September 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

Improving the discharge date submission process

We rely on facilities to submit timely admission and discharge notification. Doing so helps manage patient care. We tell you how and why to send us only what is necessary.

Engaging faith-based communities in mental health

Many people look to their faith for mental health support. A community approach to mental health includes providing access, building trust and increasing awareness. Know when to refer people to mental health professionals.

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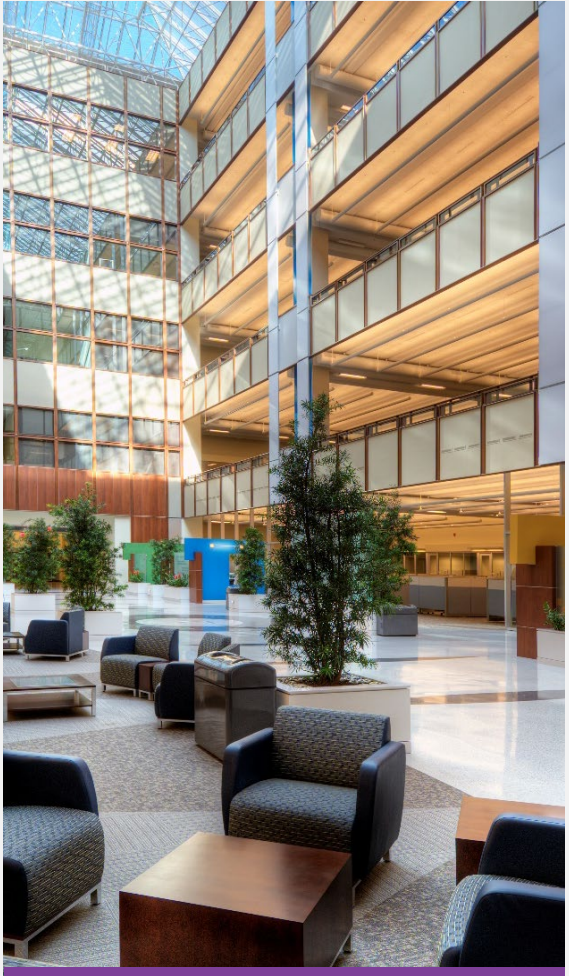

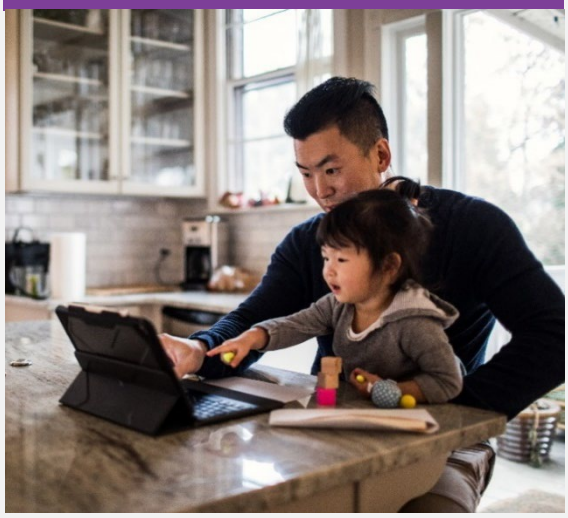

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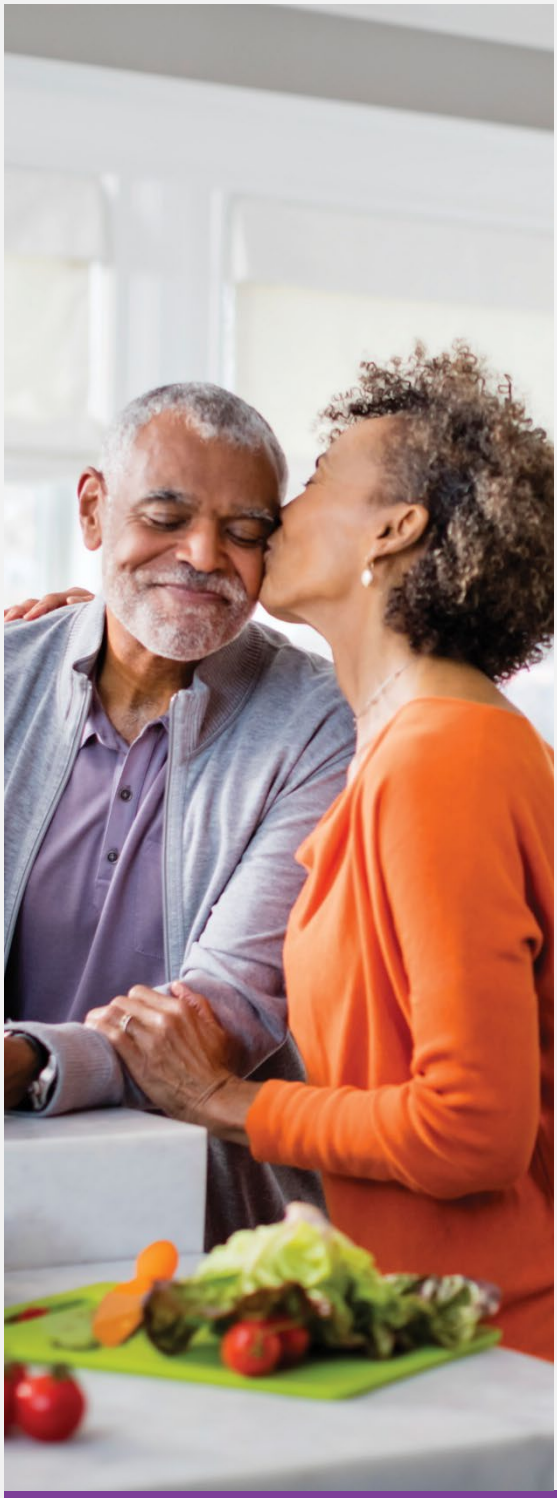

90-day notices and related reminders

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 December 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.

