March 2025

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

We continue to make improvements to our Aetna Virtual Assistant based on your feedback

We're delighted so many of you continue to use the Aetna Virtual Assistant to check the status of precertification requests or if precertification is required.

Enhancements to our SNF clinical questionnaire to accept same day stay requests

Based on your feedback during our training sessions, we've updated our clinical questionnaire process to allow you to submit same day stay requests.

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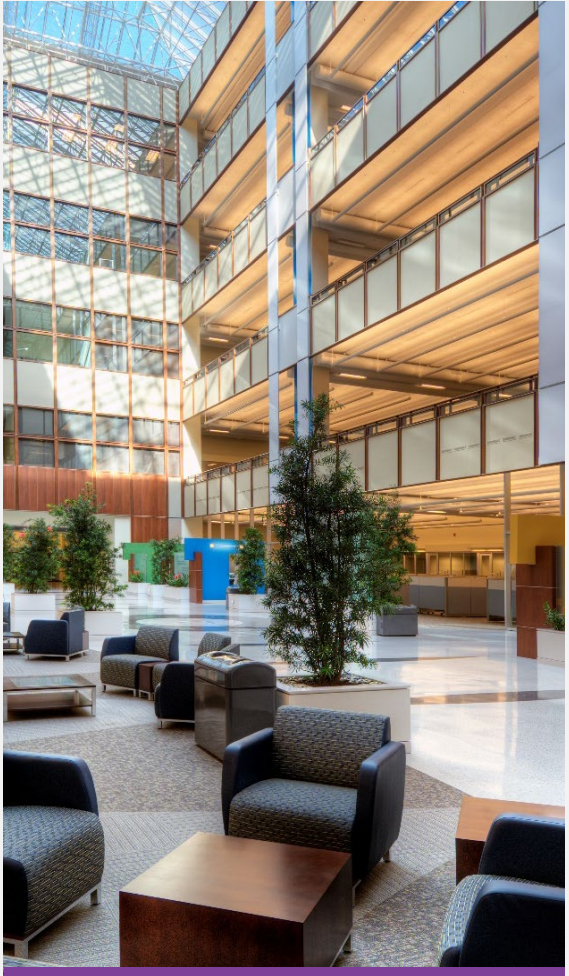

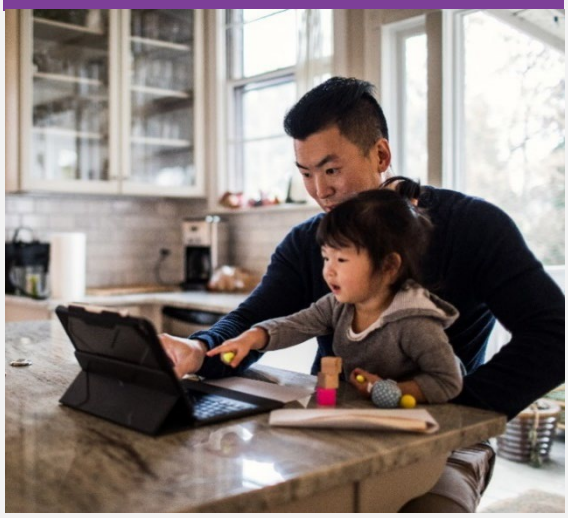

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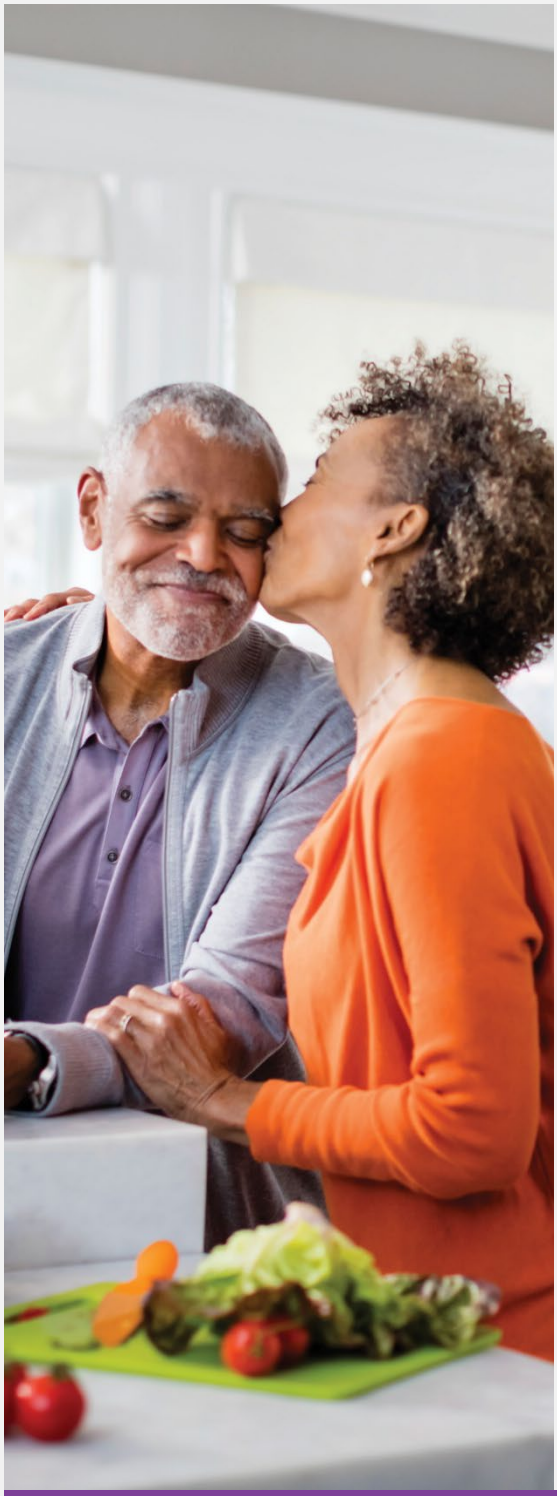

Important policy updates (including pharmacy)

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. 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

Starting June 1, you'll see new claim edits.

This will apply to both our commercial and Medicare members.

Beginning June 1, 2025, 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 > Search > 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 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.

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

Note to Washington State providers: For commercial plans, your effective date for changes described in this article will be communicated to you 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.

Note to Maine and Vermont providers: For commercial plans, your effective date for routine changes described in this article will be the statutory date of January 1, April 1, July 1 or October 1, whichever date follows the effective date(s) referred to in this article. Changes required by state or federal law, or pursuant to revisions of Current Procedural Terminology (CPT®) codes published by the American Medical Association, may be effective outside the statutory dates outlined above.

Changes to commercial drug lists begin on July 1

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

On July 1, 2025, 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 May 1, 2025. They'll be on our **Formularies and Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug PA

- Submit your online PA through **covermymeds.com**.
- 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. Select the Providers tab. In the "Call us" column, choose "Special programs" from the drop-down menu and use the "Pharmacy management" number.

CORRECTION: Reimbursement for modifiers SA and SB

This article corrects information we ran in January 2025.

This update applies to both our commercial and Medicare members.

In our **January edition of OLU**, we indicated that, effective April 1, 2025, we would pay eligible services at 85% of allowed for modifiers SA (nurse practitioner) and SB (nurse midwife).

We will not be moving ahead with that change, and we apologize for the confusion.

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.

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 (PA) 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 PA 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).

Supporting you and your patients with the January 1, 2025, changes to our medical plan drug lists

We're making an important prior authorization (PA) change.

We previously told you about the changes to the January 1, 2025, medical drug lists. Now, we're making an important PA change for drugs covered under the medical pharmacy benefits.

Transition to preferred option

For members taking drugs affected by the changes, we'll issue PAs for the newly preferred drugs.

If you're currently managing patients with PA for a drug that moved to non-preferred status, you don't need to initiate the PA process again. The current PA will remain in place, along with the newly issued PA for the new preferred option.

