December 2023

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

Your Boeing Medicare patients may have a new Aetna® plan in 2024

The new plan is the Aetna Medicare℠ Plan (PPO) with ESA.

Find out about this plan, how to identify patients and how to access electronic transaction functions on Availity®.

Telemedicine coverage clarification

Our previously announced coverage changes apply only to self-insured commercial plans, and certain behavioral health codes will continue to be covered after December 1, 2023.

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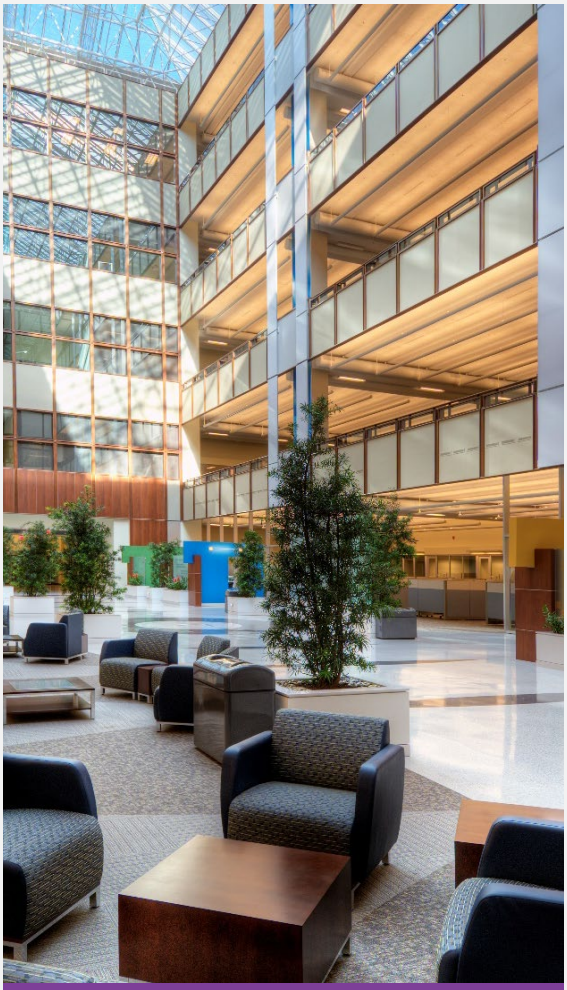

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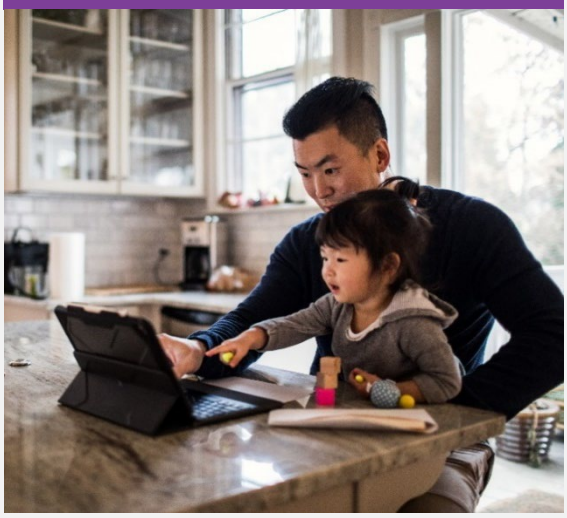

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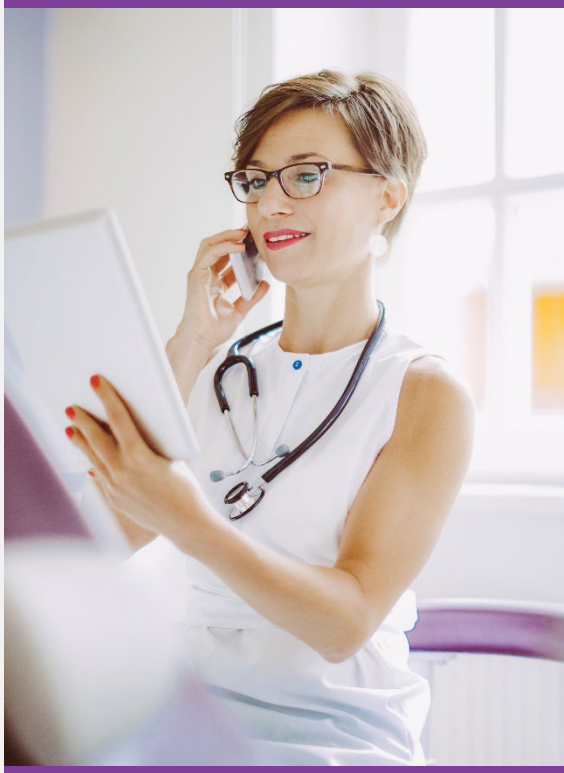

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90-day notices and related reminders

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.

Assistant surgeon services update

Starting March 1, we will not allow an assistant surgeon to perform procedures included in code 38900.

This update applies to both our commercial and Medicare members, and to both commercial and participating Medicare Advantage (MA) claims.

What's changing

Starting on March 1, 2024, we will not allow an assistant surgeon to perform procedures included in code 38900. That code is for intraoperative identification (for example, mapping) of sentinel lymph nodes and includes injection of non-radioactive dye, if needed.

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

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

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 March 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 **Availity provider portal**.*

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

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

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

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

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

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

Evaluations billed with G2082 or G2083

This update applies to both our commercial and Medicare members.

CPT® codes* G2082 and G2083 include the evaluation with the administered drug. Aetna® will no longer reimburse CPT codes 99212–99215 or 99415–99417 when billed with code G2082 or G2083 on the same date of service by the same provider. Modifier 25 will not override this edit.

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

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

Code H2034 update

This update applies to our commercial members.

CPT® code* H2034 is used for alcohol and/or drug abuse halfway house services, per diem.

Starting March 1, 2024, we will no longer consider code H2034 to be a covered medical service. This change aligns us with Medicare.

*CPT® is a registered trademark of the American Medical Association. 2022 All rights reserved.

NCCI for outpatient facility

This update applies to both our commercial and Medicare members.

The National Correct Coding Initiative (NCCI) is a collection of edits created by the Centers for Medicare & Medicaid Services (CMS). NCCI edits are for services performed by the same provider on the same date of service only.

Note that we are updating and adding additional edits based on the NCCI policy to the Hospital Outpatient PPS in the Outpatient Code Editor.

Co-surgeon services coding update

This update applies to both our commercial and Medicare members.

Co-surgeon services should be reported with modifier 62. Effective March 1, 2024, when we allow an eligible surgical procedure submitted with modifier 62, and a second provider submits for the same procedure code on the same date of service without modifier 62, we will consider that second provider's service to be a co-surgeon service and allow it at 62.5% of the eligible rate. The combined allowed amount is 125% of the eligible rate.

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

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

Immunization and vaccine coding update

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

What's changing

The codes below will be assigned a monetary value, effective March 1, 2024.

This update applies to all contracts with the Immunizations and Vaccines Contract Service Grouping.

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

How to reach us

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

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

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

Changes to commercial drug lists begin on April 1

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

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

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

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

More information

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

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

Important pharmacy updates

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

Medicare

Visit our **Medicare drug list** 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 Employees Health Benefits (FEHB) Plan** website to view the most current formularies (drug lists).

Telemedicine coverage clarification

In the **September 2023 issue of OLU**, we ran an article titled "Telemedicine: coverage ending for certain services." We indicated that we were not going to cover some telehealth codes/modifiers starting on December 1, 2023.

How this change applies to fully insured commercial plans

The policy change does not apply to fully insured commercial plans in any of the 50 states.

How this change applies to self-insured commercial plans

The audio-visual behavioral health codes previously identified in Availity® will continue to be covered.

Check the **Availity provider portal*** for the remaining procedures/modifiers that we will not cover after December 1, 2023. Go to Aetna Payer Space > Resources > Claim Resources > Telemedicine liberalized codes no longer covered effective 12.1.23.

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

State-specific updates

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

GEHA will cease accessing the Aetna® National PPO network

Currently, GEHA members in certain states access the network via Aetna Signature Administrators®

Note: This article applies to the following states: Alaska, Arizona, Colorado, Connecticut, Georgia, Kentucky, Maine, Massachusetts, Michigan, Nevada, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont and Washington.

What is the Government Employees Health Association (GEHA)?