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 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.

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

Service code update

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

Unless noted, all updates take effect on January 1, 2025.

Codes	Provider types affected	What's changing
97760 and 97761	Facilities, including acute short-term hospitals	Will be added to Physical, Occupational and Speech Therapy (PHYTHY).

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.

Immunization and vaccine coding update

After further review, we've decided not to add certain codes to the vaccine grouping.

Changes to your compensation depend on the presence or absence of specific service groupings in your contract.

In our **December 2023 newsletter** (page 9), we indicated that the following codes would be tied to the Immunizations and Vaccines Contract Service Grouping effective March 1, 2024.

90471	Immunization admin, single
90472	Immunization admin, 2+

90473	Immunization admin, oral/nasal
90474	Immunization admin, oral/nasal additional
90460	IM admin 1st/only component
90461	IM admin each additional component
90476	Adenovirus vaccine, type 4, live, for oral use
90477	Adenovirus vaccine, type 7, live, for oral use
G0008	Admin influenza virus vaccine
G0009	Admin pneumococcal vaccine
G0010	Admin hepatitis B vaccine

Upon further review, we decided to not add the above codes to the grouping. Therefore, no grouping change took effect on March 1.

We apologize for the confusion.

How to reach us

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

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.

Changes to our National Precertification List (NPL)

Effective January 1, 2025, we'll require precertification for the following (commercial and Medicare plans):

- Whole Genome Sequencing (81425, 81426, 81427, 0214U, 0215U, 0318U, 0335U, 0336U, 0417U)

Effective January 1, 2025, we'll require precertification for the following (Medicare plans only):

- Vafseo (vadadustat) (J3490, C9399)

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®.

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Changes to commercial drug lists begin on January 1

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

On January 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 October 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. Select the Providers tab. In the "Call us" column, choose "Special programs" from the drop-down menu and use the "Pharmacy management" number.

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Medical plan drug list changes start on January 1, 2025

Drug list changes support our commitment to high-quality, cost-effective health care. It's likely some of your patients are taking these medical plan drugs, and we will notify them about the changes.

You can view the changes by referring to our **medical clinical policy bulletins** as early as October 1, 2024. We urge you to prescribe a preferred alternative drug if appropriate.

Medical exceptions

You can request a medical exception for drugs that need precertification. If we approve the exception, your patients will pay their plan copay or cost share amount after they meet their deductible or other out-of-pocket requirements.

To request a medical exception for specialty drugs that are covered under the medical benefit and that are on the Aetna® National Precertification List, you can:

- Go to the **Contact Aetna** page. Select the Providers tab. In the "Call us" column, choose "Precertification" from the drop-down menu and use the "Non-Medicare pharmacy (injectable drugs)" number.
- Go to **Aetna.com** and access the forms library (under Resources) to complete the Specialty Pharmacy precertification form specific to the relevant medication. Then fax the completed form to the number listed on the form.

Ways to request a drug prior authorization

Submit your completed request form through our **provider portal on Availity**.*

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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).

Pharmacist payer reimbursement for medical benefits services

This update applies to our commercial members.

Effective January 1, 2025, the Mid-Level and Other Qualified Health Care Professional payment policy will apply to pharmacist providers providing medical benefit services within the scope of their licensure in states with laws requiring payer reimbursement.

State-specific updates

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

California: Individual & Family Plan (IFP) member language patterns

Here are the top 5 non-English languages spoken in nine counties.

Aetna® offers IFPs in the following counties: Alameda, Contra Costa, El Dorado, Fresno, Kings, Madera, Placer, Sacramento and Yolo. We are committed to reducing health disparities in all communities, including our IFP members, and improving the health of our IFP members.

We have collected data on the prevalent languages of our IFP membership, and we believe that sharing this information with you will help improve the quality of the patient-provider relationship and mitigate language barriers. The table below shows the top 5 non-English languages that our IFP members speak.

California (IFP) member language patterns										
	Alameda	**Contra Costa**	**El Dorado**	**Fresno**	**Kings**	**Madera**	**Placer**	**Sacramento**	**Yolo**	**Total**
English	89%	92%	95%	82%	70%	69%	91%	80%	72%	82%
Spanish	3.07%	1.26%	3.87%	16.1%	28.84%	30.33%	3.36%	7.95%	24.9%	13.3%
Mandarin Chinese	4.32%	2.83%	0.17%	0.08%	0.0%	0.0%	0.85%	1.53%	1.0%	1.2%
Russian	0.14%	0.0%	0.0%	0.1%	0.0%	0.0%	3.17%	5.64%	1.04%	1.12%
Vietnamese	0.0%	0.0%	0.0%	0.27%	0.0%	0.0%	0.14%	0.95%	0.08%	0.16%
Yue Chinese	0.70%	0.63%	0.06%	0.14%	0.0%	0.0%	0.0%	1.33%	0.48%	0.37%

Note: Column percentages may not add up to 100% due to rounding.

The language assistance requirement

As a contracted provider, you are required to provide language assistance at the time of the appointment. Please contact our Language Assistance Program (LAP) if a patient needs interpreter services. There is no charge for this interpretation service. You can call **1-800-525-3148 (TTY: 711)** to reach a qualified interpreter directly.

