performing the procedure when that procedure is scheduled.
- Approvals have both authorization numbers and CPT® codes specific to the approved services.**
- If you perform services without approval, we may deny payment. Please don't ask members for payment, as outlined in your agreement with us.
- We'll determine coverage under the applicable policy in accordance with the policy's terms and conditions and with our policies and procedures.

Questions?

If you have questions, you can send an **email message**. You can also refer to our **Contact Aetna** page. To find out about our radiation oncology criteria, go to our **Cancer Care Management** page after May 31, 2024.

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California: Access standards

These access standards cover appointment availability, exceptions to appointment time frames and criteria for rescheduling.

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 services that do not require prior authorization	48 hours from request
Urgent care services that require prior authorization	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
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

Note: A referral to a specialist by a primary care provider or another specialist is subject to the relevant time-elapsed standards listed above.

Exceptions to the above appointment time frames

- The above time frames may be extended if the referring or treating provider determines and notes 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 that 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.

California: 2024 Provider Appointment Availability Survey (PAAS)

We might contact your office with our brief survey questions, and we are required to send your responses to the DMHC and the CDI.

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

Aetna® has contracted with the Center for the Study of Services (CSS) to administer the PAAS for 2024. Aetna will assess compliance through the PAAS and report the results to the California Department of Managed Health Care (DMHC) and to the California Department of Insurance (CDI).

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

Providers to be surveyed

- Primary care physicians (PCPs)
- Specialty physicians
- Psychiatrists
- Non-Physician Mental Health (NPMH) providers and Substance Use Disorder (SUD) providers
- Ancillary providers who offer mammogram appointments and ancillary providers who offer physical therapy appointments

Survey questions

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

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

The importance of your response

Because you are a contracted provider, we encourage you to make every effort to respond to the survey. Your response should accurately reflect your appointment availability for Aetna members. We will report all responses, including non-responses, to the DMHC. If your office does not respond to the survey, we might issue a corrective action plan.

California: How to meet the linguistic needs of Individual & Family Plan (IFP) members

Fee-for-service providers: Learn about your patients' language preferences.

Aetna® is committed to providing equitable, high-quality health care. To help reduce health disparities and promote health equity, we collect member language preferences.

We can provide you with a patient's language preference, if you ask for it, when you call the Provider Contact Center (PCC) at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** to verify eligibility.

A member's preferred language is not currently visible in Availity®.* Please call the PCC for this information to help you anticipate the language needs of your patients.

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

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

California: Make member grievance forms available at your office

You can get these forms, which allow members to file grievances with numerous entities, in English or Spanish.

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

Aetna® members may file a grievance with Aetna, the California Department of Managed Health Care (DMHC), or the California Department of Insurance (CDI) for any reason, including delays in timely access to care or timely referrals.

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

California: Use our interpretation service at no cost

This program is for both providers and members, and our hotlines and help centers can provide translations of important medical documents.

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. The department's Internet website is **www.dmhc.ca.gov**. It provides written translation of independent medical review and complaint forms in Spanish, Chinese and other languages. You can get paper copies of the forms by submitting a written request to:

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

Or, for traditional plans, the **California Department of Insurance** at:
https://www.insurance.ca.gov/01-consumers/101-help/index.cfm

Massachusetts: How to code for annual mental health wellness exams

You can process these claims using three codes.

In 2023, the Commonwealth of Massachusetts approved access to an annual mental health wellness exam with no patient cost-sharing, provided the member is covered by a fully insured plan not subject to the federal Internal Revenue Code. For details, see **Bulletin 2023-05**.

In January 2024, the Commonwealth offered coding information. See **Bulletin 2024-02**.

Coding information

You can process claims for the annual mental health wellness exam using the following codes:

- Procedure code 90791 (an integrated biopsychosocial assessment, including history, mental status and recommendations)
- Diagnosis code Z13.30 (encounter for screening examination for mental health and behavioral disorders, unspecified)
- Modifier 33 (to make clear that the evaluation is for preventive purposes and not an initial evaluation due to a particular presenting issue/illness, and to indicate that it is not subject to cost-sharing)

Nevada: How to identify Individual and Family Plan ACA (Affordable Care Act) HMO members

You may start seeing more of these Aetna CVS Health® Individual and Family Plan ACA HMO members in your office.

Clark County

Individual and Family Plan (IFP) members in Clark County, Nevada, use our Aetna Whole Health℠ (AWH) network. If you are a provider in Clark County and participate in our AWH network, you are in network for our IFP members. IFP ID cards will have "HMO" on them.