No medical exception is needed if the patient needs to remain on their current medication through the remainder of their current PA.

Your next steps

- Review your patients' current treatment plans.
- Consider transitioning patients to the newly preferred options using the proactive PA already in place.

State-specific updates

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

Aetna® Medicare offers chiropractic care through WholeHealth Living®

Find out whether you participate in the Dual-Eligible Special Needs Plans (D-SNPs).

Note: This article applies to the following states: Alabama, Arkansas, Louisiana and Mississippi.

In 2025, we'll offer a chiropractic benefit through WholeHealth Living—an NCQA-CVO-accredited company.

The benefit is offered on all Medicare Advantage D-SNP (HMO and PPO) plans in Alabama, Arkansas, Louisiana and Mississippi, and it includes 12 in-network annual visits with a $0 copay and no referral requirement.

You can find out whether you participate by checking the **Medicare provider directory**.

For more information, refer to the **Contact Aetna** page. Select the Providers tab. In the "Call us" column, choose "Aetna service programs" from the drop-down menu and use the "Medicare medical and dental plans" number.

Illinois and Pennsylvania: We require Verification of Chronic Condition (VCC) forms for C-SNP enrollees

You must submit the VCC form within 30 days of member enrollment in a C-SNP.

Note: This article applies to the following states: Illinois and Pennsylvania.

New in 2025, we introduce Chronic Special Needs Plans (C-SNPs), a type of Medicare Advantage (MA) plan, in select counties in Illinois and Pennsylvania. These plans help members with diabetes and/or heart disease better manage their chronic conditions and improve their overall health.

The Centers for Medicare & Medicaid Services (CMS) requires you to verify that the member has an eligible condition.

C-SNP Enrollment is a two-step process

Step 1: Enrollees complete a Medicare Pre-Qualification Assessment Tool (PQAT) form.

> Enrollees *must* complete a PQAT form with their qualifying diagnosis and the contact information for at least one provider who is able to verify the member's qualifying chronic condition.

Step 2: Providers complete the VCC form within the first 30 days of enrollment.

> We'll send a VCC form to you for completion within the first 30 days of the member's enrollment. Forms will be sent via Adobe Acrobat Sign or fax. If we don't receive it, we'll disenroll the member at the end of the second month enrolled.

Please complete the VCC form as quickly as possible after you receive it.

Need a copy of the form?

Access the VCC form (PDF) on:

- Our **provider portal on Availity***
- **Aetna.com** (Choose "Working with us" then "Forms")

You can fax the completed form to our Enrollment Department at: **1-866-756-5514** or send via secure email to **VCC@Aetna.com**.

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

Champaign, Illinois and St. Louis, Missouri: Our contract notice address has changed

Note: This article applies to the following states: Illinois and Missouri.

Effective immediately, all contract related notices should be sent to Aetna® at the PO box noted below:

Aetna
Attn: Heartland Network Management
PO Box 818093
Cleveland, OH 44181-8093

Virginia, Maryland and District of Columbia (DC): Our contract notice address has changed

Note: This article applies to the following states: Virginia, Maryland and District of Columbia.

Effective immediately, all contract related notices should be sent to Aetna® at the PO box noted below.

Aetna
Attn: Capitol Network Management
PO Box 818044
Cleveland, OH 44181-8044

Kentucky: New pre-approval requirements

Find out which services require pre-approval and how to send requests to EviCore healthcare.

This article applies to Kentucky members in Aetna® Medicare Advantage (MA) HMO/PPO products.

Our Enhanced Clinical Review program will require authorization for certain procedures starting on June 1, 2025.

Services that require pre-approval

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

Visit our **Precertification Lists** page for a complete list of procedures that need authorization.

Authorization requests

Board-certified EviCore physicians need to review authorization requests for medical necessity. To get paid for services, you must send authorization requests before providing services.

If treatment starts before June 1, 2025, and you haven't already called Aetna, contact EviCore to request continuity-of-care authorization. This will allow us to consider claims for dates of service after June 1, 2025.

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

How to secure an authorization

You can:

- **Go to EviCore**
- Call **1-888-622-7329** during normal business hours
- Fax a request form, which is available online
    - For radiology, cardiology and radiation therapy requests, use fax number **1-800-540-2406**.
    - For sleep requests, use fax number **1-866-999-3510**.
    - For interventional pain requests, use fax number **1-855-774-1319**.

Urgent requests

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

What you should know

- We recommend that ordering physicians get authorizations and share the approval numbers with the facility performing the procedure when it is scheduled.
- EviCore will fax its approval decision to the ordering physicians and requested facilities.
- Approvals have authorization numbers and one or more CPT® codes* specific to the approved services.
- If the service you ask for differs from what EviCore approves, the facility must contact EviCore for review and approval before submitting claims.
- If you perform services without approval, we may deny payment. Please don't ask members for payment, as outlined in your agreement with us.

- We'll determine coverage under the applicable policy in accordance with the policy's terms and conditions and with our policies and procedures.

Questions

If you have questions, refer to our **Contact Aetna** page. Choose the Providers tab. In the Call Us column, choose "Aetna service centers."

Visit EviCore to review criteria and get request forms.

New York: Introducing Aetna Medicare Assure Plus (HMO D-SNP)

This plan combines Medicare and Medicaid benefits to streamline care.

We're launching the Fully Integrated Dual Eligible (FIDE) Medicare Advantage Plus (MAP) plan in New York. This plan combines Medicare and Medicaid benefits to streamline care for dual-eligible members in Kings County.

Aetna Medicare Assure Plus Health Maintenance Organization Dual-Eligible Special Needs Plan (HMO D-SNP)

This plan is designed to enhance member outcomes by integrating Medicare and Medicaid benefits. Members receive comprehensive medical and long-term care services with reduced cost-share, simplifying care coordination and provider billing.

Participation requirements

If you're contracted with Aetna Medicare Advantage or Aetna Better Health of New York, you're eligible to serve Aetna Medicare Assure Plus (HMO D-SNP) members.

Note: Balance billing is prohibited. Medicare cost-sharing is fully covered, ensuring members have no out-of-pocket expenses.

We've made submitting claims easy

You should submit claims to Aetna Medicare Assure Plus (HMO D-SNP) via:

- **Electronic submission**: Use ECHO Health, Inc. (Submitter ID: 60054)

- Our **provider portal on Availity**:* Select “Aetna (Medicare and commercial)” as the payer
- **Paper claims**: Mail to PO Box 981106, El Paso, TX 79998

You’ll receive two remittance advices (one for Medicare and one for Medicaid) per submission. Secondary claim submissions aren’t required.

Annual training is required

The Centers for Medicare & Medicaid Services (CMS) mandates annual completion of our Model of Care training for you and your staff to ensure compliance with dual-eligible care guidelines. Visit the **Aetna Provider Training page**.

Questions?

Need support? Here’s how to reach us:

- For more information, refer to the **Contact Aetna** page. Select the Providers tab. In the “Call us” column, choose “Aetna service programs” from the drop-down menu and use the “Medicare medical and dental plans” number.
- Log in to our **provider portal on Availity**: Check eligibility, manage claims and access helpful tools.

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

Pennsylvania Employees Benefit Trust Fund (PEBTF) New Gene-Based Therapy benefit

Benefits now administered through us.

Effective January 1, 2025, coverage for gene-based therapies under all three PEBTF plans (Aetna®, Geisinger Health Plan and Highmark) will be administered solely through us.

If you have questions about the program and what is covered, please contact the Aetna dedicated PEBTF gene therapy unit at **1-833-398-0650** **(TTY: 711)**.

The following medications are currently in the PEBTF Gene-Based Therapy benefit, administered by us. This list is subject to change as new medications come to market.

