OfficeLink Updates™

Find updates on important changes to plans and procedures, drug lists, Medicare and state-specific information.

aetna™

June 2021

Inside this issue

90-day notices and important 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. This change may not be considered a material change in all states.

Diagnosis-related group (DRG) transfer policy expansion

Our current DRG transfer policy applies to facilities contracted with a DRG Base x Weight (DRGWT) methodology payment. The policy focuses on paying per diem rates as follows:

Commercial members
Commercial members transferring from an acute care facility to acute care facilities

Medicare members
Medicare members transferring from an acute care facility to:

- Acute care facilities
- Long-term-care facilities
- Skilled nursing facilities
- Cancer centers
- Children's hospitals
- Receiving home health care services
- Inpatient rehab facilities
- Psychiatric hospitals or facilities

Beginning September 1, 2021, our DRG transfer policy is expanding.

Commercial members

Commercial members transferring from an acute care facility to:

- Long-term-care facilities
- Skilled nursing facilities
- Cancer centers
- Children's hospitals
- Receiving home health care services
- Inpatient rehab facilities
- Psychiatric hospitals or facilities
- Critical access facilities

Medicare members

Medicare members transferring from an acute care facility to:

- Critical access hospitals

We convert to a per diem rate when the case meets these criteria:

- The transferring acute care facility has a contract based on DRG-defined reimbursement rates and does not have defined rates for transfer cases
- The actual length of stay is at least one day less than the average length of stay for the DRG.
- The patient discharge status code is any of the following as indicated on the transferring facility claim: 02, 03, 05, 06, 07, 62, 63, 65, 66, 82, 83, 85, 86, 90, 91, 93 or 94.
- For post-acute care settings only: the DRG is subject to post-acute care as defined by the Centers for Medicare & Medicaid Services (CMS).

The converted per diem rate is then calculated as follows:

1. DRG contracted rate / the average length of stay for the DRG = per diem rate
2. Per diem rate x the patient's actual length of stay + 1 additional day = allowed amount

This policy does not apply to facilities paid based on Medicare Allowable contracting.

Note: This is subject to regulatory review and separate notification in Washington state. This article is also a notice of material amendment to contract in Ohio and a notice of material change in Kentucky.

Incidental supplies, materials and equipment

Our standard payment policies don't allow us to pay for services, including related supplies, material and equipment, that are incidental to the overall episode of care. Examples of supplies, materials and equipment include the following:

- Digital analysis of electroencephalogram
- Lab sample preparation

Starting September 1, 2021, we will deny CPT® codes 88380, 88381 and 95957 as incidental for facility providers. (Facility providers include but are not limited to hospitals, ambulatory surgical centers and skilled nursing facilities.)

We will continue to deny these services as incidental for nonfacility providers.

Note: This is subject to regulatory review and separate notification in Washington state.

Technical-component-only codes

As of September 1, 2021, we will no longer pay for professional services performed in a hospital setting for technical-only procedure codes. The Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule lists these codes as diagnostic only. They do not have a related professional code.

Note: This is subject to regulatory review and separate notification in Washington state.

Pay percent reductions for multiple endoscopies

Effective September 1, 2021, we will adjust payment for multiple endoscopy procedures in the same family when billed by the same surgeon or assistant surgeon on the same date of service for the same member. Multiple surgery reductions can also apply, and the multiple procedures will be ranked according to their Centers for Medicare and Medicaid Services (CMS) Relative Value Units (RVUs). The payment reduction is based on a formula using CMS guidelines.

Here's an example:
Elbow Arthroscopy procedures 29837 and 29834 from the same endoscopic family reported with same surgeon or assistant surgeon are submitted for the same member, provider and date of service. The procedures will be ranked according to the RVU. Procedure 29837 has the higher RVU and will be assigned a rank of 1; procedure 29834 has the lower RVU and will be assigned a rank of 2. A pay percent value of 0.16 will be assigned to procedure code 29837 and a pay percent value of 0.011 (0.07 x 0.16) will be assigned to procedure code 29834.

Note: This is subject to regulatory review and separate notification in Washington state.