If you would like to be in our AWH network, please **email a letter of interest** to Intermountain Health and ask to join their network as an affiliate. Your request should include practice information, clinic locations and a current W-9. Note that submitting a request does not guarantee inclusion in the network.

Washoe County

IFP members in Washoe County, Nevada, use our standard commercial network. If you are a participating provider in Washoe County, you are in network for our IFP members. IFP ID cards will have "HMO" on them.

Questions?

Just visit our **Contact Aetna** page. We're available Monday through Friday from 8 AM to 5 PM in all time zones.

Oklahoma: Please update or add your website URL to our Oklahoma provider directories

Oklahoma law 2023-OK-407_S 442 says that we are required to collect and publish provider websites in our Oklahoma provider directories.

Please take the time to make sure your profile is updated.

Utah: How to identify Individual and Family Plan ACA (Affordable Care Act) HMO members

You may start seeing more of these Aetna CVS Health® Individual and Family Plan ACA HMO members in your office.

Individual and Family Plan (IFP) HMO members in Utah use either the Aetna Choice® network (non-tiered) or the Peak Preference network (tiered). The member ID card will indicate which network the member uses. If you participate in those networks, you are in network for our IFP members.

Contact us by visiting our **Contact Aetna** page. We're available Monday through Friday from 8 AM to 5 PM in all time zones.

2024 Utah provider networks

Easily identify the five Utah networks and find out how to identify a member's network.

Aetna® offers five different Utah networks, which give our members access to quality and affordable health care. The network participation for the major health care providers in Utah is summarized in the table below, along with key information that will assist in identifying a member's network.

Utah networks

	2024 Utah provider networks				
	Aetna Whole Health℠ — Connected Utah Network	**Aetna Choice® Network (Standard Network)**	**Peak Preference Network**	**Aetna Extended Network**	**Utah Connected Network** (ends 6/30/2025)
Intermountain Health					
Primary Children's Hospital	**Y**	**Y**	**Y - Level 1**	**Y**	**Y**

Rural (all other county locations not listed below)	Y	Y	Y - Level 1	Y	Y
Urban (Salt Lake, Utah, Weber and Davis County locations)	Y	N	N	Y	Y
University of Utah Health					
Pediatrics	Y	Y	Y - Level 2	Y	Y
Dermatology	Y	Y	Y - Level 2	Y	Y
Behavioral Health	Y	Y	Y - Level 2	Y	Y
Huntsman Mental Health Institute	Y	Y	Y - Level 2	Y	Y
All other, not listed above	N	Y	Y - Level 2	Y	N
HCA/MountainStar Healthcare	N	Y	Y - Level 1	Y	Y
CommonSpirit/Holy Cross	N	Y	Y - Level 1	Y	N
		Used for Individual and Family (IFP) plans			

Network indicated on member ID card	aetna and "Aetna Whole Health — Connected Utah" Note: ID cards are gold colored	aetna	aetna and "Peak Preference Network"	aetna and "Aetna Extended Network"	aetna and "Utah Connected Network"

Verifying eligibility

Please be sure to check the member's network and make in-network referrals. You can check a member's network through Availity® and get other information you need about Aetna.*

Not registered for Availity yet?

Go to our **provider portal on Availity** or call Availity Client Services at **1-800-282-4548** between the hours of 8 AM and 8 PM ET, Monday through Friday.

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

News for you

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

New provider onboarding webinar for providers and their staff

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

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

We'll show you how to:

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

Register today

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

Questions?

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

Our office manual keeps you informed

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

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

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

What's in the manual

The manual contains information on the following:

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

How to reach us

Contact us by visiting our **Contact Aetna** page, calling the Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** and selecting the "precertification" phone prompt, or calling patient management and precertification staff using the Member Services number on the member's ID card. The Medicare phone number is **1-800-624-0756, TTY: 711**. Our medical directors are available 24 hours a day for specific utilization management issues.

More information

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

Cultural competency can help your practice

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

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

Our commitment

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

Culture, race and ethnicity

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

Language

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

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

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

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

Want to learn more?

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

Take accredited health equity courses to better serve your patients

Help meet the cultural and linguistic needs of your diverse patients.

Health equity means that everyone has a fair and just opportunity to achieve optimal health. A culture of learning and engagement is key to advancing health equity goals.

The **Think Cultural Health website**, sponsored by the Office of Minority Health (OMH), offers a free online educational program accredited for physicians, physician assistants and nurse practitioners. It's called **A Physician's Practical Guide to Culturally Competent Care**, and it's intended to furnish the knowledge, skills and awareness to best serve all patients, regardless of their cultural or linguistic background.