Members who do not receive language assistance services may **file a grievance**.

Idaho: New pre-approval requirements

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

This article applies to Oregon and Idaho members in our Aetna® Medicare Advantage (MA) HMO/PPO products.

Our Enhanced Clinical Review Program will require authorization for certain procedures starting on September 1, 2024.

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 September 1, 2024, 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 September 1, 2024.

We review radiation therapy services in accordance with the 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.

Illinois: Help us comply with a law about how we communicate contractual changes

We need to collect and store a current email address for you or an authorized staff member.

Illinois law requires insurers and HMOs to email you about nonroutine changes to contractual fee schedules as outlined in a newsletter, website listing or other method.

As a result, we need to collect and store a current email address for you or a staff member who is authorized to receive this information.

How to give us a current email address

If you use Availity,* follow these steps:

1. **Log in to Availity**.
2. Go to My Providers > Provider Data Management (user must have access and be listed as Key Staff by their office Availity Administrator).
3. Select Business/Provider to update > select Key Staff name.
4. Complete the Key Staff information, including email address.
5. Choose Save.

We appreciate your help

Thank you for giving us an address. If you have any questions about how to provide or update your email address or if you would like more information on why we need it, visit our **Contact Aetna** page to find out how to reach us.

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

New Jersey: Aetna® does not cover vitamin D testing for routine visits

Lately we have seen some New Jersey providers ordering vitamin D tests as part of the blood panel for routine patient visits. Since early 2019, Aetna considers measurements of serum 25-hydroxyvitamin D to be experimental and investigational for routine preventive screening. This means that the patient gets the bill for the vitamin D test.

For more details, go to our **Medical Clinical Policy Bulletins** page and type 0945 in the search box. Aetna covers the test for people who meet certain conditions.

North Carolina (NC) State Health Plan open enrollment is coming soon

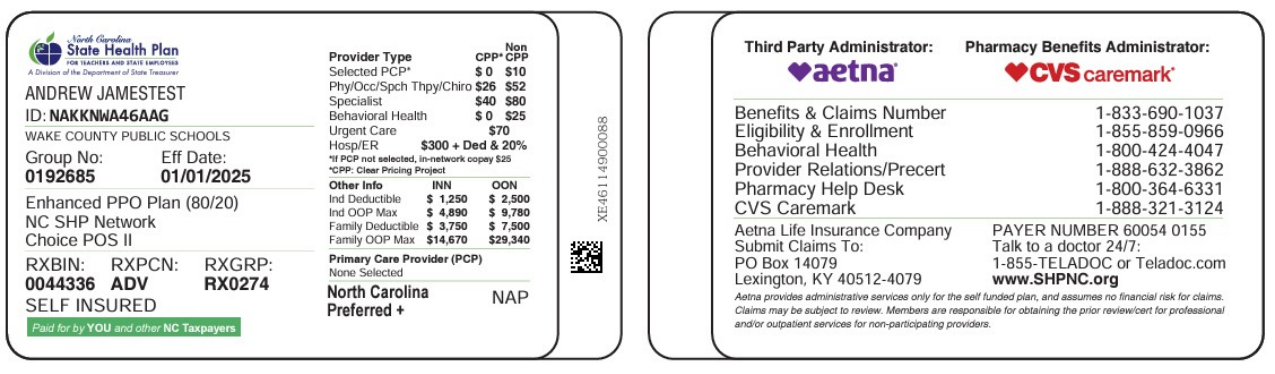
Enrollment begins on September 30, 2024.

Aetna® will be the new third-party administrator for the NC State Health Plan beginning January 1, 2025. Open enrollment begins on September 30, 2024, and runs through October 25, 2024.

New member ID cards with unique ID numbers

NC State Health Plan members will have unique ID cards. ID numbers will start with “N” and be followed by either 11 letters or 11 alphanumeric characters (for example, NABCDEFGHI6P).

Here’s what the card looks like:



Stay up to date on the latest NC State Health Plan news

Visit the **NC State Health Plan** page for important information and updates. Check back often, since we regularly update the site.

Oregon primary care provider (PCP) assignments

Oregon members will soon have PCPs assigned to them.

We believe that primary care is critical to maintaining health and preventing and managing serious diseases, and we encourage our members to establish a consistent relationship with a PCP.

As a result, you may notice a change in Aetna® member identification cards in the coming months.

What's the change?

We've moved some members to a PCP-enabled plan that complies with the PCP selection, assignment and notification rules of SB 1529. PCP assignment information will appear on member ID cards; however, members are not limited to seeing only the PCP on their ID card, and referrals are not required for visits to specialists.

We will make our best efforts to assign a PCP that gives the member the best opportunity to access primary care services without unreasonable delay. Members may select a different PCP at any time.

If you believe we have assigned a member to your panel in error, please visit our **Contact Aetna** page to find out how to reach us.

What you need to do

To ensure that we have the most accurate information about you, please review it, including your practice address, phone number, and panel status (that is, whether you accept new patients), and make any updates in the Provider Data Management (PDM) tool on our provider portal on Availity.*

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- Polysomnography (attended sleep studies)

- Interventional pain management
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What you should know

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- 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.

News for you

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

Facilities: We'd like your help in improving the discharge date submission process

You might want to change how you submit member discharge information to us.

Since you are an acute or post-acute care facility, we rely on you to submit timely notification of admissions and discharges to help manage patient care. Timely notification helps us coordinate patients' post-discharge care. We prefer to receive notification of discharge and disposition within 1 to 2 days after the patient has been discharged.