GCIT product name	GCIT clinical name	Medical indication
BeqVez	fidanacogene elaparvovec	Hemophilia B

Casgevy	beta-thalassemia	Beta-Thalassemia
Casgevy	exagamglogene autotemcel	Sickle Cell Disease
Elevidys	delandistrogene moxeparvovec-roki)	Duchenne Muscular Dystrophy (DMD)
Hemgenix	etranacogene dezaparvovec	Hemophilia B
Lenmeldy	atidarsagene autotemcel	Juvenile Metachromatic Leukodystrophy (MLD)
Luxturna	voretigene neparvovec-rzyl	Inherited Retinal Dystrophy (RPE65)
Lyfgenia	lovotibeglogene autotemcel	Sickle Cell Disease
Spinraza	Nusinersen	Spinal Muscular Atrophy (SMA)
Skysona	elivaldogene autotemcel	Cerebral adrenoleukodystrophy (CALD)
Roctavian	valoctogogene roxaparvovec	Hemophilia A in adults
Zolgensma	onasemnogene abeparvovec-xioi	Spinal Muscular Atrophy (SMA)
Zynteglo	betibeglogene autotemcel	Beta-Thalassemia

Pennsylvania: Prior authorization (PA) for closely related services

Please submit these services for review within three days of the completion of the service.

Pennsylvania Act 146 of 2022

This act introduced several new PA requirements. One was that carriers cannot deny a claim for a closely related service* due to the provider's failure to obtain PA.

What you need to do

To have a closely related service reviewed, you must:

- Provide relevant clinical information for us to evaluate the medical necessity and appropriateness of the service.

If the original service did not require PA, you do not need to do anything. If your claim is denied, follow our standard appeal procedure.

*From **Act 146 of 2022**: A closely related service is a service subject to prior authorization that is closely related in purpose, diagnostic utility or designated health care billing code, and provided on the same date of service as an authorized service, such that a prudent health care provider, acting within the scope of the provider's license and expertise, may reasonably be expected to perform the service in conjunction with or in lieu of the originally authorized service in response to minor differences in observed patient characteristics or needs for diagnostic information that were not readily identifiable until the provider was actually performing the originally authorized service. The term does not include an order for or administration of a prescription drug or any part of a series or course of treatments.

Pennsylvania and Illinois: We require Verification of Chronic Condition (VCC) forms for C-SNP enrollees

You must submit the VCC form within 30 days of member enrollment in a C-SNP.

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Please complete the VCC form as quickly as possible after you receive it.

Need a copy of the form?

Access the VCC form (PDF) on:

- Our **provider portal on Availity*
- **Aetna.com** (Choose "Working with us" then "Forms")

You can fax the completed form to our Enrollment Department at: **1-866-756-5514** or send via secure email to **VCC@Aetna.com**.

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News for you

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

Revenue Integrity team launches online risk adjustment training

Find out more about these educational opportunities including how to access the courses.

Self-guided training modules on topics including risk adjustment for Medicare and the Affordable Care Act (ACA), coding and documentation are now available on **Aetna.com**. To access the courses, navigate to the provider site and look under Resources > Education, trainings, and manuals > Risk adjustment training. Courses can also be accessed directly on **Aetna.com**.

Each course includes audio narration, a transcript and a knowledge check quiz at the end:

- The Coding and Documentation courses deliver industry standard guidance on the fundamentals to help ensure coding and documentation is complete, accurate and compliant.
- In the Risk Adjustment course, learn the similarities and key differences in how risk adjustment programs function for Medicare and commercial ACA plans. Better understanding in these areas can lead to improved coordination of care, enhance the provider and patient relationship and help reduce potential gaps in care.

All courses allow the learner to participate at their convenience and desired pace. Each serves as an excellent introduction or refresher on the foundational elements of risk adjustment.

To learn more, or to schedule other risk adjustment educational opportunities, please **contact us**.

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 to 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 and medical record documentation.

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 and Banner|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
- 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)**

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's 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 our **cultural competency training video**.

Submitting prior authorization requests for power wheelchairs

This guidance will improve the process for everyone.

We'd like to offer tips on how to submit prior authorization (PA) requests for power wheelchairs. Following this guidance will help make the process easier for everyone.

Submit your requests electronically

We prefer you submit your PA requests electronically, whether on our **provider portal on Availity*** or **another participating electronic vendor or clearinghouse**. Submitting your requests electronically is faster than calling or faxing. If you submit your PA requests on Availity®, you can enjoy these additional benefits:

- Upload supporting clinical documentation during your request.
- Check the status of pending requests on the Availity Authorization/Referral dashboard—we push updates every hour.

Although your experience may vary with another electronic vendor or clearinghouse, continue to use the one you're most comfortable with.

Tips for submitting PA requests on Availity

Though not all codes are on our National Precertification List (NPL), we'll still need you to submit all Healthcare Common Procedure Coding System (HCPCS) codes in the "Authorization Add" request on Availity within your final PA submission. You'll see the following messages on Availity after step 3:

- For codes not on the NPL, you'll see a green message stating, "No auth required."
- For codes on the NPL that require PA, you'll see a red message stating, "Auth required."

To proceed with your request on Availity, at least one of the codes you include in your PA request must be on our NPL.

You can enter a maximum of five diagnosis or procedure codes on Availity. Press the "Add another diagnosis code" or "Add another procedure code" link to display more of each field (up to five each).

- If you have less than five HCPCS codes, enter all of them on the request.
- If you have more than five codes:
    - Enter the first five on Availity, prioritizing those that are on our NPL.
    - Use the Message box to enter the remaining codes (after the first five), or

- Add the remaining codes in your clinical documentation and upload it in step 4 of your PA request.

Submitting all the codes in advance helps us review requests timely.

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

Now available: Updated Spinal Surgery Precertification Information request form

Neurosurgery offices that need to request precertification for spinal surgery should use the revised form and submit it as part of their request.

When submitting a precertification request for spinal surgery we might need more information. If so, we'll have to pend your request. Review the revised form ahead of time. You can find it on our **Forms for Health Care Professionals** page in the Medical Precertification folder and on our **provider portal on Availity**.* On Availity®, find the form in Aetna Payer Spaces, in the Resources tab.

We'll need additional information for every spinal surgery precertification request, so we recommend downloading the form and completing it in advance. If you're using Availity to initiate your prior authorization (PA) request, you can upload the form and any requested clinical information during step 4 of the Authorization Add request. Or submit your request, click on the pended request in your Availity Authorization/Referral dashboard and upload the form and clinical information.

Incomplete forms may delay our review

We designed the form to list all the information we need to process your PA request. We may ask you to repeat some of the information you already added to your electronic PA request. Having all the information in one place helps our clinical staff process your request. We won't be able to process your request without the information.

Make sure these fields are complete

We'd like to highlight certain questions on the form that help us process your request quickly.

- You'll need to provide the requesting provider's information, including their National Provider Identifier (NPI); your information, including your phone and fax numbers (include an extension, if you have one); and whether you'll be using an assistant surgeon.
- If your request is for a re-do or revision surgery, fill out the associated field.

- If the patient had formal physical therapy during the last 12 months, include the start date and duration. Physical therapy needs to be confirmed by the therapist's notes. If the patient was formally discharged from physical therapy due to not being able to tolerate it, include the discharge summary from the physical therapist.
- For spinal fusions only, you'll need to provide the patient's nicotine status; and for patients who quit using nicotine within the last 12 months, a copy of their last blood or urine nicotine/cotinine test. This test should be drawn within the six weeks prior to surgery.
- Add what device(s) you'll be using, including the brand and device names.

We suggest using the form's checklist to ensure you've completed or submitted all the requested information.

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

Enhancements to our SNF clinical questionnaire to accept same day stay requests

We've updated our clinical questionnaire process based on your feedback.