There are three courses in the program:

- Course 1 covers the fundamentals of **Culturally and Linguistically Appropriate Services (CLAS)**, including strategies for delivering patient-centered care.
- Course 2 covers communication and language assistance, including how to work effectively with an interpreter.
- Course 3 covers organizational CLAS-related activities, including strategic planning and community assessment.

What is CLAS?

CLAS advances health equity, improves quality and helps eliminate health care disparities by establishing a blueprint for health and health care organizations to provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Please take advantage of the free courses. We are happy to help you meet the cultural and linguistic needs of our members.

Don't turn away Nippon Life Benefits members

Nippon Life Benefits members access the Aetna Open Choice® PPO medical network and the Aetna Dental Access® PPO dental network via Aetna Signature Administrators® (ASA) nationally.

Nippon Life Benefits is a long-term partner of Aetna®, offering medical and dental benefits to over 40,000 members across the country. These members have access to in-network discounted care with Aetna PPO medical and dental contracted providers.

Look for key identifiers on the ID card

- The Nippon Life Benefits logo
- The Aetna logo
- A reference to Aetna Signature Administrators

How to send claims

Nippon Life Benefits handles all claims processing. Please send all claims electronically to the payer ID listed on the member's ID card or send paper claims to the address listed on the ID card. Don't submit claims directly to Aetna.

How to verify eligibility

Please check the member's ID card for phone numbers to confirm eligibility and benefits.

Aetna HealthFund® (AHF) plan Health Reimbursement Account (HRA)

The AHF HRA is a national reimbursement account, or health fund, that accompanies some medical health plans. Health funds pay toward a member's deductible until it is met.

You should not request payment from these members up front, since their fund dollars are applied to their claims when you submit them Aetna®. If a member's health fund becomes depleted and the member has not yet reached their deductible, the member is responsible for the cost of covered services until the deductible is met.

Once the deductible is met and the health fund is exhausted, the underlying medical plan starts to pay.

How to identify AHF members

Go to the Eligibility and Benefits response screen and look under Plan/Product to see if AHF is listed there.

How to check whether the member has funds available

Look at the message "Health Fund," under "Limitations." You will see the remaining dollars available to apply toward the deductible. This amount is based on claims that we have fully adjudicated.

If you see funds there, you should bill the claim to us. Don't ask for money up front.

We're ready to receive your electronic claim attachments

Now you can get paid faster and track claims easily.

We're now accepting electronic attachments. **Jopari** is our first vendor ready to receive solicited attachments. **PNT Data** will be ready soon. If you work with another vendor, reach out to them to see when they'll be able to receive attachments.

Why switch to electronic claim attachments

Switching to attachments means you can:

- Get paid faster
- Get claims processed more efficiently
- Track claims easily
- Better safeguard Protected Health Information (PHI)
- Reduce the cost of administrative work
- Save money on mailing and printing

We accept unsolicited attachments

Check out **our vendor list** to see which vendors are working with us. Under the "Transactions Available" section, check for "Claim Attachments." If your vendor isn't listed yet, check back periodically. We update the list every time a new vendor is ready.

Prior authorizations online

If you're interested in getting prior authorization notices online, contact your vendor. We'll let you know when this transaction becomes available.

Now available: Check authorization requirements on our provider portal on Availity®

You can now check authorization requirements without having to submit a request.

We've added a new inquiry feature within the Authorization Add request on our **provider portal on Availity**.* It's called "Is Authorization Required." Here's how it works.

It takes place in step 3

Start your Authorization Add request on Availity as you normally would. Add provider and patient information, diagnosis and procedure codes, place and date of service, and quantity. In step 3 of the request process, we'll check whether the requested service(s) requires authorization and return one of the following responses:

- **No authorization required** means you're done. You can print a copy of the response for your records and move on with your day.
- **Authorization required** means we require authorization for at least one of the requested services. Use the "Next" button to finish and submit your request on Availity.
- **Undetermined** means the inquiry function is unable to determine whether authorization is required. That might be because the patient's plan has special conditions. Treat this response the same as "authorization required" and continue with your request as usual.

We'll even tell you when services are handled by another entity

When another entity handles authorization, we'll tell you the name of the entity and how to contact them. When EviCore handles services, not only will we tell you to contact EviCore, but you'll also see a "Take me to EviCore" button. Use it to go directly into EviCore's portal to complete your request.

How to register for Availity

If you're not already using Availity, **register**. Look for the "Get Started" link in the upper-right corner of your screen. There's no cost to use Availity Essentials.