Changes to our National Precertification List (NPL)

Starting **September 1, 2021,** these precertification changes apply:

- We'll require precertification for the following drugs for the multiple myeloma indication only:
  - Kyprolis® (carfilzomib)
  - Velcade® (bortezomib)
  - Bortezomib (generic Velcade®)

- We'll no longer require medical precertification for oral hepatitis C drugs. We may still require precertification through pharmacy plans.

Submitting precertification requests

Be sure to submit precertification requests at least two weeks in advance.

To save time, request precertification online. Doing so is fast, secure and simple. You can submit most requests online through **our provider portal on Availity**. Or you can use the Electronic Medical Record (EMR) system portal.

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

Not registered for Availity?

Visit **Availity** or call **1-800-AVAILITY (1-800-282-4548)**.
For one-on-one guided support from us, call **1-866-752-7021**. Then ask to talk with the Availity team.

Please use our "Search by CPT code" search function on our **Precertification Lists web page** to find out if the code needs precertification.

You can learn more about precertification under the **General Information section of the NPL**.

Third-Party Claim and Code Review Program

Beginning **September 1, 2021**, you may see new claim edits. These are part of our Third Party Claim and Code Review Program. These edits support our continuing effort to process claims accurately for our commercial and Medicare members. You can view these edits **on our provider website, Availity.**

You'll have access to our prospective claims editing disclosure tool. To find out if our new claim edits will apply to your claim, log in to the **Availity provider portal**. You'll need to know your Aetna® provider ID number (PIN) to get access.

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

Note: This is subject to regulatory review and separate notification in Washington state.

Starting August 30: request hip and knee arthroplasty authorizations on Availity®

We're introducing a new and better way to request prior authorization for hip and knee arthroplasties. Starting August 30, 2021, use our Availity provider portal to request these procedures. That means the last day you'll be able to request prior authorization for these procedures through eviCore healthcare is August 29.

How it works

Use Availity to request prior authorization for hip and knee arthroplasty procedures. This includes inpatient bed day requests. For certain procedures, we may ask you for more clinical details. Complete a short questionnaire on Availity. That'll help expedite our review. You may even receive an immediate approval.

Prepare now for the switch

We'll hold training sessions to show you how to use Availity to submit authorizations and complete the online questionnaire. Check out dates and times on **AetnaWebinars.com** or register for our Authorizations on Availity webinar. Before you join us, register for Availity at **Availity.com**.

Important dates

- August 29, 2021: the last day to request hip and knee arthroplasty prior authorizations through eviCore healthcare
- August 30, 2021: the first day to use Availity to initiate your prior authorization requests for hip and knee arthroplasty

Note: This is subject to regulatory review and separate notification in Washington state.

Enhanced clinical review physical medicine program will authorize telehealth

Beginning September 1, 2021, we will require authorization for our enhanced clinical review physical medicine program for telehealth services.

This affects members in our fully insured commercial and Medicare Advantage HMO/PPO Aetna® products in:

- Delaware
- New Jersey
- New York
- Pennsylvania
- West Virginia

Telehealth for COVID-19

Read **these COVID-19 FAQ documents**, which provide details about our COVID-19 response and our telehealth guidelines.

How to get preapproval

Visit the **Magellan Healthcare portal**.

We're here to help

If you have questions, call National Imaging Associates at **1-866-842-1542**. Or you can call us at:

- **1-800-624-0756 (TTY: 711)** for HMO and Medicare Advantage benefits plans
- **1-888-MD Aetna (1-888-632-3862) (TTY: 711)** for all other plans

Important update about service codes

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

Unless noted, all updates take effect **September 1, 2021**.

Note: This is subject to regulatory review and separate notification in Washington state.

Changes to commercial drug lists

On **October 1, 2021,** we'll update our pharmacy drug lists.