Review how (and what) you're submitting to us

We receive discharge information in several ways. It comes to us:

- As an electronic medical record (EMR) or an electronic health record (EHR)
- Within medical records
- Via fax or email

We receive most discharge date and disposition information when we need it, but some facilities send us more information than we need. For example, we may receive daily censuses (or rosters) of all the patients in a facility along with their statuses (discharged, still in house, etc.). But what we really need to know is when a patient reaches the end of their covered bed days so that we can review their stay.

Since so much time is involved in sending and reviewing excess information, we ask that you try to send only what is necessary.

Consider sending us discharge information through your EMR or EHR vendor

You're already sending us notifications, claims, etc., securely through your preferred electronic data interchange (EDI) vendor or clearinghouse. Transmitting discharge information works similarly, and it's secure. Ask your EMR or EHR vendor or health information exchange (HIE) if they can transmit the data to us securely.

For those using Epic: We have a signed agreement with Epic to accept data from their users. Users only need to grant permission to Epic to share data with us. Contact Epic for more information on sharing continuity of care document (CCD) or admission discharge transfer (ADT) data with us.

No matter what vendor you use, make sure your records include the following data:

- Aetna® member ID
- Admit date
- Admitting and attending provider National Provider Identifiers (NPIs)
- Facility name and NPI
- Authorization number

Or use our discharge clinical questionnaire

Since compiling a daily census or roster takes time, we'd like to suggest using the discharge verification and disposition clinical questionnaire. You can find it on our **provider portal on Availity** (registration required).* Here's how the process works:

- On the last covered bed day for the patient, we'll send a reminder to your Availity Authorization/Referral Dashboard. The reminder states that the patient is due to be discharged that day.
- You then choose the reminder to open the questionnaire, which contains two questions: whether the patient was discharged and, if so, when and to where. If you haven't discharged the patient, tell us "no" in the questionnaire. We might have to contact you for more information.

That's it. Using Availity® costs you nothing, and you can **register for Availity** even if you use another EDI vendor or clearinghouse.

We're looking at technology to improve the data review process

Some facilities may send us daily censuses or rosters because that's what they've been doing for years. Combing through one facility's faxed census or another facility's emailed spreadsheet takes time. We're looking at creating new technologies to help make it easier to collect the information. We may contact you to help test new products, and we'd appreciate your participation.

Let's work together to improve the discharge date submission process. That way, you'll have more time to focus on patient care. We look forward to working with you. If you'd like to share feedback, **send us an email**.

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

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.

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 education 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**.

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.

Reminder: Use the correct admission type for inpatient admissions

When submitting a request for an inpatient admission, review the available choices for admission type and select only the most appropriate one.

When submitting an electronic request for an inpatient admission, you have three choices for the admission type:

- Elective
- Emergent
- Urgent

We'll review requests using the choice you selected in accordance with established guidelines.

Some acute facilities are choosing "emergent" or "urgent" for requests that aren't either. We'd like to remind you to choose:

- "Emergent" or "urgent" only when the request is emergent or urgent, respectively
- "Elective" for standard-level requests

Choosing the correct admission type will allow our colleagues to review requests appropriately.

Reminder: We cover Exparel® only for its FDA-approved indications

See our **Clinical Policy Bulletin 941**.

FDA-approved indications include:

- Use as a single-dose infiltration to produce postsurgical local analgesia in adults and children 6 years of age and older
- The following specific blocks in adults: adductor canal block, sciatic nerve block in the popliteal fossa, and an interscalene brachial plexus nerve block for postsurgical regional analgesia

All other uses are considered unproven and are not covered.

How we pay for short-term therapy administration in our Individual and Family Plans (IFPs)

Therapy administration refers to how the benefit payment and the accumulation of physical, occupational and speech therapy benefits occur for different Places of Service.

Home visits

Physical, occupational and speech therapy visits in the home accumulate, or count toward, the Short-Term Rehab (STR) visit limit, and we pay for those visits at the STR cost share.

Outpatient settings

We treat occupational and speech therapy visits in an outpatient setting (hospital or facility) in one of two ways:

- They accumulate toward the outpatient (OP) hospital benefit limit (if applicable) and are paid at the OP hospital cost share (New Style 1).
- They accumulate toward the STR benefit limit and are paid at the STR cost share (New Style 2).

IFP plans follow New Style 2, and benefits track to the STR benefit, regardless of the Place of Service (POS).

Verification information

Please call the toll-free number on the back of the member's insurance card to verify benefit and visit limits.

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

Note that we will require precertification, contrary to what we communicated in the June quarterly OLU newsletter.

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

Precertification is required. Please note that we are correcting what we communicated in the **June quarterly issue of OfficeLink Updates**.

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.

Trustmark Health Benefits is now Luminare Health

Send claims to the TPA/Luminare, not to Aetna®.

Aetna Signature Administrators' payer partner recently changed its name from Trustmark Health Benefits to Luminare Health. To verify eligibility for patients whose card shows the

Luminare Health logo, please visit the Luminare **provider portal** or call the Luminare customer service number, located on the back of the member's ID card.

When submitting claims, send them electronically to EDI #35182 (for faster processing) or to the address on the back of the member's ID card.

Malnutrition

Malnutrition is a deficiency, excess or imbalance in a person's intake of energy or nutrients, which can cause loss of function. Below, you will find descriptors and suggested codes to ensure that clinicians and coders are consistent when conveying true diagnoses.