GEHA is a self-insured, not-for-profit association providing medical and dental plans to federal employees and retirees and their families through the Federal Employee Health Benefits (FEHB) program and the Federal Employees Dental and Vision Insurance Program (FEDVIP).

What's changing?

GEHA members residing in your state currently access the Open Choice® PPO national network via Aetna Signature Administrators.* This national access will cease on January 1, 2024.

Questions

Please contact your local Aetna network representative or visit **GEHA**.

*Aetna Signature Administrators® is the brand name for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

Aetna® to enter the individual exchange market in five new states

Note: This article applies to the following states: Indiana, Kansas, Maryland, Ohio and Utah

We're expanding! Indiana, Kansas, Maryland, Ohio and Utah will see the new Aetna CVS Health® Affordable Care Act (ACA) insurance product (subject to regulatory approval) on

the individual exchange market starting January 1, 2024. Look for “QHP” (qualified health plan) on member ID cards.

Today, our ACA exchange membership has access to our provider networks in Arizona, California, Delaware, Florida, Georgia, Illinois, Missouri, Nevada, New Jersey, North Carolina, Texas and Virginia.

Welcome our new members by checking your participation status

- If you practice in California, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Maryland, Missouri, Nevada, New Jersey, North Carolina, Ohio, Texas or Utah, go to the **Aetna CVS Health provider directory** to check your status.

- If you practice in Arizona, go to the **Banner Aetna directory** to check your participation status in the Banner|Aetna Performance Network.

- If you are an Aetna provider in Virginia, go to the **Aetna CVS Health provider directory** to check your status. If you are an Innovation Health provider in Northern Virginia, you can check the **Innovation Health provider directory**.

Questions?

If you have questions, please **refer to our FAQs** or visit the **Contact Aetna** page. Use the “non-Medicare plans” number under the “By phone” tab.

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

In 2024, we’ll introduce a new I-SNP plan in certain counties

Find out which counties and whether or not you participate in the new Aetna Medicare Longevity Plan.

Note: This article applies to New York, Ohio and Pennsylvania

What are Institutional Special Needs Plans (I-SNPs)?

I-SNPs cover people who live in a long-term-care facility. These plans offer benefits tailored to the unique medical, social and emotional needs of members who are long-term residents (90 days or longer) in one of the following:

- A long-term-care skilled-nursing facility
- A long-term-care nursing facility

- A skilled-nursing facility/nursing facility

Participation

Medicare providers who practice in the counties listed below are already enrolled in the I-SNP network. Other providers in the counties listed below will need to enroll in our I-SNP network.

Enrollment

You can join the Aetna Medicare Longevity Plan in two ways:

- Ask the facility's social worker to set up an appointment with a sales representative.
- Call **1-833-217-9081 (TTY: 711)**.

Applicable counties

- **New York:** Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Genesee, Herkimer, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Orange, Orleans, Otsego, Rensselaer, Rockland, St. Lawrence, Steuben, Wayne

- **Ohio:** Butler, Clermont, Clinton, Delaware, Franklin, Fulton, Hamilton, Lucas, Madison, Ottawa, Pickaway, Union, Warren, Wood

- **Pennsylvania (all counties):** Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Bucks, Butler, Cambria, Cameron, Carbon, Centre, Chester, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Delaware, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, Mckean, Mercer, Mifflin, Monroe, Montgomery, Montour, Northampton, Northumberland, Perry, Philadelphia, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Washington, Wayne, Westmoreland, Wyoming, York

Required Centers for Medicare & Medicaid Services (CMS) training

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

How to reach us

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

A must-pass medical records audit to come in April 2024

Prepare your office in case it is randomly chosen.

Note: This article applies to Florida and Pennsylvania.

In April 2024, Florida and Pennsylvania state regulatory requirements and National Committee for Quality Assurance (NCQA) will audit medical records to assess for compliance.

Your contract with Aetna® requires you to participate in quality improvement activities, which include supplying copies of medical records. If you are chosen for the audit, you should send all of the following records for the time frame of April 1, 2023, through March 31, 2024.

- Face sheet/demographics
- Problem lists
- Lists of allergies and adverse reactions
- Past medical history, including diagnosis
- Progress/visit notes
- Treatment plan
- Consult letters/discharge summaries
- Lab and X-ray reports

Please fax or email records within 14 days of the request. If your practice uses a copy service, it should provide timely record submission.

Hospice VBID timely submission reminder

Remember to submit hospice notices within five days and to submit claims in accordance with contract timeliness requirements.

Note: This article applies to Ohio and Pennsylvania.

Aetna® will continue participating in the Hospice Value-Based Insurance Design (VBID) model on select plans in Ohio and Pennsylvania in 2024. Through the Hospice VBID model, Aetna is responsible for full medical coverage, including the Part A Hospice benefit for members in the following participating plans:

- Ohio
    - H0628-001 — Aetna Medicare Premier (HMO-POS)
    - H0628-005 — Aetna Medicare Premier (HMO-POS)
    - H0628-017 — Aetna Medicare Premier (HMO-POS)

- Pennsylvania
    - H3959-046 — Aetna Medicare Advantra Washington Prime (HMO)

- H3959-047 — Aetna Medicare Advantra Butler Prime (HMO)
- H3959-049 — Aetna Medicare Advantra Excela Prime (HMO-POS)
- H3959-051 — Aetna Medicare Beaver Valley Prime (HMO)

Timely notice submission

Notices of Election (NOE) and Notices of Termination/Revocation (NOTR) must be submitted within five days of the election, termination, or revocation, in accordance with Original Medicare (OM) timelines. Notices must be submitted to both Aetna and your Medicare Administrative Contractor (MAC) as follows:

- Aetna Preferred Hospice VBID providers: Submit notices through the established Teams process.
- All other providers (in network or out of network): Send notices via secure email to **Medicare direct referrals**.

Timely claims filing

Claims must be submitted to both Aetna and your MAC. Aetna will process payment, and your MAC will process the notices and claims for the Centers for Medicare & Medicaid Services (CMS) to monitor. All in-network providers must submit claims according to the timely filing requirement in your Aetna contract, or else claims will be denied.

Questions?

Visit our **Contact Aetna** page. Use the "Medicare medical and dental plans" phone number under the "By phone" tab.

Colorado providers — notice of material change to contract

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

Maine: You must provide certain dental services for cancer patients

A new Maine law, which goes into effect on January 1, 2024, states that health insurance carriers must cover, when medically necessary, certain dental services for plan enrollees who have been diagnosed with cancer. This law applies only to fully insured plan sponsors.

Oral care providers, including dentists and oral surgeons, should submit claims as they normally do and include a cancer diagnosis.

More details

For the full language of the statute, see **24-A MRSA Section 4320-S**, coverage for dental services for cancer patients.

Questions

If you need assistance with processing your claim, please contact the Aetna Oral Surgery Unit at **1-800-531-7895 (TTY: 711)**.

Massachusetts: Get help for members waiting too long for psychiatric hospitalization

A recent protocol allows you to ask Aetna® for help and bill for additional charges.

Every day, Massachusetts members wait too long in hospital emergency departments for inpatient psychiatric hospitalization (this is known as “ER boarding”). Various Massachusetts government offices are committed to addressing this ongoing crisis.

A recently enacted protocol identifies and resolves barriers to psychiatric admission. It establishes how to escalate cases to senior clinical leadership at insurance carriers, inpatient psychiatric units and ultimately to the Massachusetts Department of Mental Health.

How to escalate cases

If it is taking you longer than 24 hours to place a member for inpatient psychiatric hospitalization (the member must be enrolled in a fully insured plan with a contract state of Massachusetts and you must be located in Massachusetts), you can request bed-placement assistance from Aetna by contacting your Aetna representative. If you don’t have a representative, you can email **Dr. Karey Ponist**.

Billing

You will receive your normal reimbursement rate for the ER hold. You can bill for additional related charges by using CPT® code S9485* (reimbursement rate of $506 per day).

Questions?

If you have questions, visit our **Contact Aetna** page. Use the “Non-Medicare plans” phone number.