You'll be able to view the changes as early as August 1, 2021. They'll be available on our **Formularies & 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 nonspecialty drugs on Aetna Funding Advantage℠, Premier, Premier Plus, Small Group ACA and Value Plus plans, call the Precertification Unit at **1-855-240-0535 (TTY: 711)**. Or fax your completed **prior authorization request form** to **1-877-269-9916**.
- For requests for nonspecialty drugs on the Advanced Control, Advanced Control — Aetna, Standard Opt Out, Standard Opt Out — Aetna, Standard Opt Out with ACSF, Aetna Health Exchange and High Value formulary plans, call the Precertification Unit at **1-800-294-5979 (TTY: 711)**. Or fax your completed **prior authorization request form** to **1-888-836-0730.**
- For requests for drugs on the Aetna Specialty Drug List, call the Precertification Unit at **1-866-814-5506**. Or fax your completed **prior authorization request form** to **1-866-249-6155**.

These changes will affect all drug lists, precertification, quantity limits and step-therapy programs.

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

Important pharmacy updates

Medicare

Visit our **Medicare Drug List** to view the most current Medicare plan formularies (drug lists). We update these lists at least once a year.

Commercial — notice of changes to prior authorization requirements

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

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

Important reminders

Upload supporting documentation for your authorization requests electronically through Availity®

Still faxing medical records or additional information forms for your authorization requests? There's a better way: upload your supporting documentation electronically through **our provider portal on Availity**. No faxing required.

Here's how it works.
On Availity, submit an Authorization Add or Authorization Inquiry transaction and upload your documentation. Or view the status to retrieve the event, then upload the documentation.

Didn't use Availity for the initial request? That's OK. You can still use Availity to upload your documentation. Then follow the status in your Availity Auth/Referral Dashboard.

Use a current form when needed.
No matter what you upload, it's best to include a current form with your initial request. You don't have to wait for us to ask you for it.

Get our forms from our **forms library**. Complete it online and save it to your computer to upload during your authorization request. Download a new form each time you need it, so you'll always have the most current one.

Give us an hour. We'll teach you how to use Availity.
We offer **free, live webinars** to show you it works. You'll learn how to submit authorizations and upload documentation using Availity. **Register first on the webinar page**.

Reminder: referring members to specialists

Referral to network specialists may decrease our members' out-of-pocket costs. Please keep this in mind when making referrals.

Members have different options to verify the network status of a provider. Members can call us at the phone number on their ID card or check a provider's status on our website.

Member Services can also help them find other network providers when necessary.

Practice in New York? Then please be aware of this PPE guideline

New York prohibits participating providers from charging members of insured health, dental and vision plans for Personal Protective Equipment (PPE). If you've charged our members for PPE, contact your Aetna® network representative or call our service center at **1-888-632-3862**. Doing so will help us ensure that they get refunds.

You can find the latest information on COVID-19 liberalizations on our **provider page**. You can also visit the **New York Department of Financial Services website**.

News for you

Caring for transgender individuals

Transgender individuals have health care needs and human needs, such as the need for respect, love and access to care. Aetna® standard plans provide access to medically necessary transgender-related health care. Plan documents outline the member's specific coverage.

Hormone therapy

The pharmacy benefit usually covers testosterone or estrogen therapies. **Clinical Policy Bulletins #510 Progestins** and **#501 Gonadotropin-Releasing Hormone Analogs** outline the coverage of relevant medications.

Surgical transition

Our Clinical Policy Bulletin **#615 Gender-Affirming Surgery** outlines what surgeries are covered by standard Aetna plans. Also, find out more about **gender affirmation surgery precertification**.

To find a breast surgeon in the network, **visit our website**.

Behavioral health services

Individuals considering a surgical transition will need:

- One letter from a mental health care provider for breast (top) surgery
- Two letters from a mental health care provider for genital (bottom) surgery

Reproductive services
Some Aetna® plans may cover fertility preservation. These services need precertification. Check the benefits plan documents for coverage details.

Ongoing health and wellness

- Benefits for preventive health services (such as cancer screening) are based on the individual's birth anatomy (cervix, breast, prostate).
- Discuss safe sex practices and screenings for sexually transmitted infections.
- Discuss the risks of alcohol and tobacco while undergoing hormone therapy and preparing for surgery.

Recently launched: 2021 Health Trends Report

Health care has faced a year of crisis and innovation. What's ahead? Read more in our 2021 Health Trends Report.