Terminology

- **Anorexia** refers to a decrease in appetite. It may be physiologic with advanced age or pathologic with an underlying etiology.
- **Cachexia** is a metabolic syndrome associated with an underlying illness and is typified by the loss of muscle mass. Identify any underlying etiology if known.
- **Kwashiorkor** is a clinical syndrome of malnutrition evidenced by bilateral pedal edema that progresses upward. It may co-exist with marasmus.
- **Malnutrition** is a general term that does not specify under-nutrition or over-nutrition, etiologies or manifestations. Please consider clarifying terms when selecting this description.
- **Marasmus** is a wasting syndrome from acute malnutrition. It is a subset of malnutrition and may be associated with kwashiorkor.
- **Protein energy (calorie) malnutrition** applies to three separate clinical syndromes: stunting, acute malnutrition (marasmus and kwashiorkor) and wasting due to an underlying illness.
- **Sarcopenia** refers to the syndrome of decreased muscle mass and strength.

Coding tips

E40	Kwashiorkor
E41	Nutritional marasmus wasting due to malnutrition
E42	Marasmic kwashiorkor
E43	Unspecified, severe protein-calorie malnutrition
E44.0	Moderate protein-calorie malnutrition
E44.1	Mild protein-calorie malnutrition
E45	Retarded development following protein-calorie malnutrition
E46	Unspecified protein-calorie malnutrition
E88.0	Wasting disease (syndrome) due to underlying condition
R63.0	Anorexia loss of appetite
R64	Cachexia

M62.84 Sarcopenia

PCR testing for vaginitis

Aetna® considers polymerase chain reaction (PCR) testing to be medically necessary in women with symptoms of vaginitis. The clinical documentation must support symptomatic vaginitis for this testing to be a covered benefit.

The covered diagnosis codes listed in **Clinical Policy Bulletin 0643**, Diagnosis of Vaginitis, are listed below. Note that this test is not covered for any other diagnosis codes, such as N89.9 — Noninflammatory disorder of vagina, unspecified.

ICD-10 codes covered if selection criteria are met	
B37.31, B37.32	Candidiasis of vulva and vagina
L29.2	Pruritus vulvae
L29.3	Anogenital pruritus, unspecified
N76.0	Acute vaginitis
N76.1	Subacute and chronic vaginitis
N76.2	Acute vulvitis
N76.3	Subacute and chronic vulvitis
N76.89	Other specified inflammation of vagina and vulva (vaginal burning, irritation and erythema)
N77.1	Vaginitis, vulvitis and vulvovaginitis in diseases classified elsewhere
N89.8	Other specified noninflammatory disorders of vaginitis (vaginal discharge)
N94.10–N94.19	Dyspareunia
R30.0	Dysuria

It's important to keep your demographic information up to date

Giving us your race, ethnicity and language information is voluntary, but keeping your information current helps our members connect with you to get care. Update your information via Availity® using our how-to guide.

How we use demographic details

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

Giving us your race, ethnicity and language information is voluntary. You can request that this information be removed from your profile at any time.

It's easy to update

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

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

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

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

Update your profile in minutes

Follow the steps shown in our **quick reference guide**, which you can use for making updates in our **provider portal on Availity**.* The guide will help you update essential information like:

- Email addresses
- Telehealth status
- Appointment phone number
- Mailing address
- NPI number
- Languages spoken by providers and office staff
- Race/ethnicity

More information

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

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

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

Reminder: When you update your profile, be sure to update your panel status

Ensuring accurate panel status and provider information is crucial for our members' access to care. Prompt updates within 30 days of a change improve the member health care experience.

Remember, inaccuracies can cause frustration when members are most vulnerable.

Find out how to update your information.

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.

Help improve the health care transition for adolescents and young adults

Use the resources listed in this article to give your young patients the help they need.

We know that adolescents and young adults are a vulnerable population with evolving health conditions, high rates of behavioral health risks, and low use of health care services. Health care clinicians play a crucial role in supporting the transition from pediatric to adult health care. For optimal health outcomes, transitioning adolescents need supportive primary care providers and specialists.

We're here to help

To support our youth and help facilitate an effective transition, we provide resources you can use when you talk with your patients:

- The health plan's website to learn more about available plan benefits and special programs
- The Aetna Health℠ app, so you can keep a safe and handy health record online
- The Health Risk Assessment, which helps provide personalized health results that can be shared with clinicians confidentially
- Access to Aetna® nurses, who can help navigate the health care system and find needed resources
- Access to behavioral health counselors to help arrange mental health or substance use disorder care and connections to community resources
- Access to telehealth services, which offer flexible ways to get care

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 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 do not tell members that Aetna doesn't cover them. You must call the phone number to obtain eligibility and benefits information.

A note about the Epic system

If you are using the Epic system for your 270/271 transactions and it shows that the patient has been rejected or is not 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 cannot 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 are working to correct this problem and will be in touch when we have more details.

Behavioral health

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

2024 Aetna® behavioral health quality management program summary

Read about what we've achieved and what's on the horizon.

Quality management and improvement efforts

We work hard to improve the service, quality and safety of our health care. Learn about our efforts and how far we've come.

Behavioral health initiatives

Enhancing health and mental well-being can improve people's lives. Our quality management program continually monitors the behavioral health care we provide to our members.