Massachusetts: Two Aetna® Medicare plans allow members to pay for medical expenses using the Aetna® Medicare Payment Card

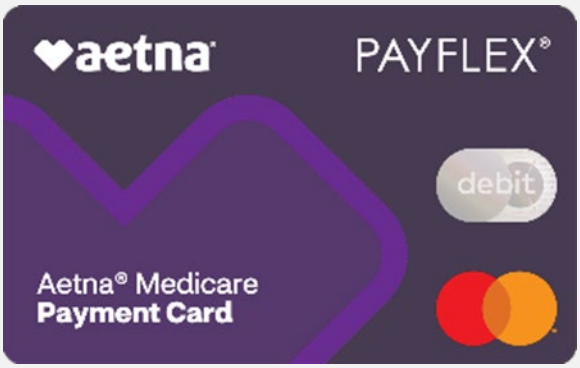
Find out what the card is and how your patients will use it.

Effective January 1, 2024, members enrolled in the following two Massachusetts plans will get an Aetna Medicare Payment Card (PayFlex®) with a Medical Expense Wallet to use toward out-of-pocket medical costs:

- Eastern Massachusetts: Aetna Medicare Discover Plan (PPO) H5521-451
- Central Massachusetts: Aetna Medicare Discover Plan (PPO) H5521-450

What is the Aetna Medicare Payment Card?

It is a preloaded Mastercard® with a Medical Expense Wallet that members can use toward out-of-pocket medical costs, including copays or cost shares, for plan-covered medical expenses. The benefit (allowance) amount renews quarterly, and unused allowance amounts do not roll over.



How do members activate the card?

Members need to activate their card before they can use it. To activate, call **1-877-261-9951 (TTY: 711)**.

They will also receive a personal identification number (PIN) when activating their card.

How do members use the card to pay?

Members can use the card at provider offices that accept Mastercard. They can select “credit” or “debit” when checking out. If they select “debit,” they will need to enter their PIN.

If the member’s purchase is greater than the allowance amount, the member can ask for the card to be swiped for the exact balance amount, and then pay the remaining balance with

an alternate form of payment. Or the member can pay for the whole purchase with an alternate form of payment and submit a reimbursement request.

How do members manage their card through PayFlex?

Members can see their benefits amounts and check their card balance in three key ways:

- By phone
- Online at **PayFlex.com**
- The PayFlex Mobile® App

PayFlex® and PayFlex Mobile® are registered trademarks of PayFlex Systems USA, Inc. MasterCard® is a registered trademark of MasterCard International Incorporated.

New Jersey: Take a brief survey to understand how to best help your Aetna® Assure Premier Plus dual-eligible members

The Aetna Assure Premier Plus plan

Dual-eligible members of the Aetna Assure Premier Plus (HMO DSNP) plan are in a special type of Medicare Advantage Plan — one that provides both Medicare and Medicaid health benefits. If your practice provides Medicare-covered services, you are already able to see our members.

About the special needs survey

Aetna Assure Premier Plus (HMO DSNP) members have unique conditions that require providers to be attentive to their special needs. The survey is meant to help you gauge your current patients' special needs and your experience in treating them. It will also help you understand your practice's ability to handle new special needs members and how accessible and available you are to them.

How to take the survey

Simply complete the **Special Needs Provider Survey form (PDF)** and return it to your provider liaison or to Aetna Assure Premier Plus's **provider mailbox**. If you need assistance completing the survey or if you have any questions about our membership or the plan, please feel free to call Aetna Assure Premier Plus's provider services line at **1-844-362-0934 (TTY: 711)**.

North Carolina: We're getting ready for the North Carolina State Health Plan

The first step is for you to join the Clear Pricing Project (CPP) by May 31, 2024.

Aetna® will be the new third-party administrator for the North Carolina State Health Plan beginning January 1, 2025. Open enrollment begins in the fall of 2024, which is when members will select a primary care provider (PCP).

You can get ready by following these steps:

Step 1: Join the Clear Pricing Project (CPP)

Join the CPP by May 31, 2024. If you're a current CPP provider, you will need to re-enroll in the CPP with Aetna. Visit **North Carolina State Health Plan** for more information.

Step 2: Make sure your provider profile information is accurate and up to date

Our provider search tools play a key role in connecting members with providers. Ensure that your information is correct and available to our members when they need care.

You can follow along with our **quick reference guide (PDF)** to make essential updates in the Provider Data Management (PDM) tool on our **Availity provider portal**.*

If your practice is new to Availity, you can **register** to set up your account. If you're unable to use Availity, go to our **Update Your Provider Data** page.

Step 3: Credential mid-level primary care providers

If you'd like members to be able to select nurse practitioners and physician assistants as their PCPs, you need to credential them with Aetna. You can do this by visiting our **Join Our Network** page. In the "I am joining" drop-down menu, select "a provider applying under a SSN or TaxID/EIN that is currently participating with Aetna."

Questions?

Send an email message to the **Aetna Network Management staff** or call us at **1-800-353-1232 (TTY: 711)** during normal business hours.

To stay informed and keep in better touch with us, **sign up for email communications**.

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

Washington: New regulatory provision about telemedicine appointments

There's a new regulatory provision in your contract's WA State Compliance addendum.

We mailed a regulatory amendment to your Washington State Compliance Addendum on July 17, 2023. Washington State Senate Bill 5036 prompted an additional change to the regulatory amendment to your contract (see RCW 48.43.735(9)(d)(ii)(A) and (B)). That change became effective as of July 23, 2023.

The change requires extending the date by which an interactive telemedicine appointment using both audio and visual video technology may substitute for an in-person appointment to establish a patient relationship for telemedicine from January 1, 2024, to July 1, 2024.

News for you

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

New provider onboarding webinar for providers and their staff

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

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

We'll show you how to:

- Locate provider manuals, clinical policy bulletins and payment policies
- Access online transactions such as those related 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, 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, Texas Health Aetna, and Innovation Health.

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

What's in the manual

The manual contains information on the following:

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

Earn a new Care Champion badge for your provider profile

Visit our new health equity hub to get trained.

At Aetna®, we're committed to health equity and believe everyone should have a fair and just opportunity to be as healthy as possible.

New courses available

We've created a new **clinical educational hub** for health care professionals. The hub, which includes courses, addresses health equity and related topics. The courses are meant to help care teams reduce the barriers that underserved and marginalized patients experience. The hub can help empower you with the skills, knowledge and tools you need for everyday interactions with patients.

Start training today

You can access the on-demand, free, accredited courses to earn digital Care Champion badges for your provider profile in three clinical areas of focus:

- **Culturally responsive care**
- **LGBTQ+ responsive care**
- **Culturally responsive PCP behavioral health care**

To earn a badge, you'll need to:

- Complete the foundational activity course
- Complete a role-specific course
- Complete the therapeutic-area-specific courses

Your digital Care Champion badge will be added to your profile and be visible to Aetna members in our provider directories.

Prudential employees will access the Aetna Signature Administrators® PPO network starting January 1, 2024

Current billing and eligibility verification processes will also change.

Starting January 1, Prudential employees and their dependents will access the Aetna® Open Choice® PPO network nationally via Aetna Signature Administrators®.* Currently, they access the Cigna Healthcare network.

Be sure to follow instructions on Prudential members' ID cards to ensure proper billing and eligibility verification, since current processes will change as of January 1.

WebTPA serves as the third-party administrator for Prudential's health plan. WebTPA is a third-party administrator or health care to health systems, self-funded employers and insurance carriers.

*Aetna Signature Administrators® is the brand name for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

Now available: Use our virtual assistant to check precertification requirements

By calling the phone numbers you already use, you can get details about the requirements.

In our last issue, we **introduced our new virtual assistant** (see page 26) to help you check precertification status. We're pleased to announce that you can now use the virtual assistant to check if precertification is required.

How to check precertification requirements by patient

Just call any Provider Services telephone number you already use. When asked, say "precert," then "check if precertification is required." The virtual assistant will ask you:

- For the patient's ID number and date of birth
- Whether the service will be performed in an outpatient setting
- For the National Provider Identifiers (NPIs) of the servicing provider and facility (if applicable)
- The expected date of service (if known)
- Procedure and diagnosis codes (if known)

Because you're inquiring about services for a specific patient, our virtual assistant will tell you whether precertification is required according to that patient's plan. It'll even tell you whether services are handled by another organization and give you their telephone number. And as with the precertification status check function, you can check whether precertification is required for multiple patients in the same call.

Our virtual assistant is one of the ways we're making it easier to do business with us. Check precertification status or if precertification is required at your convenience, without waiting on hold to talk to someone. Get the answers you need and quickly get back to your day.