The 2021 Health Trends Report gives the CVS Health® perspective on how the past year of crisis, challenge and innovation has transformed the future of health care. The report examines the forces impacting care, covering topics from the evolution of virtual care to new capabilities in data-driven medicine, and the expanding role of the pharmacist. Read the **2021 Health Trends Report**.

Helping our members choose their care

You're a valued Aetna® provider and partner in our network. So we want to tell you about our 2021 primary care physician (PCP) and orthopedic specialist hip/knee Aetna Smart Compare™ designations.

What's the purpose of the Aetna Smart Compare designations?
The *PCP designation* identifies family, internal medicine and pediatric practices that are part of an Aetna commercial plan. These practices deliver high-quality, effective care to pediatric and adult patients based on industry measures.

The *orthopedic specialist hip/knee designation* identifies practices that are part of an Aetna commercial plan. They deliver high-quality, effective care for hip and knee conditions based on industry measures.

The goal of the designations is to give our members more information to help them choose a health care provider for themselves and their families.

Learn about the PCP Aetna Smart Compare methodology
The PCP designation has two categories of measures:

- **Effectiveness** — This category measures the outcome and efficiency of treatment decisions through 108 Episode Treatment Group® conditions. They're representative of cases that a PCP would typically treat (defined using Optum Symmetry® Episode Treatment Group® software version 9.4). This category also includes three risk-adjusted utilization measures (inpatient admissions/1,000 attributed members; ER visits/1,000 attributed members; CT scan and MRI services/1,000 attributed members).
- **Clinical quality** — This category measures compliance with clinical guidelines through 21 HEDIS® measures that a PCP typically influences (for example, HbA1c poor control > 9.0% and cancer screening). The PCP designation is at the *primary care practice level*. It is based on our claims experience. We measure performance separately for two "patient populations" — commercial adults and commercial pediatrics — due to differences in clinical needs. Only primary care practices with *at least 25 attributed Aetna members* for a patient population throughout 2019 are measured for that patient population.

Learn about the orthopedic specialist hip/knee Aetna Smart Compare designation methodology

The hip/knee designation has two categories of measures:

- **Effectiveness** — This category measures the outcome and efficiency of treatment decisions through 13 Episode Treatment Groups addressing the diagnosis and treatment of joint degeneration and joint derangement conditions (defined using Optum Symmetry Episode Treatment Group software version 9.4).
- **Clinical quality** — This category measures the quality of facilities where orthopedic specialists perform hip and/or knee replacement procedures through two measures from CMS Hospital Compare (30-day readmission rate and complication rate following elective hip or knee arthroplasty) and the presence of Joint Commission Advanced Total Hip and Knee Replacement Certification.

The orthopedic specialist hip/knee designation is at the *practice level*. We only measure orthopedic specialist practices with *at least three complete nonoutlier episodes of care* across commercial and Medicare between January 1, 2018, and December 31, 2019.

We look at effectiveness for hip and knee conditions separately, due to differences in clinical needs. We measure clinical quality across conditions since it is based on external data not available at a more detailed level.

How the Aetna Smart Compare designation results will be used

In 2021, we'll use the designations in two ways. The first is to help our members choose a physician for themselves and their families through *our digital search tools*:

- Our members will be able to see *up to two summary designations* next to a physician's name – one for effectiveness and one
  for clinical quality. Effectiveness and clinical quality are separate categories.
- We base designations on the practice, or practices, that a provider is associated with.
- We will only display positive outcomes (that is, situations where a primary care or orthopedic practice earned a summary designation).

The second use is to identify primary care options for members who may need a PCP or orthopedic specialist recommendation through *other channels, like a member call center*:

- We give at least three provider options each time a member asks for a provider.
- We give priority to practices with summary designations.
- We refer members to our online search tools for a full provider directory.

These designations are way to help members choose a physician using our digital tools and other channels. It should not be the sole basis for making a choice. They may consider other factors like provider location or consumer ratings.

These designations *do not impact your status as an Aetna participating provider, your reimbursement or a member's benefit level.*

Aetna Smart Compare designation results

Providers who met the evaluation criteria for each designation received a letter with their results that is valid through 2021. These designations will refresh once a year. We'll use the most recent and complete data available.