Highlights from 2023

- In January 2023, we launched behavioral health commercial member and caregiver case management satisfaction surveys, which were created for the Behavioral Health Condition Management, Aetna 360, Autism Care Team and Guardian Angel programs. As of September 2023, satisfaction scores were 95% for caregiver surveys and 94% for member surveys.
- Behavioral Health Quality Management collaborated with Health Equity teams to develop equity initiatives related to depression screening for both underrepresented ethnicities and women's health.
- We launched multiple suicide prevention strategies in 2023, with a focus on prevention of suicide attempts for our adult commercial population. As of October 31, 2023, we saw a 16% decrease in suicide attempts among our commercially insured adult members (25+), as compared to a 2019 baseline. We also saw a 20% reduction in our commercially insured young adult population (18–25), as compared to our 2019 baseline.
- We updated our searchable provider directory to include providers (including Vita Health practitioners) who have expertise in evidence-based, risk-reducing suicide care practices.
- We continued working with SafeSide, an organization dedicated to mental health education, to train primary care physicians, medical practices and their staff in identification and early intervention for patients at risk of suicide.
- Aetna 360™ Behavioral Health partnered with Vita Health to provide education about Vita via on-site training to 360 facilities in Colorado, Connecticut, Florida, New Jersey, Ohio and Pennsylvania. This education not only contributes to the goal of reducing suicide attempts by 20% by 2025 but may also increase timely post-discharge appointments for members.
- CVS Health® aims to increase access to mental health care for historically marginalized communities. More than 1,000 MinuteClinic® locations in the United States provide depression screening services, and select locations offer in-person and virtual mental health counseling services for depression, stress and anxiety from licensed mental health providers. Since the launch of MinuteClinic behavioral health services in 2021, 99% of new MinuteClinic patients have been able to see a mental health provider within seven days, and 80% reported a reduction in depression symptoms.
- We launched mental health services at 6 southern California locations, bringing the total number of states where mental health counseling is available at MinuteClinic locations to 16.
- Behavioral health commercial and Medicare plans saw an improvement in Patient Health Questionnaire 9 (PHQ-9) and Generalized Anxiety Disorder 7 (GAD-7) scores. Members who initially presented with moderate depression or anxiety demonstrated a 35% to 36% decrease on average in subjective symptoms during participation in Complex Case Management.

Plans for 2024

- Focus on behavioral health network expansion with the goal of increasing provider availability and reducing appointment wait times.
- Continue to use and refine predictive modeling to proactively identify members who may benefit from Medicare Behavioral Health Case Management.
- Continue to administer member and caregiver case management satisfaction surveys, with a satisfaction score goal of >90%.
- Continue to develop robotics expertise and work toward the creation of automated solutions to reduce manual work and data entry.
- Implement the 2024 suicide prevention roadmap to meet or exceed our bold goal for suicide prevention. Improve adolescent suicide prevention outcomes.
- Improve quality of care, achieve strong clinical outcomes and drive patient safety.
- Promote care coordination between medical and behavioral health providers.
- Behavioral Health Quality Management will continue to work on newly identified member service improvement opportunities and interventions.

More information

Find more resources on our **behavioral health member site**.

Best practices for documenting a behavioral health treatment plan

A thorough treatment plan helps you and your patients keep their care on track.

We understand that documentation is only one of your many tasks. Still, we would like to remind you that comprehensive treatment plans are essential for quality patient care, compliance with fraud, waste, and abuse policies, and avoidance of legal risk.

A treatment plan is one of the best ways for you and your patient to document progress and gaps as well as demonstrate the care you are providing to support coding and billing.

How to outline treatment goals

Behavioral health treatment plan goals should include the following elements:

- The goal should be **SMART**: **S**pecific, **M**easurable, **A**chievable, and **R**ealistic, and it should include a **T**ime frame for evaluation.
- The goal should be directly linked to the patient's presenting problem or diagnosis.
- Each goal should include a list of steps that the patient and clinician will take in order to accomplish that goal.
- Follow-up-visit notes should include an evaluation of the patient's progress toward their goals.

Here's an example:

Patient will experience a reduction in her depressive symptoms, as evidenced by a reduction in the PHQ-9 score (progress to be evaluated in December 2024).

- Activity #1: Clinician will provide the patient with a list of activities and resources for managing depression.
- Activity #2: Patient will select three activities or resources to practice or use at least three times per week.
- Activity #3: Patient will consult with a sleep specialist for an insomnia evaluation.

Resources

You can find many treatment planning resources online. **Verywell Mind** is a great place to start.

More information

Treatment plan documentation is only one element of our behavioral health documentation standards.

For a detailed list of our documentation standards, please see our new **Office Manual for Health Care Professionals**, which includes information for behavioral health providers. You can find information related to our documentation standards in the Quality Programs section. Appendix A lists the specific criteria we use when auditing treatment records.

Meeting people where they are: engaging faith-based communities in a conversation about mental health

People of color are less likely to verbalize concerns about their mental health and less likely to be asked about their mental health during visits with their doctor.

For years, the conversation around mental health has been met with shame and judgement, which in some cases can cause more harm or stop people from seeking help. For many, specifically Black Americans, church is not only a place to worship; many rely on their faith for mental and physical support.

Relationships, consistency and follow-up can build trust

A community approach to mental health includes providing access, building trust and increasing mental health awareness through conversation. By talking about the shame that causes a person to put off mental health treatment and then providing facts that show how seeking help is OK, people feel more comfortable doing exactly that.

Wellness is mental, physical, emotional, spiritual, social and environmental

CVS Health® believes in meeting people where they are, which is why CVS Health recently connected with Dr. Sidney Hankerson to launch a pilot at the site of two historically black churches in the Washington, D.C., and Virginia areas to offer health screenings. The screenings focused on depression, with 3- and 6-month follow-ups (as requested), while providing on-site mental health support and community resources.

We gave 716 participants access to mental health and community resources, and 138 participated in the depression screening.

- 50% screened positive for depression.
- 13% screened positive for suicidality.
- 85% requested follow-up by a clinician.
- 62% received mental health support and resources during the 6-month follow-up period.