Now you can send electronic claims attachments using a new secure solution

Get paid faster and save money by submitting claims attachments electronically.

We're ready to receive your electronic claims attachments using the X12N 275 transaction. We recently began working with **Passport**, in addition to **Change Healthcare**, **Waystar**, **PNT Data** and **SSI**. If you submit claims through any of these vendors, contact them to find out how to send supporting documents to us online.

Not sure if your claims go through one of these vendors?

Ask your vendor if they use one of these companies. If not, check out our **vendor list** and look for "Claim Attachments" in the "Transactions Available" column. Check back periodically because we update the list every time a new vendor is ready.

Why send claim attachments electronically?

You can:

- Get paid faster
- Track the attachments
- Get protection for personal health information (PHI)
- Save on mailing, printing and labor costs related to paper mail

Are you interested in digital prior authorizations (PAs)?

If you're interested in getting PA notices online, reach out to your vendor. We'll let you know when digital PAs become available.

How to contact us about utilization management (UM) issues

Our staff members, including medical directors, are available 24 hours a day to answer your UM questions. You can call us during and after business hours.

During business hours

Health care providers and staff may contact Aetna® during normal business hours (8 AM to 5 PM, Monday through Friday) by calling the toll-free precertification number on the

member ID card. When only a Members Services number is on the card, you'll be directed to the Precertification Unit through a phone prompt or a Member Services representative.

After business hours

You can reach us in various ways.

- Visit our **Contact Aetna** page.
- If you have a question about a member covered by a commercial plan, call the Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** and choose precertification.
- If you have a question about a member covered by a Medicare plan, call the Provider Contact Center at **1-800-624-0756 (TTY: 711)** and choose precertification.
- Call the patient management and precertification staff using the Member Services number on the member's ID card.

Documentation tips for pediatric respiratory illnesses

Use these tips for documenting cases of flu, RSV and croup.

Influenza

Flu is a highly contagious respiratory disease caused by any of several viruses that cause annual outbreaks of varying severity. Symptoms include sudden fever, extreme fatigue, coughing, chills and muscle aches. It can also cause serious complications, including pneumonia.

How to document:

- Document only confirmed cases of influenza, and document the identified virus if possible.
- In the treatment plan, document any diagnostic tests and results as well as the date of any follow-up appointments.

Respiratory syncytial virus (RSV)

RSV infects the lungs and breathing passages. In healthy people, symptoms of RSV are usually mild and will resolve in a week. But RSV can cause serious illness or death in vulnerable individuals like premature and very young children with chronic lung disease, a weakened immune system, or neuromuscular disorders (especially if they include difficulty swallowing or clearing mucous).

RSV is the most common cause of bronchiolitis in children younger than 1 year old and causes approximately 58,000 to 80,000 hospitalizations annually among children. Early

symptoms of RSV are runny nose, decreased appetite, and a cough that may progress to wheezing or difficulty breathing. In young infants, RSV might present as irritability, decreased activity, decreased appetite, or apnea (pauses in breathing for more than 10 seconds). Fever may not always occur.

How to document:

- Document the presence and/or absence of any current symptoms associated with RSV.
- Document a clear and concise treatment plan that includes linking of medications when appropriate, referrals or consultations, diagnostic tests, any follow-up visits.

Croup

Croup is an inflammation of the larynx and trachea. It causes difficulty breathing, a barking cough and hoarse voice. The cause is usually viral but could also be allergies or reflux. Croup will usually start out as a cold, but the trachea and larynx become swollen, which causes the hoarseness and cough. There can also be fever and stridor when breathing. In rare cases, croup can be serious and interfere with a child's breathing.

How to document:

- Document the current symptoms and their duration.
- Document a clear and concise treatment plan that includes, when appropriate, linking of medications, referrals or consultations, diagnostic tests, and when the patient is to be seen again.

Update to Timely Notification of Hospital Admissions Payment Policy

Beginning December 1, 2023, notify us of all inpatient admissions, including those through the emergency department, within two business days of the admission.

What's changing

Based on the UM Reimagined Initiative, we are updating our Timely Notification of Hospital Admissions Payment Policy.

Currently, our policy states that acute medical-surgical hospitals must notify us of all inpatient admissions within one business day of the admission. We are extending this time frame to 2 business days with an effective date of December 1, 2023.

Additional information

Hospital inpatient admissions require precertification by the hospital. The timely notification policy and all Aetna® payment policies can be found on our **Availity provider portal**.* You can also visit our **Contact Aetna** page.

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

Somatic tumor profiling made simpler

Use Aetna® preferred labs for better service and quality.

When you use preferred labs for covered services, your patients get quality, cost-effective testing. Our preferred lab network offers comprehensive tissue and liquid testing options, such as:

- Tumor profiling
- Liquid biopsy
- Tumor Mutational Burden (TMB) testing
- Microsatellite Instability (MSI) testing
- Homologous Recombination Deficiency (HRD) testing

How to determine coverage

For Medicare members, applicable **National Coverage Determinations** or **Local Coverage Determinations** outline what services we cover.

For commercial plan members, you can consult the following **Clinical Policy Bulletins (CPBs)** to find out what services we cover:

- CPB #0352 Tumor Markers
- CPB #0715 Pharmacogenetic and Pharmacodynamic Testing

Aetna's preferred labs

Aetna's national somatic tumor profiling network labs are:*

- **Quest Diagnostics**
- **Labcorp**
- **BioReference Health, LLC/GenPath**
- **Tempus**
- **NeoGenomics**

*All trademarks and logos are the intellectual property of their respective owners.

Updates to official notice addresses

Over this past year, we have been migrating several of our office-based Provider Notice addresses to a specific PO box as we move to a digital mail system.

If you have been using any of the following old addresses, please start using the new address on January 1, 2024.

Old California addresses

Old address: Woodland Hills, CA 21255 Burbank Blvd
New address: PO BOX 818090 CLEVELAND OH 44181-8090

Old address: Fresno, CA 1385 East Shaw Ave
New address: PO BOX 818012 CLEVELAND OH 44181-8012

Old address: Concord, CA 1401 Willow Pass Rd
New address: PO BOX 818024 CLEVELAND OH 44181-8024

Old Connecticut address

Old address: Hartford, CT 151 Farmington Ave
New address: PO Box 818048 CLEVELAND OH 44181-8048

Old Delaware address

Old address: Newark, DE 750 Prides Crossing
New address: PO BOX 818086 CLEVELAND OH 44181-8086

Old Florida addresses

Old address: Jacksonville, FL 9000 Southside Blvd
New address: PO BOX 818099 CLEVELAND OH 44181-8099

Old address: Tampa, FL 4630 Woodland Corporate Blvd
New address: PO BOX 818088 CLEVELAND OH 44181-8088

Old address: Plantation, FL 261 North University Dr
New address: PO Box 818043 CLEVELAND OH 44181-8043

Old Georgia address

Old address: Atlanta, GA 2000 Riveredge Pkwy
New address: PO BOX 818000 CLEVELAND OH 44181-8000

Old Illinois addresses

Old address: Chicago, IL 333 West Wacker Dr
New address: PO BOX 818030 CLEVELAND OH 44181-8030

Old address: Downers Grove, IL 3200 Highland Ave
New address: PO BOX 818031 CLEVELAND OH 44181-8031

Old Kansas address

Old address: Overland Park, KS 9401 Indian Creek Pkwy Ste 1300
New address: PO BOX 818045 CLEVELAND OH 44181-8045

Old Missouri address

Old address: St. Louis, MO 1285 Fern Ridge Pkwy
New address: PO BOX 818093 CLEVELAND OH 44181-8093

Old Nebraska address

Old address: Omaha, NE 11819 Main St
New address: PO BOX 818038 CLEVELAND OH 44181-8038

Old New Jersey address

Old address: Parsippany, NJ 9 Entin Rd
New address: PO BOX 818092 CLEVELAND OH 44181-8092

Old New York address

Old address: New York, NY 101 Park Ave
New address: PO BOX 818089 CLEVELAND OH 44181-8089

Old North Carolina address

Old address: High Point, NC 4050 Piedmont Pkwy
New address: PO BOX 818013 CLEVELAND OH 44181-8013

Old Ohio addresses

Old address: New Albany, OH 6005 Nacot Pl
New address: PO BOX 818086 CLEVELAND OH 44181-8086

Old address: New Albany, OH 7400 W. Campus Rd
New address: PO Box 818051 CLEVELAND OH 44181-8051

Old Pennsylvania addresses

Old address: Bethlehem, PA 1015A Club Ave
New address: PO Box 818023 CLEVELAND OH 44181-8023

Old address: Blue Bell, PA 1425 Union Meeting Rd
New address: PO Box 818047 CLEVELAND OH 44181-8047

Old Texas addresses

Old address: Houston, TX 14955 Heathrow Forest Pkwy
New address: PO BOX 818026 CLEVELAND OH 44181-8026

Old address: Arlington, TX 4300 Centreway Pl
New address: PO BOX 818091 CLEVELAND OH 44181-8091

Old address: Irving, TX 750 W. John Carpenter Fwy. Ste. 1200
New address: PO BOX 818042 CLEVELAND OH 44181-8042

Old Utah address

Old address: Sandy, UT 10150 South Centennial Pkwy
New address: PO BOX 818087 CLEVELAND OH 44181-8087

Old Virginia address

Old address: Richmond, VA 9881 Mayland Dr
New address: PO Box 818044 CLEVELAND OH 44181-8044

Behavioral health

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

New appointment wait time standards coming in January 2024

You will be required to have appointments available, in person or via telemedicine, within the time frames shown here.