Attend a free webinar to learn more about authorizations on Availity

We offer free webinars every month on how to use Availity to submit your authorization requests and more. Go to **our webinar page** and register for the next "Authorizations on Availity" webinar or any of the other listed webinars.

We're innovating to meet your needs

Questions about authorization requirements generate the most calls to us. With the Is Authorization Required function, you can check authorization requirements on your schedule, without having to speak to anyone. It's one of the ways we're innovating to meet your needs and making it easier to do business with us.

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

Reminder: Create NICU authorization requests under the parent's member ID

At times, when babies are admitted to the neonatal intensive care unit (NICU), all you know is that the baby is covered under an Aetna® medical plan. Parents have 31 days to add a

baby to their plan. For that reason, we might create a temporary member ID, which includes the temporary name of “Baby Boy” or “Baby Girl,” in order to track the services the baby is receiving until the parent adds the baby.

But the temporary member ID is just that: temporary. We’ll cancel the temporary member ID once the baby is added to the parent’s plan. So don’t use it to create authorization requests. Instead, use the parent’s member ID, as usual.

Submit your authorization requests electronically

When you’re ready to submit your authorization request, be sure to use our **provider portal on Availity*** or your preferred electronic vendor.

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

Check out the recent enhancements to the Aetna® Virtual Assistant

We’re thrilled so many of you are using the Aetna Virtual Assistant to check if precertification is required for a service or the status of an existing request. We’d like to thank those of you who’ve shared comments after your calls. We’re listening to those comments, and we’d like to share some of the recent changes we’ve made.

Use your telephone’s keypad in more places

You can use your telephone’s keypad to input values in more places. Such as when entering a case reference number, National Provider Identifier (NPI) or date of service. You can still speak your entries for these values. Allowing you to use your telephone’s keypad gives you an alternative to speaking multiple digits.

Ask for a call reference number before the end of the call

When inquiring if precertification is required, the Virtual Assistant will give you a call reference number at the end of call. Some callers hang up before getting their call reference number. You can interrupt the Virtual Assistant to get your call reference number without waiting for the end of the call. That way, you can end the call at your convenience and move on with your day.

Coming soon: Search by the patient’s Aetna member ID number

When calling for the status of a submitted request, if you don’t have the case reference number, soon you’ll be able to inquire on the status using the patient’s Aetna member ID number. Just input the requested values, and the Virtual Assistant will return the status for

the correct request. We'll announce in a future newsletter issue when you can use the member ID.

We made these changes based on your comments. We'd appreciate if you'd keep sharing them with us, so we can create solutions that make it easier for you to do business with us.

Documentation and coding for sickle cell anemia

Read on for tips about how to document and code for this disease.

Sickle cell anemia (Hb-SS) is a type of sickle cell disease (SCD), the most common inherited blood disorder in the United States. This disease gets its name from the abnormal crescent, or "sickle," shape that some red blood cells develop.

People who have this form of SCD inherit two genes, one from each parent, that code for hemoglobin "S" (Hb-SS). Hemoglobin S is an abnormal form of hemoglobin that causes the red cells to become rigid and sickle shaped. Sickle cell anemia is usually the most severe form of the disease.

Because of their sickle shape and other abnormalities, these red blood cells can block the flow of blood through the body and cause recurring episodes of pain, or pain crises.

Diagnosis

SCD is diagnosed with a simple blood test. In the United States, SCD is most often found at birth during routine newborn screening tests at the hospital.

SCD can be diagnosed while the baby is in the womb. Tests like **chorionic villus sampling and amniocentesis** can check for chromosomal or genetic abnormalities in the baby. Chorionic villus sampling tests a tiny piece of the placenta. Amniocentesis tests a small sample of amniotic fluid surrounding the baby.

Documentation tips

- Document the location of pain (chest, back, shoulder, abdomen)
- Document type of pain (throbbing, sharp, dull or stabbing)
- Document the trigger of any crisis, if known
- Document any end-organ dysfunction (such as end-stage renal failure)
- Document any complications of any treatment
- Document any underlying chronic comorbid conditions

Coding tips

D57.0	• Hb-SS disease with crisis • Sickle cell disease with crisis • HB-SS disease with vasoocclusive pain
D57.00	• Hb-SS disease with crisis, unspecified • Hb-SS disease with (painful) crisis NOS • Hb-SS disease with vasoocclusive pain NOS
D57.01	• Hb-SS disease with acute chest syndrome
D57.02	• Hb-SS disease with splenic sequestration
D57.03	• Hb-SS disease with cerebral vascular involvement; code also, if applicable, cerebral infarction (I63.-)
D57.1	• Sickle cell disease without crisis • Hb-SS without crisis • Sickle cell anemia NOS • Sickle cell disease NOS • Sickle cell disorder NOS

How to get your overpayment refund processed quickly

Please submit refunds with the proper information.