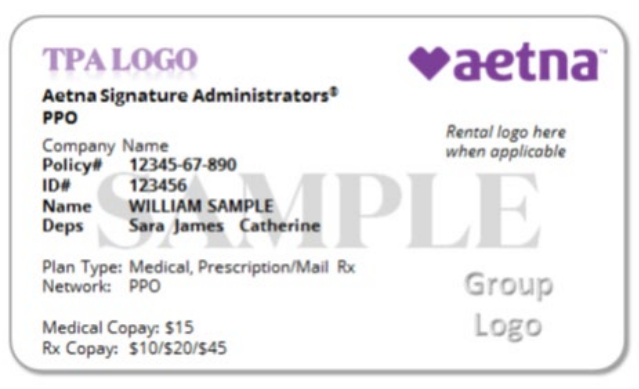
Our program page on **Aetna.com** has more details, including overview guides of the designation measures.

For questions or feedback on the program, please send a message to **SmartCompare@Aetna.com**.

Submitting claims for Aetna Signature Administrators® plan

The member ID card generally has three identifiers:

1. The payer's logo
2. The Aetna® logo
3. The Aetna Signature Administrators name with "PPO" directly below



Send claims to the correct payer
Send claims to the payer. You'll find the payer ID (for electronic claims) and address (for paper claims) on the member's ID card.

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

For more support
You can direct your questions to the appropriate payer on the ID card. The payer will contact us if needed.

To learn more, see **the Aetna Signature Administrators solution flyer**.

A new way to access our payer partner Lucent Health
Our payer partner Lucent Health has a new way to check eligibility and verify benefits. Use the URL on the member's ID card to register for the portal. Then you can verify benefits, check eligibility, download forms and verify claim status.

2021 HEDIS® Medical Record Collection Project Results have been submitted

Each year, we collect Healthcare Effectiveness Data and Information Set (HEDIS)* data. The data come from claims, encounters, administrative data and medical records. We support a consumer-obsessed culture. To us, this is a culture that:

- Enhances member health and quality of life
- Expands provider relationships to support an enhanced patient experience
- Closes data and care gaps

We have sent our data for 2020 to the National Committee for Quality Assurance (NCQA).

Thank you to the offices that gave us access to medical records.

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

New central fax number will help reduce turnaround times

We have a new central fax number for utilization management and inpatient concurrent review. You should send all faxes to **1-833-596-0339**. (Exception: Some members have plans with a dedicated service team.) This is now an automated process. It attaches incoming clinical information to pending precertification and concurrent review files.

Benefits of this change

There are three immediate benefits of using this new fax number.

- You no longer have to worry about sending clinical information to the right number.
- Your fax is less likely to be misdirected.
- Processing turnaround time can be reduced by a day or more.

Here's what you need to know

We've noticed that many fax submissions can't be auto processed. This is usually because the fax cover sheets have one or more errors. Here's a list of the most common errors.

- A missing Aetna® member ID number
- A missing case reference number
- An invalid Aetna member ID number
- An invalid case reference number or expired reference number

How to reduce faxing errors

When you send clinical information, use a separate fax cover sheet for each member. Be sure to include a valid:

- A fully typed reference number (including zeros) as provided by Aetna
- The member ID, written as "Member ID: **ME**XXXXXX or "**W**XXXXXXXXX"

When you follow these steps, you'll see faster processing for your precertification and concurrent reviews.

We also encourage you to use Availity®, our provider portal to submit clinical information.

Questions?

Just email us at **StrategicCoordination@Aetna.com**.

Thank you for following this new process.

Top 10 medical record documentation tips

A provider should submit accurate medical record documentation and coding of diagnoses and conditions. Documentation should reflect the patient's current health status. We have developed a top 10 documentation tips list to help in this process.