To meet Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) requirements, we are updating our appointment wait time standards for primary care physicians (PCPs) and behavioral health providers.

We will regularly monitor timely access to care to ensure compliance with these standards, and we will take corrective action, as necessary.

What are the new requirements?

You will be required to have appointments available, in person or via telemedicine, within these time frames:

New appointment wait time standards ("access to care")	Primary care physicians (PCPs)	Behavioral health (BH) providers
Emergency and urgently needed services	Immediately (or referred to the emergency room, as appropriate)	Immediately (or referred to the emergency room, urgent care/crisis center, as appropriate)
Non-emergency/Non-urgent; but requires medical attention	Within 7 business days	Within 7 business days
Routine and preventive care	Within 30 business days	Within 10 business days
Follow-up care	As appropriate, if needed	• Non-prescribers of medication: within 3 weeks • Prescribers of medication: within 5 weeks
24/7 answering service	Must have reliable 24 hours per day, 7 days per week (24/7) answering service or machine with notification system for call backs. • PCPs must have appropriate backup for absences. • A recorded message or answering service that refers members to emergency rooms is not acceptable.	Must have a reliable live answering service or voicemail system in place 24 hours per day, 7 days per week (24/7). • Prescribing providers are required to have a designated provider backup and/or an answering service and/or a machine with a beeper/paging system in place 24/7. • Non-prescribing providers are required to have a voicemail greeting which provides contact information for a licensed BH provider who is available 24/7;

		and/or direction to go to the nearest emergency department; and/or direction to call 911/988 in a crisis.

Note: State requirements supersede the above standards and are in the **Provider Manual State Supplement (PDF)**.

Participation criteria

You can find our participation criteria in our **Provider and Facility Participation Criteria handbook (PDF)**.

Definitions

Emergency and urgently needed services (emergency medical/behavioral health services)

A medical emergency/urgently needed service is when a prudent layperson with an average knowledge of health and medicine believes that they have medical symptoms that require immediate medical attention to:

- Prevent loss of life (or for pregnant women, loss of an unborn child), loss or loss of function of a limb, or serious impairment to a bodily function.
- Address worsening medical symptoms of an illness, injury, severe pain, or a medical condition (such as acute suicidality) in order to prevent death or serious harm to the member or others.

Non-emergency/Non-urgent; but requires medical attention

Non-emergency care is care for non-urgent conditions that, if not treated, may pose minimal risk of immediate harm. Examples: strep throat, pink eye, rash, sprains and strains or worsening major depression.

Routine and preventive care

Routine care is used in a clinical situation that is sufficiently stable and does not have a negative impact on the member's condition. Examples: blood pressure checks and anxiety disorders.

Follow-up care

Follow-up care provides an opportunity to address unresolved concerns, respond to symptoms that remain or have worsened (even after treatment), review additional testing and confirm or change diagnosis. It can also be for routine monitoring of any specific

chronic medical condition, such as high blood pressure, diabetes, bipolar disorder or depression.

Aetna® medical necessity criteria decoded

Read on to find out how we make utilization management decisions.

Our behavioral health programs support our belief in enhancing our members' clinical experiences. We believe in providing a treatment approach that is:

- Evidence-based
- Goal-directed
- Consistent with accepted standards of care, Aetna Clinical Policy Bulletins (CPBs), and Aetna clinical practice guidelines

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

Criteria and guidelines

Note that some states may mandate the use of other criteria or guidelines.

- **Aetna CPBs**

  Our CPBs explain the medical, dental and pharmacy services we may or may not cover. They are based on objective, credible sources, such as scientific literature, guidelines, consensus statements and expert opinions.

- **Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, Local Coverage Determinations and the Medicare Benefit Policy Manual**

  CMS National Coverage Determinations outline whether a specific medical service, procedure or device is covered or not covered. These determinations are usually issued as a program instruction.

  CMS creates these guidelines through an evidence-based process that includes opportunities for public participation. In some cases, CMS supplements its own research with an outside technology assessment and/or consultation with the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC).

- ***The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition* (2013)**

This book, developed by the American Society of Addiction Medicine (ASAM), collects objective guidelines that give clinicians a way to standardize treatment planning and patient placement. It also helps clinicians provide continuing, integrated care and ongoing service planning.

ASAM consists of renowned doctors and professionals working in a variety of mental health and addiction treatment fields. The ASAM Criteria book has become the most widely used set of criteria in the United States for the treatment of substance use disorders, and it has been continually revised and updated over the years with the newest science in the field of addiction.

- **Applied Behavior Analysis (ABA) Medical Necessity Guide**

  The ABA Medical Necessity Guide helps clinicians determine the appropriate levels and types of services that are medically necessary for a patient. It can help you with the coverage determination process.

- **LOCUS® and CALOCUS/CASII®**

  As of 2021, Aetna began using the Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS/CASII) for its medical necessity reviews. These replaced the Level of Care Assessment Tool (LOCAT) for behavioral health reviews. These person-centered approaches aim to best match individual needs with the appropriate behavioral health services. LOCUS and CALOCUS/CASII help identify the array of services that best meet the needs of a population.

Sharing information can lead to better care

Coordinating care among all providers helps patients get what they need.

Sharing information helps patients get better care and eases their transitions between health care settings. It ensures that providers can use the patient's medical history to guide treatment. As a result, the quality of care, safety, and effectiveness of provider recommendations can improve.

Care coordination between behavioral health (BH) and medical providers improves patient care

Care coordination improves patient interactions with the health care system in these ways:

- It eliminates disjointed care by creating the feeling that patients are working with a team focused on their care.

- It provides referral clarity by helping patients schedule appointments and telling them what to expect from a referral.
- It improves care with primary care and BH providers by sharing relevant diagnosis and treatment information to allow for necessary adjustments to treatment plans.
- It prevents information loss by making direct connections between providers to reduce administrative errors or lost information.

HIPAA guidelines related to sharing BH information

- Physicians may disclose Protected Health Information (PHI) (whether orally, on paper, by fax or electronically) for treatment, payment and health care operations without consent or authorization.
- HIPAA treats mental health information the same as other information.
- Health care providers may share any PHI contained in the medical record for treatment, case management, and coordination of care. Examples of mental health information in the medical record and subject to the same HIPAA standards as other PHI 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

Exception: Covered entities must obtain authorization to disclose separately maintained psychotherapy session notes.

You can help improve patient care coordination

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 is necessary.

Care coordination is reimbursable

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

Suicide prevention training and support for primary care practices

Starting again in February, contracted providers can enroll in two Aetna-sponsored programs to get CME and MOC (Maintenance of Certification) 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 an opportunity to participate in a no-cost suicide prevention and quality outcome measure training for our Aetna® contracted providers.

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

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 six one-hour quality-improvement sessions with complimentary MCO credit.

The first 2024 session launches in February.

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 participate in ECHO or learning more?

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

[1] Centers for Disease Control and Prevention. **Suicide prevention**. March 13, 2023. Accessed on September 20, 2023.
[2] Mental Health.gov. **Suicide and suicidal behavior**. August 10, 2023. Accessed on September 20, 2023.

Risk-reducing suicide-specific subspeciality care for youth

You can refer patients for evidence-based suicide interventions as a critical enhancement to your general mental health treatments.