We often need to return overpayment refunds due to insufficient information. Please submit the needed information so that we can apply your refund.

What we need

Please send the following:

- A check issued to Aetna® in the amount of the overpayment
- The name and ID number of the member for whom we have overpaid (include a copy of the member's Aetna ID card, if available)
- The dates of service
- The claim ID number
- Supporting documentation, including but not limited to:
    - A letter explaining the specific reason for the refund
    - A copy of your Explanation of Benefits (EOB) statement
    - In the case of incorrect coordination of benefits, the primary carrier's EOB statement

- The corrected bill
- Any other documentation that would assist in accurate crediting of the refund
- The overpayment letter (if we ask for it)

Mail this information, along with the refund check, to the address on the EOB statement or on the member's ID card.

Member access to care

Read about how and what we measure.

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 and after-hours care. More stringent state requirements supersede these access standards and can be found in the Provider Manual State Supplement.

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.

Our annual transition to the new edition of the MCG care guidelines

We use evidence-based clinical guidelines from nationally recognized authorities, such as MCG Health (MCG), to make utilization management (UM) decisions.

Every year, we coordinate with MCG to update to their new edition. Starting April 27, 2024, we started using the 28th edition of the MCG care guidelines and will continue to use it for designated reviews.

Help improve communication between treating providers

Use our forms to make it easier to communicate with other practitioners.

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:

- **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. They perform the surveys at market levels accredited by the National Committee for Quality Assurance (NCQA).

Federal Employees Health Benefits (FEHB) program contraceptive coverage

Under the Patient Protection and Affordable Care Act (PPACA), coverage of certain preventive services, including contraceptives, must be provided at no cost.

Patients who have coverage under the FEHB program can find details in section 5(f) (prescription drug benefits) of the plan brochure. To find the brochures, go to the **FEHB plan information page** and choose the relevant state. Each listed plan provides a link to its brochure.

If you believe that a non-formulary contraceptive is medically necessary for your patient, you may request an exception via the Contraception Exception Process by calling the number on the back of the member's ID card.

You can learn more about contraception resources and reproductive rights by visiting the **U.S. Office of Personnel Management** and the **Department of Health and Human Services**.

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

Quest Diagnostics®, Labcorp and BioReference® Health 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 bulletin** for coverage and coding.

Behavioral health

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

Follow-up care for ADHD

We encourage you to work with parents, care providers and schools for better outcomes.

Aetna® uses HEDIS® (Healthcare Effectiveness Data and Information Set) to measure improvement in clinical outcomes for our members.*

One measure identified for improvement is the HEDIS ADD measure, which is the rate of members from age 6 to 12 on ADHD medication with at least three follow-up visits within 10 months of the first ADHD medication dispensed. A typical breakdown is as follows:

- The Initiation Phase (a follow-up visit with a prescribing provider within 30 days of receiving medication)
- The Continuation and Maintenance Phase (continued ADHD medication during the 9 months after the initiation phase in addition to receiving two additional follow-up visits within those 9 months).

Best practices

The **American Academy of Pediatrics** and the **American Academy of Child & Adolescent Psychiatry** provide recommendations for best practices when treating ADHD. Some recommendations include:

- Explaining medication options and side effects
- Discussing behavioral therapy, psychotherapy, family therapy, support groups, social skills training and/or parenting skills
- Scheduling a follow-up visit for 30 days after the initial prescription
- Scheduling monthly visits, if needed, until a good routine is in place, then every 3 months for the first year
- Collaborating with other medical providers and the school

Partner with patients for improved outcomes

Partnering with parents and service providers is important to ensure that patients understand the importance of keeping appointments. Using a combination of medication, behavior therapy and classroom interventions can improve awareness of the importance of follow-up care and medication adherence. It may also promote calmer relationships with family members, better study habits and more independence in children.

Collaboration between the prescribing physician, therapist and school is important for success. Provide parents and educators with resources such as those available from **Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD)**. There are also **several apps** that may help.

Additional resources may include:

- **Support groups**
- **The CHADD parent training program**

- Pharmacy medication alerts and reminders
- Counseling
- The local school district

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

Behavioral health clinical criteria

Read about how we determine coverage and where to go for more information.

How we determine coverage

Aetna® medical directors make all coverage denial decisions based on behavioral health clinical criteria. Only Aetna medical directors, 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, utilization review coverage denials are made, as applicable, by a physician or pharmacist licensed to practice in that state.