1. Sign, credential and maintain the record.
2. Provide clear, concise, consistent, complete and legible documentation.
3. Avoid using abbreviations and symbols.
4. Document specific dates, time lines and pertinent time frames.
5. Clearly document and indicate if the diagnosis is a confirmed or working diagnosis.
6. Make sure that documentation supports whether the condition is active or resolved.
7. Link all medications to the condition they are treating. Date the review.
8. Make sure that documentation shows whether the condition is stable or whether there are complications.
9. Review and update all lists at least once per calendar year with the patient and/or caregiver.
10. Indicate a direct link between the condition and any complication(s).

In this rapidly changing environment, our nurse educator works to ensure that providers have access to the most updated information. For more, contact us at **RiskAdjustment@Aetna.com**.

InformedDNA® is the preferred provider of genetic counseling services for Aetna®

Aetna® members can now talk with InformedDNA genetics experts from the comfort of their homes. Flexible appointments are available days, evenings and weekends. By phone or by video. Multilingual counseling is also available.

Genetic testing
Genetic testing is getting more attention than ever. Direct-to-consumer genetic tests are common now in news reports and on TV, radio and online ads. How can you decide if testing is right for your patient? How do you know which test is the most helpful?

Genetic tests are available for many reasons:
- Diagnosing inherited diseases
- Assessing the risk of passing an inherited disease to children
- Predicting risk of developing a disease
- Predicting response to medicine
- Nonhealth reasons

Genetic counseling
Genetic counseling is the process of helping people understand and adapt to the medical, psychological and familial genetic aspects of disease, such as:
- How inherited diseases and conditions affect people and their families
- How family and medical histories may impact the chance of disease occurring (or reoccurring)

- Which genetic tests should be performed and what those tests will reveal or not reveal
- How to make informed choices about health care conditions based on genetic test results

Accessing InformedDNA genetic counseling

Health care providers may make a genetic counseling referral via ou**r website**.

If you have any questions, contact us:

By email: Info@InformedDNA.com
By phone: 1-800-975-4819
Online: InformedDNA.com/physicians/refer-a-patient

Help improve communication between treating providers

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

This lack of communication is a threat to quality patient care. We know that coordinating care with many physicians, facilities and behavioral health care professionals can be a challenge. We're here to help.

Use our tools to share information

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

You can use our tools to help. Go to **Aetna.com** to find them. Click on "Providers" on the home page. Then select "Resources" and then "Forms." Scroll down until you see "Physician communications." Here are quick links for you:

- **Behavioral health sample initial evaluation form**
- **Dilated Retinal Eye examination report form**
- **Physician Communication form**
- **Physician Communication Post-Fragility Fracture Care form**
- **Specialist Consultant Report**

Thank you for your efforts to improve communications.

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

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

Consider cultural competency when caring for patients

Recognizing that members have diverse views is critical to meeting their needs. The cultural factors that will likely impact your relationships with them 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 all the National Committee for Quality Assurance (NCQA) standards. Doing so will ensure that members' access to care is satisfactory. Each year, we measure our members' perspectives via the Consumer Assessment of Healthcare Provider and Systems (CAHPS®) health plan survey. Survey responses help us learn about network providers' ability to meet our members' needs. We use this data to monitor, track and improve member experiences.

Do you have the tools you need?
We also conduct an annual physician satisfaction survey. We want to make sure we give you tools and resources to meet members' cultural needs.

Want to learn more?
To learn more about cultural competency, review **this short video and presentation**.

Stay in-network for lab services and save money

Your patients can save on out-of-pocket costs when they get lab work done in our network. Just recommend they get testing done at one of our two preferred national labs, Quest Diagnostics® and LabCorp. Or you can refer them to one of the hundreds of other labs in our network. They may be pleased at how much they can save.

Find out how in-network costs compare to out-of-network costs.

Our office manual keeps you informed

Our **Office Manual for Health Care Professionals** is available on our website. For **Innovation Health**, once on the website, select "Health Care Professionals."

Visit us online to view a copy of your provider manual (if you don't have Internet access, call our Provider Service Center for a paper copy) as well as 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 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**
- 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.

Our medical directors are available 24 hours a day for specific utilization management issues. Contact us by visiting our website, calling Provider Services at **1-800-624-0756 (TTY: 711)** or calling patient management and precertification staff using the Member Services number on the member's ID card.

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.