Faith-based leaders are ready to support church members through many types of life situations and changes: grief and loss, premarital counseling and minor relationship conflict. They are not, however, ready to respond to mental health needs and crises. As faith-based leaders start or continue the discussion around mental health, we can support them by treating mental health the way we treat physical health, particularly by knowing how and when to refer people to mental health professionals.

Catch it before it gets worse

Regular depression screenings can help providers identify mental health concerns before they worsen. Depression screenings assess for changes over the previous 2-week period. Depression can trigger or worsen other long-term physical and mental health conditions, but talking about the signs of depression and making it OK to get help can enable everyone to be seen and be heard.

The 35th Annual Lifesavers Gala, American Foundation for Suicide Prevention (AFSP)

CVS Health® was the 2024 Gala Chair sponsor.

The Lifesavers Gala is an opportunity to recognize and reflect on the progress made outstanding by individuals and organizations in preventing suicide. This year's event raised over $8 million to help AFSP continue to be a leader in suicide research, advocacy, loss and healing, and prevention education.

2024 honorees

- **Jacoby Shaddix, lead singer of the rock band Papa Roach.** Shaddix received the Public Education Lifesaver Award. Papa Roach renamed their hit song "Leave a Light On" to "Leave a Light On (Talk Away the Dark)" after AFSP's **Talk Away the Dark** campaign.

- **USAA, a financial services company devoted to serving military members, veterans and their families.** USAA received the Public Service Lifesaver Award for their suicide prevention initiative "Face the Fight." This program launched in 2023 with their founding partners Humana Foundation and Reach Resilience, an Endeavors Foundation, to raise awareness and support for preventing veteran and military suicides.

- **David Huntsman and Christena Huntsman Durham of the Huntsman Foundation.** This foundation received the Humanitarian Lifesaver Award. The Huntsmans gave $150 million to establish the Huntsman Mental Health Institute at the University of Utah. Their institute is now able to provide world-renowned care to thousands of Utah children, teens, adults and families.

- **Jeff Bridge, PhD.** Bridge was given the Annual Research Award for his work related to youth at risk for suicide. Dr. Bridge is the director of the Center for Suicide Prevention and Research in the Abigail Wexner Research Institute at Nationwide Children's Hospital. His work focuses on the risk factors contributing to suicide and suicidal behaviors in young people and on improving the quality of care they receive.

- **Barbara Stanley, PhD (1949–2023).** Stanley received a posthumous award for her trailblazing work as a clinical psychologist. Dr. Stanley specialized in the treatment of individuals with borderline personality disorder, depression and self-injurious behaviors. She codeveloped the widely used Stanley-Brown Safety Plan intervention with Dr. Gregory Brown.

Changing lives and saving lives

CVS Health shared this year's event with a few of our vendor and provider partners invested in the mission of suicide prevention. Special guests included:

- **Vita Health**, a telehealth provider specializing in suicide care for youth and adults
- **Brightside Health**, offering a first-of-its-kind national telehealth program, the **Crisis Care program**, for treating individuals with elevated suicide risk
- **Dario**, a health care company offering digital solutions for chronic conditions

Gratitude for our providers

Aetna® and CVS Health would like to express our sincere gratitude for your commitment to treating those affected by suicide. We are committed to making specialty resources available to you at no cost to address this complex health issue.

Please take a look at the following suicide prevention resources:

- **Aetna suicide prevention resources**
- **Mental Health Awareness Guide for Young Adults**
- **Mental Health Awareness Guide for Parents and Caregivers**
- **Aetna suicide prevention podcast series**
- **SafeSide Primary CARE video-based training**

Those interested in the SafeSide training for your practice should contact **Aimee Prange**.

Suicide prevention training and support for primary care practices

Starting again in September, contracted providers can enroll in Aetna-sponsored programs to get CME credits.

Suicide and suicide behavior is a major public health crisis and a leading cause of death among people from 10 to 14 years of age and from 25 to 34 years of age in the United States.[1,2] We are committed to reducing adult, commercial member suicide attempts by 20% by 2025.

We understand the important role primary care practices play in our members' well-being and want to offer no-cost suicide prevention training for our Aetna® contracted providers.

The Extension for Community Healthcare Outcomes (ECHO) model for pediatric practices returns in September

The **American Academy of Pediatrics (AAP)**, in partnership with the **American Foundation for Suicide Prevention (AFSP)**, is recruiting pediatric health professionals to join an eight-month ECHO learning collaborative for youth suicide prevention designed from the **Blueprint for Youth Suicide Prevention**.

This Aetna-sponsored program is available at no cost to participating pediatric practices and offers complimentary Continuing Medical Education (CME) credit. The eight-month program is delivered virtually via monthly one-hour Zoom sessions with the opportunity to opt in to an additional six one-hour quality-improvement sessions.

Curriculum topics:

- Addressing suicide prevention in pediatric practice
- Screening for youth suicide risk in practice
- Conducting a Brief Suicide Safety Assessment (BSSA)
- Providing appropriate care for youth at risk
- Brief interventions that can make a difference
- Resources and support
- Addressing common implementation barriers
- Preparing your practice for a suicide prevention protocol

Interested in applying to ECHO or learning more?

Please contact **Aimee Prange** or **Sara Miscannon**.

[1]Centers for Disease Control and Prevention. **Suicide prevention**. Accessed on July 2, 2024.

[2]Mental Health.gov. **Suicide and suicidal behavior**. April 24, 2023. Accessed on July 2, 2024.

How to get better health outcomes for those with substance use disorder (SUD)

Screen patients, use proper coding and work with other providers to improve outcomes.