In our last issue (page 29), we told you about our new clinical questionnaire to request skilled nursing facility (SNF) inpatient stays for Medicare patients. Based on your feedback during our training sessions, we've updated our clinical questionnaire process to allow you to submit same day stay requests.

What's new

We've added 'Skilled Nursing Facility' as an option in the "Where is the patient currently located?" question. By adding this answer choice, we've improved our ability to identify cases that are continuous stay requests. Choose this option if your patient is currently in a SNF. You'll answer the remaining questions on the clinical questionnaire based on the patient's clinical documentation.

A few reminders

- You can only access our SNF clinical questionnaire on our **provider portal on Availity**.*

  Register for Availity® by clicking on "Get Started" in the upper right corner of the Availity home page and following the steps.

- Completing the SNF clinical questionnaire isn't required, but we strongly encourage you to complete it.

- If you get an approval after completing it, you're all done. We'll send you an approval letter.
- If your request pends, you can upload additional clinical information through Availity to support your request.
- Here's a tip: Access these two documents to see the types of information we're looking for: Skilled Nursing Facility Initial Stay request form and Tips for Completing the Skilled Nursing Facility clinical questionnaire.

You can find both documents on Availity, in the Resources section of Aetna Payer Spaces.

Thank you for your feedback

We always strive to create products to make it easier for you to do business with us. We'd like to thank you for sharing your feedback.

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

You can use Availity® for Aetna Medicaid plans, too

Find out more on how to use Availity with our Medicaid plans.

Are you aware you can also use our **provider portal on Availity*** with Aetna Medicaid health plans in addition to commercial and Medicare? You can check eligibility and benefits, submit or check authorization requests and **other administrative tasks**.** There's no need to log in to individual Medicaid portals or contact us by phone or fax.

How to use Availity with our Medicaid plans

If you're not already registered for **Availity**, click "Get Started" in the upper-right corner. Follow the steps to create an account. You can also call Availity Customer Care at **1-800-AVAILITY** (**1-800-282-4548**), Mon. through Fri., 8 AM to 8 PM, ET (excluding holidays).

If you already have an Availity account to work with our commercial/Medicare plans and work with one of our **Medicaid plans**, you don't need to do anything else. Just choose "Aetna Better Health All Plans and NJ-VA MAPD-D-SNP" from the Payer drop-down list, and all the appropriate entities will appear in the state(s) where you're registered.

As a best practice, complete the Manage My Organization registration. You can find instructions for this registration in Availity's Help and Training section by searching "Manage My Organization."

Choose the correct entity for the correct patient type

When you're submitting a request for a patient with a Medicaid or Medicare-Medicaid Plan (MMP), select the entity listed above. But when you're submitting a request for a commercial/Medicare patient, be sure to change the entity in the Payer drop-down list to "Aetna (commercial and Medicare)" or one of the others in the list if you're working with one of our joint venture plans.

*Availity is available only to providers in the U.S. and its territories.
**Due to some limitations, not all functions are available with our Medicaid plans as with our commercial and Medicare plans.

We continue to make improvements to our Aetna Virtual Assistant based on your feedback

Find out more about the changes we've made to improve your experience.

We're delighted so many of you continue to use the Aetna Virtual Assistant to check the status of precertification requests or if precertification is required. We'd like to thank those of you who've left feedback on our Virtual Assistant. We listen to all comments and make regular changes to ensure you're happy with it.

We've streamlined call content

We'll ask you fewer questions, but we'll still provide the same level of service you've come to expect. When you spend less time interacting with our Virtual Assistant, you can get back to your day faster.

We're transferring you to a representative even less than before

The Virtual Assistant will answer more of your questions instead of transferring you to a representative. For example, we'll look at your participation status in relation to the patient's plan and provide an appropriate response based on the plan type.

These are some of the changes we've made because of your feedback. We invite you to continue using the Aetna Virtual Assistant—and sharing your feedback—so you can get what you need, at your convenience.

Best practices for billing Coordination of Benefits (COB) claims

Check these updated resources to help you bill COB claims.

We understand that pended COB claims can be frustrating. We've refreshed the material available to you on our **claims coordination and review page** to help.

When a COB claim has been pended

We must verify secondary coverage if we don't have it in our systems or if the two coverages don't match. Allow us 45 days to complete this verification. Read the refreshed material and confirm you're sending all necessary COB information in the correct format during electronic claim filing.

How to minimize processing and verification delays

Ensure that you capture and send us the correct information, in the correct format:

- Collect insurance name, policyholder name, member ID and employer name for each of the patient's plans.
- Bill the primary insurance first.
- Review the primary insurance company's Explanation of Benefits (EOB) document and then bill the secondary insurance electronically.
- Share our newly created **COB electronic claim filing tip sheet** with your practice management support team, billing company, vendor or clearinghouse.

Affirmative statement for financial incentives

Here's how we make coverage decisions and help members access eligible services.

How we make coverage determinations and utilization management (UM) decisions

We use evidence-based clinical guidelines from nationally recognized authorities to make UM decisions.

- We review requests for coverage to see if members are eligible for certain benefits under their plan.
- The member, member's representative or a provider acting on the member's behalf may appeal this decision if we deny a coverage request.

How we help members access services

Our UM staff helps members access services covered by their benefits plans.

- We don't pay or reward practitioners or individuals for denying coverage or care.

- We base our decisions entirely on appropriateness of care and service and the existence of coverage.
- Our review staff focuses on the risks of underutilization and overutilization of services.

Questions?

Participating physicians may ask for a hard copy of the criteria we used to make a determination. Go to our **Contact Aetna** page. In the "Call us" column, choose "Aetna service centers" from the drop-down menu and use the "Non-Medicare plans" number.

Visit us online to view a copy of your **provider manual (PDF)**.

Institutes of Quality® (IOQ) Network Update

Find out more about changes that were made to procedures included in the cardiac IOQ network.

Last January 1, we revised the procedures included in the cardiac IOQ network:

- The revision will result in the removal of Cardiac Medical Intervention (CMI) and Cardiac Rhythm Disorders (CRD) under the IOQ network product.
- To enhance the member experience and focus on high-value procedures, the cardiac care IOQ program will focus on cardiac surgery.
- All services provided under the CMI and CRD will still be covered, just not under IOQ.
- There will be additional facility access once the update is made.

We updated summary plan description language on December 31, 2024.

About IOQ

(IOQ) Cardiac Care facilities is a network of providers that have met our requirements for clinical quality, value and access for cardiac care. We worked with heart experts and professional groups to create our quality network requirements. These groups include the American College of Cardiology (ACC) and the Society for Thoracic Surgeons (STS).

Cardiac IOQ facilities provide the following services:

Surgery: Coronary artery bypass grafting (CABG), Valve with CABG, Valve without CABG—repairing or replacing the damaged flaps inside the heart to allow blood to flow more easily and in the right direction.

Aetna® HEDIS® data collection is underway

We'll be requesting timely access to members' medical records to monitor and compare health plan performance.

We'll be reaching out soon to collect medical record information on behalf of our members. We appreciate your understanding and cooperation as we complete this required quality reporting activity with minimal disruption to your practice.

Why is this necessary?

Healthcare Effectiveness Data and Information Set (HEDIS)* data collection is a nationwide, joint effort among employers, health plans and physicians. The goal is to monitor and compare health plan performance as defined by the National Committee for Quality Assurance (NCQA).

The Centers for Medicare & Medicaid Services (CMS) requires us to send health care quality data for our Aetna Medicare Advantage organizations. Most data is collected from claims and medical encounters. We also gather data from medical records.

What we may need from you

When we reach out to you, we'll ask that you give us timely access to members' medical records. Our contracted representatives will collaborate with you and provide options for sending medical records.

Meeting HIPAA guidelines

Either our staff or a contracted representative will contact your office. Our contracted representatives, Ciox Health, Sharecare Inc., and MRO, serve as our Business Associates as defined under the Health Insurance Portability and Accountability Act (HIPAA).