According to the 2021 Centers for Disease Control and Prevention (CDC) youth risk behavior survey data report, more than 40% of high school students felt so sad or hopeless that they could not engage in their regular activities for at least two weeks during the previous year. There was also a significant increase in the percentage of youth who seriously considered suicide, made a suicide plan and attempted suicide.[1] These numbers continue to trend in the wrong direction.

We are 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 is not meant to replace a general behavior therapist or crisis line. Vita Health services are available for teens and young adults and consist of:

- One-on-one teletherapy with a licensed clinician/suicidologist and parental support sessions via weekly telehealth for 12 weeks
- Additional support between sessions with an app tailored specifically for youth

Vita Health services have been proven to be effective. A recent study showed that suicide re-attempts were reduced by up to 60%.[2]

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

An Aetna® member testimonial

Here's what one Aetna 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 the following states: Arizona, California, Colorado, Connecticut, Florida, Illinois, Maryland, Massachusetts, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Virginia, and Washington, with expansion ongoing.

Ask about copay waivers; plan exceptions may apply.

Questions?

Please contact **Aimee Prange**.

[1]Centers for Disease Control and Prevention. **CDC releases the Youth Risk Behavior Survey Data Summary & Trends Report: 2011 to 2021**. February 13, 2023. Accessed on September 20, 2023.
[2]Rudd MD, Bryan CJ, Wertenberger, EG, et al. **Brief cognitive-behavioral therapy effects on post-treatment suicide attempts in a military sample: results of a randomized clinical trial with 2-year follow-up**. American Journal of Psychiatry. February 13, 2015; Volume 172 (Issue 5): 441–449.

Health equity training for primary care physicians: Help meet the unique needs of your patients

Earn Continuing Medical Education (CME) credits at no cost to you and distinguish your practice.

We are proud to partner with **CME Outfitters** to promote mental-health-specific training to primary care physicians to further expand our mission to address health inequities.

CME Outfitters has delivered innovative evidence-based educational activities to medical professionals since 2002. The CME Outfitters training identifies disparities in depression screening and care while integrating equitable depression screening into your clinical practice.

The offerings give you:

- Accredited and culturally relevant training at your convenience
- Flexible learning delivered live or on demand
- Free Continuing Medical Education units (CMEs)

Upon completion of the training, you'll receive a badge that you can display in your office.

Depression screenings are reimbursable

Conducting validated brief emotional and behavioral assessments during each and every patient visit helps ensure that your patients are being seen and heard. You can submit the following codes for reimbursement. The addition of the LOINC codes will help improve health decision making and care.

CPT® code 96127 for conducting brief emotional and behavioral assessments performed with standardized instruments.* This code corresponds to the LOINC codes below.	
Patient Health Questionnaire 9 item (PHQ-9) total score	**LOINC:** 44261-6
Geriatric depression scale (GDS) total	**LOINC:** 48544-1
Geriatric depression scale (GDS) short version total	**LOINC:** 48545-8
Patient Health Questionnaire 2 item (PHQ-2) total score	**LOINC:** 55758-7
CPT® code 96127 for administering screenings, such as the Patient Health Questionnaire (PHQ-9).* You can use it as part of initial screening or as a method of monitoring. This code corresponds to the LOINC codes below.	
Edinburgh Postnatal Depression Scale (EPDS)	**LOINC:** 71354-5
Total score (M3)	**LOINC:** 71777-7
PROMIS-29 Depression score T-score	**LOINC:** 71965-8
Patient Health Questionnaire 9: Modified for Teens total score	**LOINC:** 89204-2
G0444 (annual depression screening for Medicare patients). This code corresponds to the LOINC codes below.	
Center for Epidemiologic Studies Depression Scale — Revised (CESD-R) total score	**LOINC:** 89205-9
Beck Depression Inventory Fast Screen total score (BDI)	**LOINC:** 89208-3
Beck Depression Inventory II total score (BDI)	**LOINC:** 89209-1

Total score (CUDOS)	**LOINC:** 90221-3
Final score (DUKE-AD)	**LOINC:** 90853-3

Stay informed

Watch these pages for information about how to take advantage of our upcoming training and tools in development, in order to support culturally relevant depression screening and follow-up in your practice. We'll keep you updated on our cultural relevancy site (CVS Health® Be Seen, Be Heard™), designed to offer additional resources and support for providers.

New substance use disorder resources web page to help you provide screenings and treatments

Consult our new **resources page** for lots of help with integrating screenings and treatments into your practice.

What you will find on the website

- Substance use disorder screeners to use with patients across their lifespan
- Coding and reimbursement information for substance use disorder screening to simplify billing
- The Aetna® treatment provider directory and substance use disorder vendor partners for referral options
- Educational resources on relevant topics, including a podcast episode featuring two Aetna medical directors discussing practical ways you can help patients with substance use disorder

Why universal screening for substance use disorder matters

- We know that substance use disorder is on the rise in the United States. There are over 46 million Americans age 12 and up diagnosed with a substance use disorder.[1]
- Research has shown that early identification and ongoing screening increases the likelihood of better patient outcomes.[2]

With universal screening, providers can normalize questions about substance use disorder, identify patients at risk for a substance use disorder earlier, and intervene with patients who could benefit from education or a referral for treatment.

[1]American Hospital Association. **Most Americans with substance use disorders don't receive treatment**. January 6, 2023. Accessed on September 20, 2023.
[2]Woodward D, Wilens T, Glantz M, et al. **A systematic review of substance use screening in outpatient behavioral health settings**. Addiction Science & Clinical Practice. March 26, 2023; 18 (18). Accessed on September 21, 2023.

We value your responses to our annual provider surveys

Your feedback helps us help you (and our members).

Thank you once again for giving us essential feedback in our 2023 survey. Our yearly surveys help us:

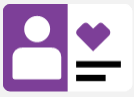
- Monitor your experience with Aetna®
- Make you aware of our programs and services
- Learn about our members' access to services

We know that it's important to include you in our quality programs because you are the ones who improve member outcomes. We review survey results and information gathered from complaints, appeals and out-of-network claims to improve our processes, services and clinical quality.

We send surveys via email, so if you have not been receiving them, please **update your contact information**.

The more feedback we get, the more we can help you

We received feedback from 7.7% of you, which was about 3% less than last year. Specific state survey response percentages were even lower. Please make your voice heard in 2024. We want to make working with Aetna easy for you.



Medicare

Get Medicare-related information, reminders and guidelines.

Medicare Advantage (MA) — billing

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

A friendly reminder: You can't balance bill most dual-eligible beneficiaries

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

Dual-eligible individuals that qualify for Medicare Part A and B cost-share protection (payment of Medicare premiums, deductibles, coinsurance and copays) cannot be billed for Medicare A & B cost share.

The chart below includes the categories of dual-eligible beneficiaries.

Full Medicaid benefits (yes/no)

- Yes — beneficiary has full Medicaid benefits
- No — beneficiary has no Medicaid benefits plan and no Medicare cost-share protection
- Conditional — beneficiary's Medicare Part B cost-share is paid by Medicaid only when service is covered by both Medicare and Medicaid and provider accepts Medicaid.

Dual-eligible category	Full Medicaid benefits	Medicaid pays Medicare cost share
QMB	No	Yes
QMB+	Yes	Yes
SLMB	No	No
SLMB+	Yes	Conditional*
QI	No	No
QDWI	No	No
FBDE	Yes	Conditional*

*If Medicaid covers service, and provider accepts Medicaid.

Medicare providers must accept the Medicare and Medicaid payment (if any) in full for services given to a beneficiary that is cost-share protected under these Medicare Savings Programs. Failure to follow these billing rules is a violation of applicable law and a breach of your provider agreement. In addition, providers who fail to comply may be subject to sanctions.

More information

- **Medicare-Medicaid general information**
- **Dual Eligible Beneficiaries Under Medicare and Medicaid (PDF)**
- **Beneficiaries Dually Eligible for Medicare & Medicaid (PDF)**

Complete your required Medicare compliance training by December 31, 2023

Participating providers in our Medicare networks need to take CMS training.

Participating providers in our Medicare networks are required 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.

- DSNP and/or FIDE providers must complete the annual Model of Care (MOC) training and attestation by December 31, 2023.
- Delegated providers/entities are required to attest based on contracted networks.