Patient education, early treatment and follow-up care are important for patients with alcohol and substance use disorders. Despite strong evidence that treatment, including Medication-Assisted Treatment (MAT), along with counseling or other behavior therapies improve patient outcomes, **less than 20% of those with SUD receive treatment**.

Please use these guidelines to help improve outcomes for your patients.

Provide adequate screening and education

Be sure to screen your patients for **alcohol use** and **substance use**, and educate them about risks. Help them **understand their diagnosis** and comorbidities. Discuss the importance of follow-up care and attending all appointments.

Managing appointments for success

After diagnosis, treatment should be initiated within 14 days, but the type of treatment can vary based on the severity of the symptoms as well as the member's motivation for treatment. Follow-up care should occur a minimum of 2 times within 34 days of the initial treatment visit.

Common treatment options:

- **Medication-Assisted Treatment** (MAT)
- Outpatient counseling
- Intensive outpatient program
- Partial hospitalization
- Inpatient admission
- Residential treatment
- **Telehealth**

Avoid problems with claims

Avoid claims issues by using the appropriate diagnosis codes. Be sure to also include place of service and procedure code (as applicable depending on the terms in your contract).

Enlist help

Encourage your patients to sign a release of information so that you can collaborate with other providers. Aetna® reimburses for coordination of care with other providers. The release should allow you to include members of the patient's primary support system in treatment discussions.

You should also provide the patient and those included in their support system with information about resources such as:

- **Shatterproof**, to learn about addiction and available resources and treatment
- **Alcoholics Anonymous**, **Narcotics Anonymous** and **SMART Recovery**, for peer support
- **Al-Anon/Alateen**, for family support

More information

We are here to support the care you give your patients. If you need help locating appropriate behavioral health providers, call the Member Services number on the patient's ID card or **consult our SUD page**.

Follow-up care after emergency department visits

Ensure that patients receive a follow-up visit within 30 days of an emergency department visit.

Emergency department visits should always be followed by a visit to a primary health provider. Many people don't make it to a follow-up appointment. You can help them get the right care at the right time by telling them how important a timely follow-up visit is.

Assess

Assess reasons why the patient needed emergency care. Review the outcome of the emergency visit and any changes made to the treatment plan. Best practice is to schedule a follow-up visit within 7 days, and no later than 30 days, after an emergency visit.

Educate

Educate your patients on where they can get routine and urgent care. Every Aetna® plan has a member portal that provides information on benefits, medical topics and behavioral health topics. When your patients know where to go, they may be able to prevent future emergency visits.

Support

You can offer follow-up visits in person or by telehealth as a way to support your patients. Depending on their care needs, telemedicine can be a convenient alternative. Their Aetna® plan may also offer medical and behavioral health support programs to supplement their care. Steer members to their plan's member portal for details.

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, 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

In July, we sent MA participating providers a training and attestation notice to the compliance email address(es) identified in your 2023 attestation. If we did not have your email address or if the email bounced, we sent a postcard reminding you to complete your attestation (and MOC training, if applicable) by October 31, 2024.

Note: The attestation you received is based on your contracted MA plans.

Our training materials

Training materials and attestations can be reviewed and completed 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**.

Advance Beneficiary Notice of Noncoverage (ABN) documents and the organization determination (OD) notice of denial

ABN documents

Providers should be aware that an ABN document is not a valid denial notice for a Medicare Advantage member. The Original Medicare program uses ABN documents — sometimes called “waivers.” But you can’t use them for patients in Aetna Medicare Advantage plans, since the Centers for Medicare & Medicaid Services (CMS) prohibits them.
What Aetna Medicare Advantage plans cover

Providers in the Medicare program should know which services Original Medicare covers and those it does not.

Aetna Medicare Advantage plans must cover everything Original Medicare does. In some cases, they may provide coverage that is more generous or benefits that go beyond what's covered by Original Medicare. We urge you to call us to verify coverage or for answers to other questions you might have.

Organization determination (OD) notice of denial

Providers in Medicare Advantage plans can't charge a Medicare Advantage member for a service not covered under their plan unless that member gets a preservice OD notice of denial from us before getting such services. If the member does not have a preservice OD notice of denial from us, you must hold the member harmless for the noncovered services. You can't charge them any amount beyond the normal copayments, coinsurance and deductibles.

If a service is never covered under Original Medicare or is a clear exclusion in the plan documents, a preservice OD isn't needed. You may hold the member financially liable for such noncovered services. Note that services or supplies that are not medically necessary or are not covered in the clinical criteria are not "clear exclusions." In such cases, the member isn't likely to know if a service is medically necessary.

You or the member can initiate an OD notice of denial. This will help determine if the member has coverage for a service before they receive care. This will also help everyone know the status of benefits before setting up a lab or diagnostic test.

You'll be able to hold an Aetna® Medicare member financially responsible for a noncovered service only if:

- A service or supply is never covered under Original Medicare
- The member has a preservice OD notice of denial from Aetna and decides to proceed with the service knowing they will have to pay the full cost

Keep your data updated in NPPES

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

Use the National Plan and Provider Enumeration System (NPPES) to correct your data and improve provider directory accuracy.

CMS suggests updating NPPES

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

data up to date.

For more information, refer to this **frequently asked questions document (PDF)**.

How do Medicare members view your office profile?

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

Updating your information is easy

Simply log in to our **provider portal on Availity**.* Navigate to My Providers and then to Provider Data Management.

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

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

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

Medicare Advantage — billing

This is a reminder to bill us the same way you bill traditional Medicare.

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