Giving medical record information to a Covered Entity and to a Covered Entity's legally contracted Business Associate meets HIPAA regulations.

We appreciate your assistance in our medical record collection efforts.

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

Be sure to verify whether Aetna® members are eligible for care before turning them away

Don't turn away Aetna Passport to Healthcare members who show as ineligible after conducting a 270/271 EDI transaction. Aetna Passport to Healthcare accesses Open Choice® PPO.

Aetna Passport to Healthcare members are appearing ineligible for care even though they are eligible. Passport to Healthcare group numbers normally start with 8639 or 1493.

Due to how our eligibility checks are run, when you do an eligibility check on Aetna Passport to Healthcare members, the system will not display eligibility or benefits information. Instead, it will give you a phone number to call.

What you should do

We ask that you please call the number you see (you might have to expand fields or scroll to find the number) instead of turning the member away.

If you can't find the number, please call the number on the back of the member's ID card.

What you should not do

Please don't tell members that we don't cover them. You must call the phone number to obtain eligibility and benefits information.

A note about the Epic system

If you're using the Epic system for your 270/271 transactions and it shows that the patient has been rejected or isn't active, Epic asks that you please submit a ticket to your technical team (if you have one) and ask them to "install the Epic fix SLG 8861771."

If you can't have the Epic fix installed, you will need to call the number on the member's ID card to confirm eligibility and benefits.

More information

We're working to correct this problem and will be in touch when we have more details.

The chronic condition improvement program (CCIP)

Learn more about how the CCIP is designed to improve your patients' quality of life.

Every year, our Quality Management Department implements the CCIP. We do this in accordance with Centers for Medicare & Medicaid Services (CMS) requirements.

The CCIP is a clinical effort designed to improve your patients' quality of life.

What does the CCIP do?

The CCIP promotes effective management of enrollees' chronic diseases over a three-year period. The program goals are to:

- Slow disease progression
- Prevent complications
- Inhibit development of comorbidities
- Reduce preventable emergency room (ER) encounters
- Decrease inpatient stays
- Improve the health of a specific group of enrollees with chronic conditions

How does the CCIP improve health outcomes?

The quality improvement model we use is based on the Plan-Do-Study-Act (PDSA) quality improvement model. In accordance with the CMS CCIP Resource Document, PDSA is cyclical in nature and includes planning, implementing, studying a change and acting on the result of that change. Care management incorporates the PDSA model into the CCIP interventions.

What you can do

Urge your patients to take part in the program so we can help manage their chronic diseases.

Resources

Learn more about our **care management initiatives** and refer to your **provider manual (PDF)**.

Kaiser Permanente of Washington (KPWA) is a new Aetna Signature Administrators® (ASA) health plan partner

Find out how to check eligibility and claims status, verify benefits and submit claims.

On January 1, 2025, KPWA members started using the ASA preferred provider organization program and medical network outside of the state of Washington.

How to check eligibility and get additional support

To check eligibility or verify benefits for KPWA members, call their dedicated Provider Assistance Unit at **1-888-767-4670** (toll-free).

For preauthorization or to determine preauthorization requirements, call KPWA's dedicated line at **1-800-289-1363** (toll-free).

You can also access the Kaiser Permanente contracted **provider portal** to view billing, authorization and clinical review, coverage and eligibility, patient services and provider support.

If you're registered with **OneHealthPort**, you can review claim status, manage referrals or verify coverage and benefit levels.

How to send claims

Our payer partners handle all claims processing and claims questions. Send claims electronically to KPWA 91051. You'll also find this number on the member's ID card.

Or send paper claims to:

Kaiser Permanente Claim Administration
PO Box 30766
Salt Lake City, UT 84130-0766

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

Please note that neither Aetna® nor ASA can verify eligibility or process claims.

More information

To learn more, see our **ASA flyer (PDF)**.

The new Postal Service Health Benefits (PSHB) program

Learn what to watch for regarding patients enrolled under the PSHB program.

The **PSHB program** is a new, separate program within the Federal Employees Health Benefits (FEHB) program. As of January 1, 2025, the PSHB Program started providing health benefits plans to eligible Postal Service employees, Postal Service annuitants and their eligible family members.

What this means to you:

- Patients covered by the PSHB program will have a new ID card.
- Patients who are Medicare-eligible annuitants will receive prescription drug coverage through a Medicare Part D Employer Group Waiver Plan (EGWP).
- Patients will generally pay less for their prescriptions.

Medical clinical practice and preventive services guidelines

We base our guidelines on the sources in this article, among other sources.

Clinical practice guidelines from nationally recognized sources promote the use of evidence-based treatment methods. This helps provide the right care at the right time. We make these guidelines available to you to help improve health care.

These guidelines are for informational purposes only. They're not meant to direct individual treatment decisions. All patient care decisions are the sole responsibility of you.

Clinical practice guidelines

American Diabetes Association (ADA): standards of care in diabetes (2023)
American College of Cardiology guidelines
Centers for Disease Control and Prevention opioid prescribing guideline (2022)

Preventive service guidelines

U.S. Preventive Services Task Force (USPSTF) recommendations
Centers for Disease Control and Prevention immunization schedules
Health Resources & Services Administration (HRSA) women's preventive services guidelines

When these sources lack sufficient evidence to recommend for or against a service or when they present conflicting evidence, we may adopt recommendations from other nationally recognized sources.

Note: These guidelines aren't decisions for coverage, benefits determinations or treatments.

Member access to care

Accessibility standards are available online.

We measure member access to care every year, 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. Any state established requirements 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.

Medical clinical criteria

Find out how we make coverage decisions and where to go for more information.

How we determine coverage

Our licensed clinical staff use evidence-based clinical guidelines from nationally recognized authorities along with the terms of a member's benefits plan to guide utilization management (UM) decisions. When the initial clinical reviewer can't approve a request, a medical director, pharmacist, dentist, or oral and maxillofacial surgeon reviews coverage requests and applies the appropriate clinical criteria or guidelines.

Our clinical staff use the following criteria as guides in making coverage determinations, which are based on information about the specific member's clinical condition.

- **Guidelines for coverage determination**
- **MCGs** (Seattle, WA: MCG Health, LLC)
- **Aetna Clinical Policy Bulletins (CPBs)**
- **Centers for Medicare & Medicaid Services (CMS)**
    - National Coverage Determinations (NCDs) (under Coverage, then Medicare Coverage Database)
    - Local Coverages Determinations (LCDs) (under Coverage, then Coverage Determination Process)
    - Medicare Benefit Policy Manual (under Regulations and Guidance, then Manuals)
- **National Comprehensive Cancer Network (NCCN) guidelines**

We may use other recognized criteria or applicable state and federal guidelines, if needed. Note that the tools above don't replace the professional judgment exercised by properly trained, licensed and experienced clinicians and professionals who evaluate the provision of services in accordance with accepted standards of care.

We're here to help

Visit our **Contact Aetna** page to request hard copies of specific criteria, if needed.

Q1 2025 provider manual updates

The updates apply to our commercial, Medicare and Student Health providers. The changes aren't considered to be material edits. When we make material edits, we'll tell you which sections of the manual have changed.

Still, we encourage you to read **the manual** once a year.

If you have any questions, get in touch with your Aetna® representative.

Improving the patient experience: tips for your practice

We base our guidelines on the sources in this article, among other sources.

Each year, Aetna® sends a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to gather feedback from members about their overall health care experience, including their experience with their personal doctor.

It's important that members have positive experiences with their providers. Better outcomes lead to healthier, happier patients.