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

More information about our behavioral health clinical criteria

- **Aetna clinical policy bulletins**
- **Guidelines for coverage determination**
- **Centers for Medicare & Medicaid Services (CMS)**
    - National Coverage Determinations (in the blue box at the top of the page)
    - Local Coverage Determinations (under Coverage Process)
    - Medicare Benefit Policy Manual (under Related Instructions)
- **The American Society of Addiction Medicine (ASAM) Criteria textbook**, third edition (applies only to our commercial line of business starting on January 1, 2024). The ASAM criteria content is copyrighted. Contact the **American Society of Addiction Medicine** for information on how to purchase it.
- **Applied behavior analysis (ABA) medical necessity guide**
- Substance use disorder care in New York state: **Level of Care Determination for Alcohol and Drug Treatment Referral (LOCADTR)**
- **LOCUS and CALOCUS-CASII**
- **CMS Medicare Prescription Drug Benefit Manual**

- **CMS Medicare Managed Care Manual**
- **Custodial Care guidelines**

States may also mandate the use of other criteria and guidelines.

Hard copies

Need hard copies of a specific criteria for a specific determination? We're here to help. Visit our **Contact Aetna** page.

Medical record documentation standards

You can find treatment documentation standards in our provider manual.

We maintain standards related to behavioral health treatment documentation

Accurate and comprehensive treatment records are an essential component of quality patient care and safety. We also must show compliance with state treatment documentation regulations. For those reasons, we maintain specific standards regarding treatment documentation. In some cases, we are required to audit treatment records. It is important that you understand and apply these standards.

Find medical record documentation standards in the provider manual

For detailed information, please see page 84 of the **2024 provider manual**. You can find information related to our documentation standards in the Behavioral Health Quality program section (starting on page 83). Appendix A (page 89) lists the specific criteria we use when auditing treatment records.

Thank you for your efforts to maintain detailed, comprehensive and organized treatment records.

Mental health resource guidebooks

Use our guidebooks to help manage suicide rates.

According to the Centers for Disease Control and Prevention (CDC), suicide is the 11th-leading cause of death overall in the United States and the 2nd-leading cause of death among individuals between the ages of 10 and 34.[1,2]

As part of our comprehensive strategy toward suicide prevention, Aetna® and CVS Health® created mental health resource guidebooks for several targeted populations to address their unique mental health concerns. With the right intervention, support and resources, management of suicide thoughts and death by suicide can be prevented.

Guidebooks

Please use and share these guidebooks (available in English and Spanish) with your patients, consumers and the general public.

- **LGBTQ+ coming out support guide for youth and young adults (PDF)**
- **LGBTQ+ coming out support guide for youth and young adults (es) (PDF)**
- **Mental health awareness guide for young adults (PDF)**
- **Mental health awareness guide for young adults (es) (PDF)**
- **Mental health awareness guide for parents and caregivers (PDF)**
- **Mental health awareness guide for parents and caregivers (es) (PDF)**
- **Suicide prevention guide for older adults (PDF)**
- **The High School Educator Guide (PDF)**

By sharing these resources, we can empower individuals to take action to protect their own mental health and well-being — and that of others.

[1]American Foundation for Suicide Prevention. **Suicide statistics**. Accessed on March 14, 2024.

[2]Centers for Disease Control and Prevention. **Facts about suicide**. Accessed on March 14, 2024.

No-cost Continuing Education (CE) suicide prevention training series

Understanding how to determine risk of suicide is everyone's responsibility.

As part of our comprehensive strategy to address suicide as a leading cause of death in the United States, commercial network behavioral health providers can access a series of suicide prevention education courses at no cost to build risk assessment and safety planning skills.

We encourage you to complete the **Suicide Prevention Series** offered by PsychHub. The series consists of the following courses:

- Cognitive Behavioral Therapy Foundations: A Skills Based Approach (3.25 CE credits)
- CBT for Reducing Suicide Risk (3.50 CE credits)
- Counseling on Access to Lethal Means (2.25 CE credits)
- Foundations in Safety Planning Intervention for Clinicians (2.50 CE credits)

To achieve certification, you must complete the Clinical Application Project (CAP) practical application simulation at the end of the four courses.

Those who complete the series will earn a searchable flag designation in our **provider directory**. The flag will indicate the following:

> Suicide Prevention Specialist — one who is trained and qualified in treating people at risk of suicide

The Suicide Prevention Specialist designation will patients find specialized care and services.

New website helps patients be seen and heard

Get resources and support for patients with mental health challenges.