Aetna Medicare Advantage (MA) plans include HMOs, PPOs, and DSNPs

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

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

Training materials and attestations are posted on our **Medicare page**.

Our training materials

- **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 all supporting materials published on our **Medicare page** or review the quarterly **First Tier, Downstream and Related Entities (FDR) compliance newsletters**.

Find out what types of plans are included in Aetna Medicare Advantage (MA) plans

What's included, what's not included, and a word about I-SNPs.

What do Aetna MA plans include?

Aetna MA plans include HMO plans, PPO plans, and SNPs (Special Needs Plans), all of which provide benefits to Medicare-qualified members.

Aetna® offers Dual-Eligible Special Needs Plans (D-SNPs) to members who receive Medicaid benefits and/or assistance with Medicare premiums or Parts A & B cost-sharing and live in a county where Aetna Medicare Advantage offers a D-SNP. D-SNPs include any of the following:

- Dual-Eligible Special Needs Plans (D-SNPs)
- Highly Integrated Dual Special Needs Plans (HIDE-SNPs)
- Fully Integrated Special Needs Plans (FIDE-SNPs)

Aetna Institutional Special Needs Plans (I-SNP)

Aetna also offers Institutional Special Needs Plans (I-SNPs) in select markets. An I-SNP is a Medicare Advantage plan offered to those who are eligible for Medicare.

What plans are not included in Aetna MA?

The Aetna Medicare-Medicaid Plan (MMP) is not an Aetna MA plan. The MMP is a plan that provides coordinated Medicare and Medicaid benefits for dually eligible individuals.

More information

For more information, view our **Aetna Medicare Advantage quick reference guide (PDF)**.

New wig benefit for all Aetna Medicare Advantage (MA) plans in 2024

The supplemental benefit is for hair loss as a result of chemotherapy, and you bill Aetna® using code A9282.

Starting in 2024, all Aetna MA plans will offer a wig supplemental benefit for hair loss that is a result of chemotherapy. Our benefit allows the member to receive an annual allowance of $400 toward the purchase of a wig by locating an in-network post-mastectomy provider on **Aetna.com** or by paying for services upfront and submitting a claim for reimbursement.

Coding

Aetna network providers should bill Aetna using code A9282 and the applicable diagnosis code(s). Members are responsible for any amount above the wig coverage limit.

Important update about your Boeing Medicare patients: Many may have a new Aetna® plan for 2024

Read on for how to identify these Boeing retirees, plus additional Aetna programs that support them.

Your office may see patients who are Boeing retirees or dependents of these retirees. Starting January 1, 2024, many of these retirees will have a new Aetna Medicare Advantage plan with prescription drug coverage (MAPD). It's called the Aetna Medicare℠ Plan (PPO) with ESA.

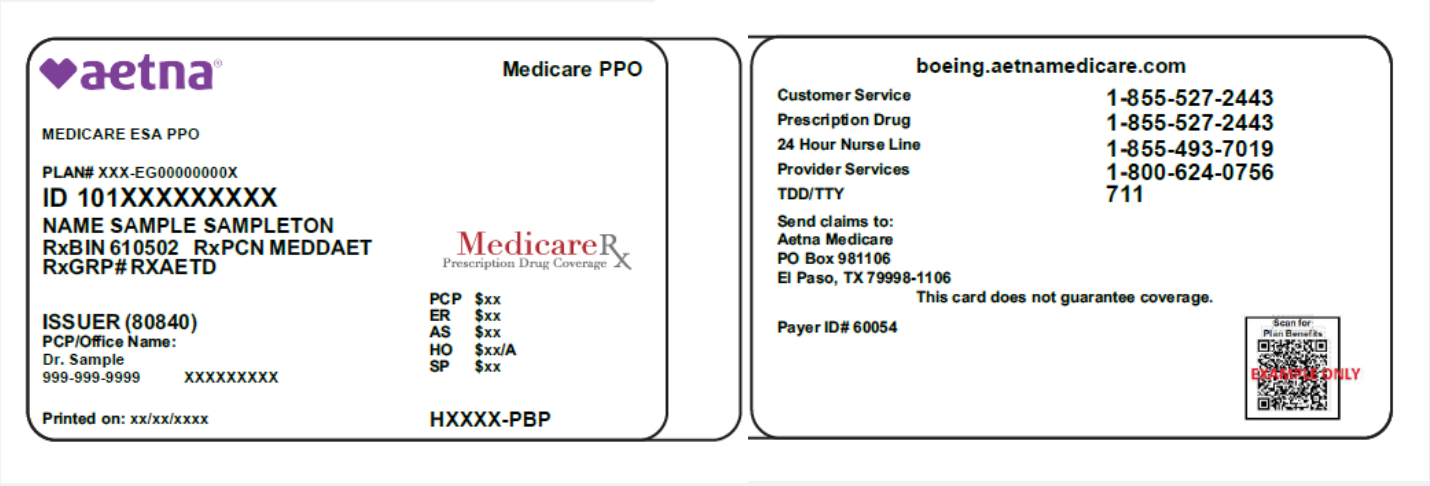
Since you are already a participating provider in the Aetna Medicare network, we expect a smooth transition for these Boeing retirees.

Things to know about the Aetna MAPD PPO:

- Referrals are not required.
- Precertification is required for some services.
- "Medicare PPO" appears in the upper-right corner of the ID card.
- It provides all the benefits of Original Medicare and more, such as additional health and wellness support programs.

ID card

Here's what the ID card for these patients looks like:



More information

If you have questions about the plan, just visit our **Contact Aetna** page. Use the "Medicare medical and dental plans" phone number under the "By phone" tab. We're available Monday through Friday from 8 AM to 5 PM in all time zones.

You can also visit our **Availity provider portal*** for information about the plan and to access electronic transactions, online resources, patient care programs and more. You can use Availity at no extra cost, but you do need to register for it.

Additional support for your patients

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

Our programs can help your patients:

- **Manage a chronic condition, such as diabetes or high blood pressure.** Let your patients know we offer personalized nurse support to help them. Our nurses can:

    - Ensure they're taking their medications as prescribed
    - Help them make healthy lifestyle choices
    - Answer questions they may have about their condition

    In some cases, they may benefit from having a case manager assigned to help coordinate their care.

    Aetna members can call **1-855-527-2443 (TTY: 711)**, Monday–Friday, 8 AM–9 PM ET.

- **Find resources in their community.** A Resources For Living® life consultant can refer members to services in their area that make life easier and more enjoyable. We can help with resources in the following categories:

    - Help at home
    - Social and recreational activities
    - Caregiver support, and more

    Members will have to pay for any services they decide to use.

    Aetna members can call **1-866-370-4842 (TTY: 711)**, Monday–Friday, 8 AM–6 PM in all continental U.S. time zones.

- **Get nonemergency transportation to appointments.** Your patients can get up to 24 one-way nonemergency trips to medical appointments, with up to 60 miles per trip.

    Aetna members can call **1-855-814-1699 (TTY: 711)**, Monday–Friday, 8 AM–8 PM in all time zones

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

  Aetna members can visit **MDLIVE** or call **1-888-865-0729** (**TTY: 1-800-770-5531**).

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

  Aetna members can call **1-855-493-7019 (TTY: 711)**, 24/7.

- **Check for health, wellness and safety concerns in their home.** Your patients can sign up for a Healthy Home Visit. A licensed doctor or nurse will come to their home to:

  - Review their health needs
  - Do a home safety assessment
  - Review medications
  - Ask about their medical and family history

  During the visit, they might recommend services Aetna offers to help support their health journey.

  Aetna members can call **1-877-503-5802 (TTY: 711)**, Monday–Friday, 7 AM–7 PM CT, or visit **Signify Health** to schedule an appointment.

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

Aetna Individual Medicare Advantage (MA) 2024 plan expansion

You might be a participating provider for the new counties.

We're expanding our Individual MA plans to 236 new counties for 2024. Depending on your contract, you may be listed as a participating provider in our MA networks.

What are the new counties?

On **Aetna.com**, you can view our **2024 MA Individual expansion counties (PDF)**.

2024 Annual Enrollment Period (AEP)

The Medicare AEP is from October 15, 2023, through December 7, 2023. We believe that Medicare beneficiaries will be interested in our plans because of our healthy Star Ratings. For 2024, our overall enrollment-weighted rating is 3.98 out of 5 stars (measurement period FY 2022 and early 2023). These ratings reflect the care you give to your patients.