Tips for how to improve the patient experience

Encourage open communication

Tips	Benefits
Use receptive body language (for example, sit down, lean in and maintain face-to-face engagement)	Shows patients you acknowledge that their time is important
Maintain eye contact with the patient and avoid interrupting while the patient is speaking	Shows patients that they are being heard
Use simple, easy-to-understand words, and avoid using medical terminology and abbreviations	Facilitates adherence and better health outcomes

Offer flexible access to care

Tips	Benefits
Consider offering evening and/or weekend	Better access to care

appointments	
See patients within 15 minutes of the appointment or arrival time	Patients feel that you spent sufficient time with them
Call patients 24 to 48 hours before their appointments to confirm and remind them about items they'll need to bring	Reduces no-shows
Explain after-hours access to the physician on call, Aetna's after-hours nurse line and when to seek urgent versus emergency care	Reduces ER visits

Keep the patient informed

Tips	Benefits
Consider providing a preventive health care visit at the same time that you see a member for a sick visit	Addresses patient needs and improves health outcomes
Review the member's chart for any consults or specialist treatment prior to seeing the patient to help facilitate coordination of care	Shows patients you acknowledge that their time is important Addresses coordination of care
Review all treatment options with member and/or parents/guardians and allow their input, questions and collaboration	Patients feel sufficient time was spent with them Facilitates adherence and better health outcomes
Provide handouts, brochures, diagrams and other materials to help members understand diagnostic tests, medications and prevention	Reduces patient anxiety Facilitates adherence and better health outcomes

Additional resources for office staff and patients

The 24-Hour Nurse Line

Our 24-Hour Nurse Line gives members ready access to registered nurses who can answer their questions on a variety of health topics, which can prevent an unneeded trip to the emergency room. Aetna members can reach these nurses 24 hours a day, 7 days a week, via a toll-free phone number. Refer members to their health plan's customer service department for additional information.

Aetna care management

The Aetna One® care management program is transforming the health care experience using predictive analytics, personal outreach and local access. We engage members in a more proactive and connected way. Our care management model takes a holistic approach to physical and emotional well-being. Refer members to their health plan's customer service department for additional information.

Our provider portal

Our **provider portal on Availity*** helps you spend less time on administration so you can focus more on patient care. You get a one-stop portal to quickly perform the key functions you do every day. If you're already registered with Availity® for another payer, you're all set. You can use your existing log-in credentials to get started with us.

You can:

- Submit or check claims
- Submit or check prior authorizations
- Check patient benefits and eligibility
- Upload medical records and supporting documentation
- File disputes and appeals
- Update your information, including race and ethnicity

Cultural competency webinar

Good health—and a good doctor–patient relationship—begins with understanding patients' cultural, ethnic, racial and linguistic needs. Watch this short **cultural competency video** to learn more about cultural competency and the important roles that you and your office staff members play.

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

Behavioral health

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

SafeSide Framework for suicide prevention in primary care

We're excited to offer a no-cost suicide-prevention workshop.*

This upcoming workshop will help you understand how to identify patients at risk of suicide. **Join us** Wednesday, March 12, 2025, from 12:00 to 3:30 PM (ET) via Zoom.

Seats are limited, and this special event will not be recorded to protect privacy and encourage participation.

Here's what we'll cover

In the workshop, you'll learn how to:

- **Connect**—ask directly and clearly about suicide without losing your connection with a patient.
- **Assess**—use a consistent structure for gathering and communicating information.
- **Respond**—make initial plans for how the patient and others will respond to foreseeable changes that might increase risk.
- **Extend**—employ the suicide-related warm handoff.

In addition to this learning opportunity, you'll benefit from:

- Three AMA Category 1 CMS credits
- A one-year subscription to SafeSide Prevention, which includes exclusive access to the library of resources, Community of Practice (a global network sharing insights and experiences) and monthly office hours.

*Behavioral health clinicians housed in a primary care practice are welcome to register.

Risk-reducing suicide-specific subspecialty care for teens and adults

We've enhanced our network with providers who specialize in these protocols and interventions.

Suicide rates continue to rise. According to the Centers for Disease Control and Prevention (CDC), suicide rates in 2022 and 2023 were nearly the same, approximately 49,500 deaths.[1] The last time rates were this high was in 2018 and before that in 1941. As rates continue to be at an all-time high, it's important for individuals to receive specialty care to address their suicidality.

We're committed to reducing member suicide attempts by enhancing our network with providers who specialize in risk-reducing suicide protocols and interventions. Access to subspecialty care is as important with mental health as it is with physical health.

Find out more about our **new protocol**.

Vita Health

Vita Health provides subspecialty enhancement to current outpatient treatment. This enhancement isn't meant to replace a general behavior therapist or crisis line. Vita Health provides virtual, easy to access therapy for teens and adults that's proven to reduce suicide attempts and death. Services can include:

- One-on-one therapy with a licensed clinician and parental support sessions
- Therapy as a covered benefit with most copays waived, depending on member plan
- Weekly telehealth sessions with a consistent suicidologist (12 weeks per term)
- Exclusive protocols developed by distinguished suicide experts
- Additional support via the proven Aviva app, tailored for youths
- Vita therapy services are supplemental to current treatment and not a replacement for a general behavior therapist or crisis line.

Vita therapy offers flexible treatment options:

- A member can engage in specialty care with Vita Health even if the member is currently seeing a behavioral health provider. However, the member isn't required to have a behavioral health provider in order to engage in Vita Health treatment.
- Members who prefer in person therapy are encouraged to maintain services in that environment. Virtual specialty care services with Vita Health are convenient and can be effective as a supplemental treatment.

Hear more about Vita Health from Dr. Set Feuerstein, CEO of Vita Health and OUI Therapeutics as he **dispels misconceptions about suicide** and going digital in suicide prevention.

An Aetna member testimonial

Here's what one member had to say in 2023 about Vita Health's program:

"I cannot fully convey the incredible amount of gratitude I have for this program. It changed my life. It is not only bearable—pleasant, even—for my loved ones to be around me, but also, and more importantly, it is now bearable and even pleasant to live with myself. That is honestly the best gift I have ever received; greater than the gift of life itself. Because life deserves to be enjoyed, not just endured. And now I know how to do that. Thank you."

How to make a referral

Visit the **Vita Health** site or call **1-844-866-8336** (**1-844-866-TEEN**). Vita Health services are currently available in all states except for Montana, Louisiana, Alaska and Hawaii.

Ask about copay waivers; plan exceptions may apply.

Questions?
Please contact **Aimee Prange**.

[1]Associated Press. **US suicides held steady in 2023—at a very high level**. September 2024. Accessed December 5, 2024.

Depression in primary care

Our program can help you screen and treat depression at the primary care level. Find out how to get started.

Approximately 8.4% of U.S. adults who are 18 or older reported symptoms of depression in 2020, and 6% of adults had a major depressive episode with severe impairment.[1] These numbers increased because of the COVID-19 pandemic.

Throughout 2021, the Centers for Disease Control and Prevention (CDC) conducted an online **Household Pulse Survey**. The results showed the national prevalence of Depressive Symptoms ranging between 20.2% and 31.1%. **An earlier study** found that only about 4% of adults were screened for depression in primary care settings.

The role of primary care physicians

Primary care physicians serve as the entry point to the health care system for many patients and play a critical role in recognizing and treating symptoms of depression. According to a 2019 article in the New England Journal of Medicine, "An estimated 60% of mental health care delivery occurs in the primary care setting, and 79% of antidepressant prescriptions are written by providers who are not mental health care providers."[2] Research indicates that screening for and treating significant depression among primary care patients may improve the quality of medical care and decrease the burden of physical illnesses.

The Aetna® **Depression in Primary Care program** is designed to support the screening for and treatment of depression at the primary care level.