People with mental health challenges often feel as though the life they once lived is slowly fading away. We believe that in times like those, everyone deserves to get the help they need.

Be Seen, Be Heard

Our commitment to health equity inspired the creation of our new **Be Seen, Be Heard** site, which is open to everyone — providers, patients and the community. This site allows everyone to access mental health resources such as:

- Depression education
- The Patient Health Questionnaire (PHQ-9)
- Depression screening best practices

Early intervention and access matters

Screening patients at every visit empowers you make your patients be seen and heard. We encourage you to visit and share our new site — support resources can help everyone improve their mental health.

Medicare

Get Medicare-related information, reminders and guidelines.

Complete your required annual Medicare compliance attestation by October 31, 2024

This year we require all participating providers to sign an attestation.

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

This year we require all participating providers to sign an attestation:

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

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

2024 direct provider notification

Email notifications with the training and attestation were sent to the compliance email(s) identified within your 2023 attestation prior to June 1, 2024. If we do not have your email address or if the email bounces, you will receive a postcard in the mail this summer reminding you to complete your attestation (and MOC training, if applicable) by October 31, 2024.

Note: The attestation you will receive will be based on your contracted MA plans.

Our training materials

You can now view training materials and complete attestations on our **Medicare page**.

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

Where to get more information

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

Help seniors overcome common challenges to exercise

Pain, fear of injury and cost all contribute to a reluctance to get more active.

We all know exercise is good for us. It helps us live longer, healthier lives. This is especially true for seniors. In fact, it is one of the most important things seniors can do for their health. It can help prevent or delay many chronic conditions, help improve balance and prevent falls, and so much more.[1] But how can we best help our senior patients?

Challenges to exercise

Some seniors may be hesitant to exercise, but there are ways you can help them overcome these common challenges.

- **Pain and discomfort.** It's no secret that age brings new aches and pains, not to mention some chronic conditions that create their own level of discomfort. But many chronic conditions can improve with low-exertion exercise and flexibility training.[2]
- **Fear of injury.** Many seniors don't want to exercise because they are afraid that they will fall and hurt themselves. What they don't realize is how physical activity can prevent falls.[3] There are many exercises seniors can do to improve their balance. They can even try this **7-Day Better Balance Challenge with SilverSneakers**.
- **The high cost of a gym membership.** Gyms can be expensive, but one in four seniors are eligible for the SilverSneakers® fitness benefit.

Your patients can get active with SilverSneakers

SilverSneakers is more than a traditional fitness program — it's a way of life. It's designed specifically for seniors to help them get started and achieve their health and fitness goals. And it may be included with their Medicare Advantage plan at no additional cost.

With SilverSneakers, members get access to:

- A nationwide network of participating locations, with group fitness classes at select locations*
- SilverSneakers community classes offered in neighborhood locations outside of the gym
- **Silver Sneakers LIVE** online classes and workshops taught seven days a week by instructors trained in senior fitness
- The **SilverSneakers On-Demand** library with 200+ online workout videos

- The SilverSneakers GO mobile app with digital workout programs
- Burnalong®, a supportive virtual community and thousands of classes for all interests and abilities

How your patients can get started

Have members go to **SilverSneakers.com/GetStarted** to get their SilverSneakers member ID number.

*Participating locations ("PLs") are not owned or operated by Tivity Health, Inc., or its affiliates. Use of PL facilities and amenities are limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

[1]Centers for Disease Control and Prevention. **How much physical activity do older adults need?** April 13, 2023. Accessed on March 13, 2024.

[2]Centers for Disease Control and Prevention. **Adults with chronic health conditions and disabilities**. July 7, 2021. Accessed on March 13, 2024.

[3]Mayo Clinic. **Fall prevention: simple tips to prevent falls**. February 3, 2022. Accessed on March 13, 2024.

Referral requirements for Dual-Eligible Special Needs Plans (DSNPs)

Also find out how to use Availity® to check referral status.

If a plan requires a referral, it must be issued from the primary care physician (PCP) for all specialist visits, including those services performed in a facility. A referral isn't the same as precertification. Visit our website to see if a service requires **precertification**.

Electronic referrals

You can request an electronic referral for any plan that requires it.

You can find our "Referral Add and Inquiry" transaction on our **provider portal on Availity**.* Or find another vendor on our **electronic transaction vendor list**.

Why use Availity?