More about our MA products

- View our **Aetna Medicare Advantage plans quick reference guide (PDF)**.
- View the **At a Glance reference guide (PDF)**.
- Find out how to **verify your patients' eligibility**.

How to get contracted for MA plans

If you're not currently contracted for our MA plans, please visit our **Contact Us** page. Use the Medicare medical and dental plans phone number listed under the "By phone" tab.

The FEHB Program now allows carriers to offer Medicare Part D

Read on to know what to watch for regarding federal retirees.

The Federal Employees Health Benefits (FEHB) Program, which covers over 4 million federal retirees and their families nationwide, will now permit participating carriers to offer group Medicare Part D plans to their members. While not all carriers will offer the Part D plan, this offering will affect most FEHB Program retirees beginning January 1, 2024.

What this means for you:

- Your retired patients covered by an FEHB Program plan may have a new Part D ID card.
- These patients will have a new Part D formulary.
- These patients will generally pay less for their prescriptions.

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

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

You can request an electronic referral for any plan that requires it. If a plan requires a referral, it must be issued from the primary care physician (PCP) for all specialist visits,

including those services performed in a facility. A referral isn't a substitute for a service that requires precertification. Visit our website to see if a service requires **precertification**.

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

Why use Availity?

The "Referral Add and Referral Inquiry" transaction on Availity is a quick, easy way to request or check the status of a referral. You can:

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

Referrals training

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

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

Other ways to get help

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

Refer members to participating providers

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

DSNPs that require referrals through December 31, 2023

- California: Aetna Medicare Preferred Plan (HMO D-SNP)
- Florida: Aetna Medicare Assure (HMO D-SNP)
- Florida: Aetna Medicare Assure Plus (HMO D-SNP)
- Kentucky: Aetna Medicare Assure 1 (HMO D-SNP)
- Ohio: Aetna Medicare Assure 1 (HMO D-SNP)

Beginning January 1, 2024, referrals will be required only for California and Florida HMO DSNPs.

PCP selection

All DSNPs require PCP selection.

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

Two Aetna® Medicare plans allow members to pay for medical expenses using the Aetna® Medicare Payment Card

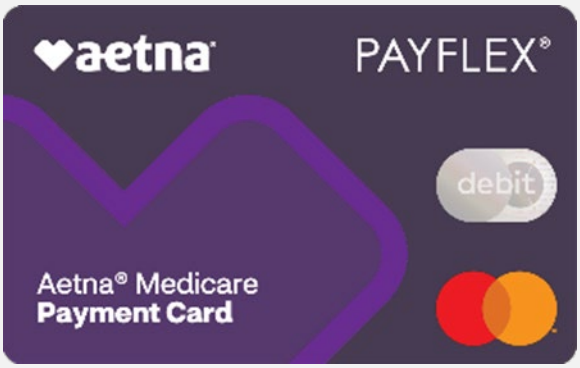
Find out what the card is and how your patients will use it.

Effective January 1, 2024, members enrolled in the following two Massachusetts plans will get an Aetna Medicare Payment Card (PayFlex®) with a Medical Expense Wallet to use toward out-of-pocket medical costs:

- Eastern Massachusetts: Aetna Medicare Discover Plan (PPO) H5521-451
- Central Massachusetts: Aetna Medicare Discover Plan (PPO) H5521-450

What is the Aetna Medicare Payment Card?

It is a preloaded Mastercard® with a Medical Expense Wallet that members can use toward out-of-pocket medical costs, including copays or cost shares, for plan-covered medical expenses. The benefit (allowance) amount renews quarterly, and unused allowance amounts do not roll over.



How do members activate the card?

Members need to activate their card before they can use it. To activate, call **1-877-261-9951 (TTY: 711)**.

They will also receive a personal identification number (PIN) when activating their card.

How do members use the card to pay?

Members can use the card at provider offices that accept Mastercard. They can select "credit" or "debit" when checking out. If they select "debit," they will need to enter their PIN.

If the member's purchase is greater than the allowance amount, the member can ask for the card to be swiped for the exact balance amount, and then pay the remaining balance with an alternate form of payment. Or the member can pay for the whole purchase with an alternate form of payment and submit a reimbursement request.

How do members manage their card through PayFlex?

Members can see their benefits amounts and check their card balance in three key ways:

- By phone
- On the **PayFlex** site
- The PayFlex Mobile® App

PayFlex® and PayFlex Mobile® are registered trademarks of PayFlex Systems USA, Inc. MasterCard® is a registered trademark of MasterCard International Incorporated.

Reminder about Organization Determination (OD) processing time frames

Members, or providers on behalf of members, can request either a standard or expedited OD (a determination concerning the rights of the member about items or services covered by Aetna®).

- While the Centers for Medicare & Medicaid Services (CMS) requires that the Medicare Advantage plan make a standard OD decision within 14 days of receipt of the request, standard OD decisions are typically made within just a few days.
- Expedited Organization Determination (EOD) decisions must be made within 72 hours.
- A pre-service OD should be requested as expedited only when the time frame of the standard decision-making process could place the member's life, health or ability to regain maximum function in serious jeopardy.
- The EOD time frame is inclusive of the entire decision-making process. This includes submission of supporting clinical information and an immediate peer-to-peer offering when a coverage request is unable to be approved.
- EODs should not be requested for cases when the only issue involves a claim for payment for services that the member has already received.

New appointment wait time standards coming in January 2024

You will be required to have appointments available, in person or via telemedicine, within the time frames shown here.

To meet Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) requirements, we are updating our appointment wait time standards for primary care physicians (PCPs) and behavioral health providers.

We will regularly monitor timely access to care to ensure compliance with these standards, and we will take corrective action, as necessary.

What are the new requirements?

You will be required to have appointments available, in person or via telemedicine, within these time frames:

New appointment wait time standards ("access to care")	Primary care physicians (PCPs)	Behavioral health (BH) providers

Emergency and urgently needed services	Immediately (or referred to the emergency room, as appropriate)	Immediately (or referred to the emergency room, urgent care/crisis center, as appropriate)
Non-emergency/Non-urgent; but requires medical attention	Within 7 business days	Within 7 business days
Routine and preventive care	Within 30 business days	Within 10 business days
Follow-up care	As appropriate, if needed	• Non-prescribers of medication: within 3 weeks • Prescribers of medication: within 5 weeks
24/7 answering service	Must have reliable 24 hours per day, 7 days per week (24/7) answering service or machine with notification system for call backs. • PCPs must have appropriate backup for absences. • A recorded message or answering service that refers members to emergency rooms is not acceptable.	Must have a reliable live answering service or voicemail system in place 24 hours per day, 7 days per week (24/7). • Prescribing providers are required to have a designated provider backup and/or an answering service and/or a machine with a beeper/paging system in place 24/7. • Non-prescribing providers are required to have a voicemail greeting which provides contact information for a licensed BH provider who is available 24/7; and/or direction to go to the nearest emergency department; and/or direction to call 911/988 in a crisis.

Note: State requirements supersede the above standards and are in the **Provider Manual State Supplement (PDF)**.

Participation criteria

You can find our participation criteria in our **Provider and Facility Participation Criteria handbook (PDF)**.

Definitions

Emergency and urgently needed services (emergency medical/behavioral health services)

A medical emergency/urgently needed service is when a prudent layperson with an average knowledge of health and medicine believes that they have medical symptoms that require immediate medical attention to:

- Prevent loss of life (or for pregnant women, loss of an unborn child), loss or loss of function of a limb, or serious impairment to a bodily function.
- Address worsening medical symptoms of an illness, injury, severe pain, or a medical condition (such as acute suicidality) in order to prevent death or serious harm to the member or others.

Non-emergency/Non-urgent; but requires medical attention

Non-emergency care is care for non-urgent conditions that, if not treated, may pose minimal risk of immediate harm. Examples: strep throat, pink eye, rash, sprains and strains or worsening major depression.

Routine and preventive care

Routine care is used in a clinical situation that is sufficiently stable and does not have a negative impact on the member's condition. Examples: blood pressure checks and anxiety disorders.

Follow-up care

Follow-up care provides an opportunity to address unresolved concerns, respond to symptoms that remain or have worsened (even after treatment), review additional testing and confirm or change diagnosis. It can also be for routine monitoring of any specific chronic medical condition, such as high blood pressure, diabetes, bipolar disorder or depression.

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