Program benefits

Reimbursement is available for you when you submit claims using a combination of one of the following diagnostic codes in conjunction with one of the following billing codes:

Diagnostic codes

- Z13.31 (encounter for screening for depression) or
- Z13.32 (encounter for screening for maternal depression) or
- Z13.29 (encounter for screening examination for other mental health and behavioral disorders)

Billing codes

- 96127 (brief emotional/behavioral assessment) or
- 96160 (patient-focused health risk assessment) or
- 96161 (caregiver-focused health risk assessment) or
- G0444 (annual screening for depression)

How to get started

To get started, you simply need to:

- Be a participating provider
- Use a validated tool to screen/monitor your patients
- Submit your claims using the combination coding

Learn more about the **Depression in Primary Care program**.

[1]National Institute of Mental Health. **Major depression**. January 2022. Accessed on December 8, 2023.

[2]Park LT, Zarate CA Jr. **Depression in the primary care setting**. New England Journal of Medicine. February 7, 2019; 380 (6): 559–568. Accessed on December 8, 2023.

Depression screening for pregnant and postpartum women

Aetna® maternity program identifies depression and helps women get behavioral health support.

The Aetna Maternity Program assists pregnant and postpartum members by identifying depression and getting them behavioral health support. Our nurses provide educational and emotional support and case management to eligible members, helping them reach their goal of a healthy, full-term delivery.

Program elements

- The clinical case management process focuses on members holistically. This includes behavioral health and comorbidity assessment, case formulation, care planning and focused follow-ups.
- Our nurses, who have high-risk obstetrical experience, help members follow their providers' plan of care. They also refer members with positive depression or general behavioral health screens to behavioral health condition management if they have the benefit and meet the program criteria.
- A behavioral health specialist is part of the Aetna Maternity Program team. This specialist helps enhance effective engagement and helps identify members with behavioral health concerns.
- Our nurses reach out to members who have experienced a loss in their pregnancy, if appropriate. They offer condolences and behavioral health resources.

How to contact us

- Members or providers can call **1-800-272-3531 (TTY: 771)** to verify eligibility or register for the program.
- Members can also enroll through **Aetna.com** by logging into their member website online and searching under the "Stay Healthy" section.

Aetna® reimburses for maternal mental health screening during and after pregnancy

Provider and member resources are available to support perinatal mental health screening.

The American College of Obstetricians and Gynecologists (ACOG) recommends screening for perinatal depression and anxiety at the initial prenatal visit, later in pregnancy, and at postpartum visits—though there are no limitations on screening frequency.

Clinical practice guidelines support well-woman and perinatal depression screening using standardized, validated instruments such as the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ-9).

Reimbursement

To help you meet professional recommendations, our commercial medical benefits plans reimburse you up to four times for depression screening during the perinatal period.

Billing

The following CPT® codes are reimbursed in addition to the global maternity fee at existing rates in provider fee schedules.*

- 96127
- 96161
- 96160

You can view more information about these codes, including applicable visit limits, on our **provider portal on Availity**.** Go to Aetna Payer Space > Resources > Benefit Guidance Statements > Routine Preventive Care Services.

Provider and member resources

- **Postpartum Support International (PSI)**
- National Maternal Mental Health Hotline—call/text **1-833-TLC-MAMA** **(1-833-852-6262)**
- **MinuteClinic maternal mental health therapy**

Provider training:

- **Perinatal mental health training**

Access to mental health experts:

- **Perinatal Psychiatry Access Programs — Maternal Mental Health Leadership Alliance: MMHLA**—no-cost clinician-to-clinician consultation program

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

Behavioral health clinical practice guidelines

These sources could help you improve patient care.

Clinical practice guidelines from nationally recognized sources promote the use of evidence-based treatment methods. This helps provide the right care at the right time. We make them available to you to help improve health care.

These guidelines are for informational purposes only. They're not meant to direct individual treatment decisions. All patient care decisions are the sole responsibility of you.

Adopted guidelines

American Academy of Pediatrics (AAP)
Clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder (ADHD) in children and adolescents (2019)

American Society of Addiction Medicine (ASAM)
Clinical practice guideline on alcohol withdrawal management (2020) (PDF)

American Psychiatric Association (APA)
Practice guideline for the pharmacological treatment of patients with alcohol use disorder (2018) (PDF)

Centers for Disease Control and Prevention (CDC)
Clinical practice guideline for prescribing opioids for pain (2022)

American Society of Addiction Medicine (ASAM)
Clinical considerations: buprenorphine treatment of opioid use disorder for individuals using high-potency synthetic opioids (2023)

VA/Department of Defense
Clinical practice guideline for the management of major depressive disorder (MDD) (2022) (PDF)

American Academy of Child & Adolescent Psychiatry (AACAP)
Clinical practice guideline for the assessment and treatment of children and adolescents with major and persistent depressive disorders (2023) (PDF)

We also encourage you to stay up to date with the **US Preventative Services Task Force (USPSTF) Recommendations** (Grade A & B) for healthy children and adults with normal risk. These recommendations help improve health care and the appropriateness of its delivery.

Note: These guidelines are not decisions for coverage, benefits determinations or treatments.

Care coordination contributes to better patient outcomes

We expect our behavioral health providers to work with medical providers, and this collaboration is both reimbursed and audited.

Many of your patients receive care from other behavioral health providers, primary care providers and medical specialists. The Collaborative Care Model is an evidence-based practice which leads to better outcomes for patients. And using it is reimbursable.

Care coordination improves patient interactions

Coordination works in the following ways:

- It eliminates the feeling of disjointed care by helping patients feel that they're working with a team focused on their care.
- It smooths out the referral process by helping patients schedule appointments and telling them what to expect from a referral.
- It improves the quality of medical and behavioral health care via sharing of relevant diagnosis and treatment information between providers to allow for necessary adjustments to treatment plans.

See the **American Psychiatric Association** for more information on the importance of the Collaborative Care Model and how it works.

HIPAA guidelines

Note the following **HIPAA guidelines (PDF)** related to sharing behavioral health information:

- You may disclose Protected Health Information (PHI) (whether orally, on paper, by fax or electronically) for treatment, case management, coordination of care, payment and health care operations without consent or authorization.
- HIPAA treats mental health information the same as other health information.
- Mental health information in the medical record is subject to the same HIPAA standards as other PHI* and may include:
    - Medication prescription and monitoring
    - Counseling session start and stop times
    - The modalities and frequencies of treatment offered
    - Results of clinical tests
    - Summaries of diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date

Please request that patients sign release of information forms for all providers involved in their care. This will help ensure prompt communication between providers when it's necessary.

We expect collaborative care and reimburse for it.

The CPT® codes for collaboration include: 99484, 99492, 99493 and 99494.**

We evaluate our behavioral health providers on care collaboration. We do this via our Annual Behavioral Health Practitioner Experience Survey and via treatment record audits. Please see the Coordination of Care section (page 49) of the current **Aetna Provider Manual** for more information.

*Covered entities must get patient authorization to disclose separately maintained psychotherapy session notes.
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Refer patients to our Complex Case Management (CCM) program

Our CCM program is a collaborative process that includes the Aetna® clinician, the member, the caregiver and providers.

We thoroughly assess the member's physical and emotional health, including the member's current condition, presence of co-existing mental health and substance use disorder issues, and treatment history. We give patients with complex conditions extra help understanding their health care needs and benefits. We also help them access community services and other resources available to them.

Improved outcomes

Members who participate in at least 60 days of CCM have been shown to have significantly reduced behavioral health symptoms. Assessments completed upon enrollment and case closure for these members show an average of 25% to 35% reduction in symptoms of depression and anxiety. Re-admission rates are also lower for members participating in CCM compared to members who have not.[1]

How members get connected

Our goal is to produce better health outcomes while managing health care costs. We welcome referrals to the program from many sources. These include:

- Primary care physicians
- Specialists
- Facility discharge planners
- Family members

- Internal departments
- The member's employer
- Organization programs
- Vendors or delegates

You can submit a referral in two ways:

- Call **1-800-424-4660 (TTY: 711)**
- Email **Aetna Behavioral Health Referrals**

[1]Aetna. Annual analysis of the effectiveness of complex case management, 2022. The analysis was based on pre- and post-scores of the PHQ-9 and GAD-7 assessment tools.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

The Institute of Medicine encourages you to use the SBIRT model, and we'll reimburse you if you do.