The "Referral Add and Referral Inquiry" transaction on Availity allows you to:

- Request referral authorization
- Inquire about the status of a referral

Referrals training

You can access help right on Availity by following these steps:

1. Log in to **Availity**.
2. Click the down arrow next to “Help & Training.”
3. Select “Get Trained.”
4. In the search bar, type “Referrals.”
5. Select ”Auth/Referral Inquiry — Training Demo.”
6. Click the orange “Enroll” button on the left-hand side.
7. Click the “Start” button within the Auth/Referral training box.

Other ways to get help

- You can visit the **Electronic Transaction Tools** page on **Aetna.com** and click the down arrow next to “Patient Referrals.”
- You can view the **Electronic Transaction Vendors** page for information on the vendors and clearinghouses with which Aetna has a relationship.
- For help understanding how to use the National Provider Identifier (NPI) in the Referral transaction, see the Referral Add (278) section of **Using Organizational (Type 2) National Provider Identifiers (NPIs) in HIPAA standard electronic transactions (PDF)**.
- You can take one of our **live webinar events**.

Refer members to participating providers

Search for participating providers in our **referral directory**. Referrals may be issued to an individual specialist using their National Provider Identifier (NPI) or to a specialty using a taxonomy code.

DSNPs that require referrals

Beginning January 1, 2024, only California and Florida HMO DSNPs require referrals.

PCP selection

All DSNPs require PCP selection.

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

Medicaid redetermination changes

Help ensure that your patients don't lose their Medicaid benefits.

Members may be disenrolled automatically

Members who no longer meet eligibility requirements or who don't take the steps to confirm their eligibility will lose their coverage. In many cases, recipients are not aware that they need to recertify their eligibility. Recertification is a continuous process in many states, and each state process is different.

Recertification education is a collaborative effort

It takes a collaborative and consistent effort to educate enrollees about Medicaid redetermination changes. We encourage you to educate staff members, provide fliers at the front desk and in patient rooms, send emails to patients and post content on your websites.

Important reminders

Take note of the following:

- Renewals may or may not be automatic. Ask your patients to connect with the agency managing their Medicaid enrollment.
- Ask your patients to make sure their contact information is up to date with the agency managing their Medicaid enrollment.
- Tell your patients that they might be contacted by mail or through their online account when it's time to renew.
- Please stress the importance of completing state renewals on time.

As always, verify eligibility and benefits prior to administering services.

Medicare skilled nursing and therapy coverage standards and training reminders

Read about skilled nursing and skilled therapy services under Medicare's skilled nursing facility, home health, and outpatient therapy benefits.

Medicare programs cover skilled nursing and skilled therapy services under Medicare's skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met).

The Jimmo settlement of 2013

The Jimmo settlement might have reflected a change in practice for those providers, adjudicators and contractors who might have erroneously believed that Medicare programs cover nursing and therapy services only when a beneficiary is expected to improve.

The settlement is consistent with Medicare regulations governing:

- Maintenance nursing and therapy in skilled nursing facilities
- Home health services
- Outpatient therapy (physical, occupational and speech)
- Nursing and therapy in inpatient rehabilitation hospitals for those who need that level of care

Maintenance coverage standard for skilled nursing services

Skilled nursing services are covered when those services are necessary to maintain the patient's current condition or to prevent or slow further deterioration, for as long as the beneficiary requires skilled care for the services to be safely and effectively provided.

Maintenance coverage standard for skilled therapy services

Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered for as long as the beneficiary requires skilled care for the safe and effective performance of the program.

Information from the Centers for Medicare & Medicaid Services (CMS)

We recommend that all our Medicare contracted providers who provide skilled nursing and skilled therapy services under Medicare's skilled nursing facility, home health, and outpatient therapy benefits review the following CMS materials:

- **Medicare Learning Network, February 8, 2024, edition** (see the Skilled Nursing Care & Skilled Therapy Services to Maintain Function or Prevent or Slow Decline: Reminder section)
- **Medicare Benefit Policy Manual** (see chapters 1, 7, 8 and 15)
- **Important Message About the Jimmo Settlement**
- **Frequently Asked Questions (FAQs) Regarding Jimmo Settlement Agreement**
- ***Jimmo v. Sebelius* Settlement Agreement Program Manual Clarifications Fact Sheet (PDF)**
- **Manual Updates to Clarify SNF, IRF, HH and OPT Coverage Pursuant to *Jimmo v. Sebelius* Settlement Agreement (PDF)**

- **Manual Updates to Clarify Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) Requirements Pursuant to *Jimmo v. Sebelius* Settlement Agreement (PDF)**

We submitted the 2024 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 2023 data in accordance with the National Committee for Quality Assurance (NCQA) reporting requirements.

We want to thank staff members who provided medical records in support of our HEDIS efforts.

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