Update your information — here's why

It's important to regularly update your office information. Our members rely on the information in our online provider directory when seeking medical and behavioral health care services. In addition, accurate information helps us pay you without delay or error.

It's easy to update your information on **Availity** and to get started.

We need your current information, such as:

- Name
- Specialty
- Office hours, location, email address and appointment phone number
- Types of services you provide (e.g., televideo)
- Languages that you or your staff members speak
- Hospital affiliations
- Whether you are accepting new patients

Other reasons why it's important to keep your information up to date:

- To receive important information about new products and initiatives
- To get increased referrals
- To receive communications from CVS Health® and Aetna®
- To meet state, CMS and NCQA requirements
- To ensure that your patients can find you and have the correct phone number to call for appointments

Important message for Massachusetts and New York commercial and Medicare providers

Beginning April 1, 2021, you must use **Availity** to update and validate your demographic information.

Behavioral Health updates

We're helping you stay informed about behavioral health coverage updates so you can deliver the best possible treatment to your patients.

Working together to save lives

We're dedicated to working with you to prevent suicide. So, we're here with resources you need to best support your patients.

Partnering with PsychHub

Our behavioral health providers are in a position to have a meaningful impact on our members. That's why we're partnering with **PsychHub**, the world's largest online platform for mental health education.

PsychHub offers access to **best-in-class resources** on evidence-based interventions, built with the provider and their patients in mind.

What you'll receive

You will have *free* access to a series of **eLearning certifications** developed by leading experts at Columbia, University of Pennsylvania and Harvard.

Cognitive Behavioral Therapy Foundations

Case conceptualization, behavioral action planning, coping techniques and measurement-based care

CBT for Depression
Behavior activation and ABCDE methodology for symptom reduction

Safety Planning
Collaborative approach to identifying risk, warning signs and proactive prevention strategies

CBT for Reducing Suicide Risk
Specialized CBT focus on suicide, patient's suicide story, Hope kits and reducing risk

Counseling on Access to Lethal Means
Why means matter, risk assessment and safe storage

The eLearning certifications include:

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

You can earn national continuing education (CE) credits and continuing medical education (CME) credits for these courses.

When you can start

This offering will be available to behavioral health providers beginning in May. Be on the lookout for more detailed communications and instructions for accessing.

Behavioral health clinical criteria

How we determine coverage

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

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

Staff members use the following criteria as guides in making coverage determinations, which are based on information about the specific member's clinical condition:

- **Aetna Clinical Policy Bulletins**
- **Guidelines for coverage determination**
- Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, Local Coverage Determinations and Medicare Benefit Policy Manual
- MCG™ guidelines
- The American Society of Addiction Medicine (ASAM) criteria: Treatment for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition (this content is copyrighted; contact the American Society of Addiction Medicine at **ASAMcriteria@asam.org** for information on how to purchase it)
- For substance abuse treatment in Texas, the **Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers** (28 TAC §§3.8001–3.8030) (in place of the ASAM criteria)
- Applied Behavior Analysis (ABA) Medical Necessity Guide
- For substance abuse care in New York State, the **Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)**
- Level of Care Assessment Tool (LOCAT)
- LOCUS® and CALOCUS-CASII®

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

Hard copies

Need hard copies of criteria for a specific determination? We can help. Just call us at **1-888-632-3862 (TTY: 711)**.

Follow-up care for ADHD

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

Medication follow-ups

The **American Academy of Pediatrics** recommends that physicians who prescribe medication for ADHD:

- Schedule an in-person follow-up visit with the patient 30 days after the initial prescription
- Schedule two more follow-up visits after the initial visit — these visits are to review and check how the child is doing and look for any side effects
- Schedule monthly visits, if needed, until a good routine is in place
- Schedule visits every three months for the first year

Track progress
Treatment plans for ADHD often involve medications plus behavior therapy and everyday support strategies. Using a mix of these actions can promote calmer relationships with family members, better study habits and more independence. Parents can track their child's progress with **report cards**. There are also **several apps** that may help.