In 2023, more than 16 million people (5.8% of adults) who are 18 or older acknowledged heavy alcohol use, and 8.6% (3.3 million people) who are 12 to 20 noted binge drinking or heavy alcohol use. **The 2023 National Survey on Drug Use and Health** estimated that 27.2 million people who are 12 or older had a drug use disorder, notably highest in the 18- to 25-year-old population (18%, or 6.1 million people), followed by adults over 26 (19.3 million people, or 8.6%), and then adolescents who are 12 to 17 (6.9%, or 1.8 million people).[1]

The U.S. Department of Health and Human Services estimates that the annual economic impact of substance misuse is about $249 billion for alcohol misuse and $193 billion for illicit drug use.[2]

The importance of brief intervention

The SBIRT program effectively addresses substance use by integrating three core components:

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides access to specialty care for those identified as needing more extensive treatment.

What is SBIRT?

SBIRT is an evidence-based practice designed to support health care professionals. The goal is to improve both the quality of care for patients with alcohol and substance use disorder conditions, as well as outcomes for patients, families and communities.

The Substance Abuse and Mental Health Administration encourages using SBIRT. It recommends community-based screening for health risk behaviors, including alcohol and substance use.

Screening and reimbursement

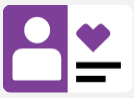
When participating practitioners treat patients with Aetna® medical benefits and provide this service, they can be reimbursed. Go to our **SBIRT** page to learn more.

More information

Background information about the program, as well as links to scholarly articles, research and coding information are available from **Substance Abuse and Mental Health Services Administration (SAMHSA)**.

[1]National Institute on Alcohol Abuse and Alcoholism (NIAAA). **Alcohol's effects on health**. September 2023. Accessed on December 11, 2023.

[2]Substance Abuse and Mental Health Services Administration (SAMHSA). **2021 national survey on drug use and health (NSDUH)**. Accessed on December 11, 2023.



Medicare

Get Medicare-related information, reminders and guidelines.

Complete your required Medicare compliance training by October 31, 2025

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 Dual-Eligible Special Needs (D-SNP) plans, view our **MA quick reference guide (PDF)**.

2025 direct provider notification

In 2025, we'll send you a training and attestation notice to the compliance email(s) identified in your 2024 attestation. If we don't have your email address (or the email bounces), you'll receive a postcard reminding you to complete your attestation (and MOC training, if applicable) by October 31, 2025.

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)**

Attestations based on contracted plans:

Providers:

- MA/MMP: **Complete MA only MA and MMP attestation (PDF)**
- MA/SNP: **Complete MA and D-SNP attestation (PDF)**

Delegates:

- MA/MMP: **Complete MA/MMP attestation for first-tier entities (PDF)**
- MA/SNP: **Complete MA and/or SNP attestation for first-tier entities (PDF)**

Where to get more information

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

You must avoid billing Qualified Medicare Beneficiaries (QMBs) for cost sharing

Most dual-eligible beneficiaries are cost-share protected, which means you must accept the Medicare and Medicaid (if applicable) payments as payment in full.

You play a critical role in ensuring compliance with regulations that protect QMBs from being billed for Medicare Part A and B cost-sharing amounts. This article outlines key protections for QMBs and other dual-eligible members, resources for confirming dual-eligible status, and emphasizes the importance of adhering to these rules to prevent billing errors and ensure compliance.

Understanding QMBs

QMBs are dual-eligible individuals who qualify for both Medicare and Medicaid due to their low-income status. The QMB program requires state Medicaid programs to cover Medicare premiums, deductibles, coinsurance and copayments for eligible beneficiaries. You must recognize that QMBs have no legal responsibility for Medicare Part A and B cost-sharing amounts. Medicare and Medicaid payments combined must be accepted as full reimbursement. As outlined in the Aetna Medicare Provider Manual, you are prohibited from billing QMBs or treating them as private pay patients.

There are multiple categories of dual-eligible beneficiaries

You should understand the classifications of dual-eligible beneficiaries to ensure proper billing practices. Below is a summary of these categories and their billing protections:

Dual-eligible category	Description	Billing protections
QMB	Eligible for QMB benefits only; Medicaid pays Medicare cost-sharing.	Cannot be billed for Medicare A/B cost-sharing.
QMB+	Eligible for both QMB and full Medicaid benefits.	Cannot be billed for Medicare A/B cost-sharing.
SLMB	Specified Low-Income Medicare Beneficiary; Medicaid pays Part B premiums only.	Can be billed for cost-sharing not covered by Medicaid.

SLMB+	Eligible for SLMB and full Medicaid benefits.	May have billing protections based on full Medicaid coverage.*
QI	Qualifying Individual; Medicaid pays Part B premiums only.	Can be billed for cost-sharing not covered by Medicaid.
QDWI	Qualified Disabled and Working Individual; Medicaid pays Part A premiums only.	Can be billed for cost-sharing not covered by Medicaid.
FBDE	Full Benefit Dual-Eligible; eligible for full Medicaid benefits.	Cannot be billed for Medicare A/B cost-sharing.

*If Medicaid covers the service, and if the provider accepts Medicaid.

Identifying dual-eligible beneficiaries

Timely access to QMB status information is crucial for compliance. The Centers for Medicare & Medicaid Services (CMS) provides resources for confirming dual-eligible status:

- Medicare Advantage Medicaid Status Data File: Monthly updates that include dual status codes (e.g., "01" and "02")
- Monthly Membership Detail Data Report (MMR): A report produced by the MARx system, showing QMB status in Field 84

You can also check member eligibility, including QMB status, through our **provider portal on Availity**,* which offers detailed eligibility and claims information.

To support compliance, we encourage you to stay informed

Accurate billing protects beneficiaries and upholds CMS regulations. You are advised to review your current practices and ensure adherence to these requirements. You should proactively verify compliance to avoid potential issues related to billing QMBs and other dual-eligible beneficiaries.

For further details, refer to the **Aetna Provider Manual** and CMS guidance on the prohibition of billing QMBs on the **CMS Medicare Learning Network**.

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

Aetna Medicare is contracted with Nations Hearing

Find out whether you participate and how to bill.

Aetna Medicare is contracted with Nations Hearing, which provides annual hearing exams, hearing-aid-related exams and hearing aids. If you participate with Nations Hearing, you can provide those services and the hearing aids for your patients. But please do not bill Aetna for those devices and hearing-aid-related exams.

If you have questions, including whether you participate with Nations Hearing, call **1-800-921-4559**.

For all other benefit questions, including benefits and eligibility for those services when a Nations Hearing network provider isn't used, refer to the **Contact Aetna** page. Select the Providers tab. In the "Call us" column, choose "Aetna service programs" from the drop-down menu and use the "Medicare medical and dental plans" number.

Change to Medicare Diagnosis Related Group (DRG) length-of-stay approvals

We're changing the length of stay for all Medicare DRG contracted acute inpatient cases.

We'll be approving all cases meeting admission criteria for a seven-day length of stay. We're offering discharge-planning assistance and requesting a discharge date every three days until we receive the information or confirm discharge.

Length of stay extensions will be made upon receipt of the discharge planning information and/or discharge date.

Reason for the change

Giving us discharge-planning information as early as possible helps us to better address any needs or concerns the patient has before going home, thereby reducing the chance of readmission.

What we'll need from you

In all cases, we'll ask you for the following:

- A discharge plan
- The expected/actual discharge date
- Discharge verification