Support for patients and parents
You may want to encourage your patients (and their parents) to seek more help from:

- **A support group**
- **Parent training program**
- **Counseling**
- **Stress-management techniques**
- **Emotional well-being resources**

Refer patients to our Complex Case Management program

Complex case management is for members with complex conditions who need extra help understanding their health care needs and benefits. We also help them access community services and other resources. The program offers an inclusive process for the member, the caregiver, the providers and Aetna®.

Program goals
We want to help produce better health outcomes while managing health care costs. Let's work together to meet these goals.

Program referrals
Know a member who could use the extra help? Program referrals are welcome from many sources, including:

• Primary care physicians
• Specialists
• Facility discharge planners
• Family members
• Internal departments
• The member's employer

Make a referral
• Call: **1-800-424-4660 (TTY: 711)**
• Email: **AetnaBehavioralHealthReferrals@aetna.com**

Screening D-SNP members for coexisting behavioral health and substance use disorders

Do you have a patient who is a **Dual-Eligible Special Needs Plan (D-SNP)** member? Our Behavioral Health Clinical team works with D-SNP members to identify those who may have a behavioral health or substance use disorder.

Identifying coexisting conditions

Using evidenced-based screening tools, a clinical team member will do an initial assessment or screening. They'll look for coexisting behavioral health and substance use disorder conditions.

Get an individualized care plan and more

A behavioral health care manager will be part of the member's care team. They will work with each member to develop a comprehensive individual care plan. The behavioral health care manager provides support to maintain continuity of care.

Refer patients to the Aetna® D-SNP program

You can help make sure these patients get the quality care they need. Refer them to **our D-SNP program**.

Resources

- **Emotional well-being resources**
- **Roadmap to behavioral health**
- **Substance Abuse and Mental Health Services Administration (SAMHSA)**

Applied behavior analysis (ABA) provider FAQs

1. **Does ABA require precertification?**
   Yes, ABA is on the Aetna® precertification list for behavioral health services.

2. **Who can I contact with benefits and claims questions?**
   You can **see these contact details** or just call the number on the member's ID card.

3. **How do I get services precertified?**
   You can call the number on the member's ID card and speak to a customer service representative. **Here's more information on precertification**. You may also use the **ABA Treatment Request form**, when applicable.

4. **Where can I find the Aetna medical necessity guidelines for ABA?**
   See the **Applied Behavior Analysis Medical Necessity Guide**.

5. **Where can I find the Aetna clinical policy bulletin on autism spectrum disorders?**

See **Autism Spectrum Disorders** and **Applied Behavior Analysis**.

6. **What procedure codes does Aetna use for ABA?**
   Aetna continues to use the American Medical Association (AMA) CPT® (Current Procedural Terminology®) codes for adaptive behavior treatment. The AMA replaced or revised the following codes effective January 1, 2019:
   - Eight new Category I codes for adaptive behavior assessments (97151 and 97152) and adaptive behavior treatments (97153–97158) were added.
   - Fourteen associated Category III codes (0359T, 0360T, 0361T, 0363T–0372T and 0374T) have been deleted.
   - Two Category III codes (0362T and 0373T) were revised and maintained.

7. **How do I join the Aetna network?**
   See **joining the Aetna network.**

Revised edition — Applied Behavior Analysis (ABA) Medical Necessity Guide

We've just updated the **Applied Behavior Analysis (ABA) Medical Necessity Guide**. A new edition is set to release in June 2021.

Highlights of the updates include:
- Improved transparency on guideline development, including a references section
- Updated criteria based on the most recent evidence-based literature
- Increased focus on objective and standardized measures for improvement

You'll find **the revised guide** on **Aetna.com**. There, you can review the revised criteria in its entirety.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Aetna® will reimburse you when you screen your patients for alcohol and substance use, provide brief intervention and refer them to treatment. SBIRT is an evidence-based practice designed to support health care professionals. Overall, the practice aims to improve both the quality of care for patients with alcohol and substance use disorder conditions, as well as outcomes for patients, families and communities.

Screen and refer your patients

Use of the SBIRT model is encouraged by the Institute of Medicine recommendation that calls for community-based screening for health risk behaviors, including alcohol and substance use. Our

participating practitioners who treat patients who have Aetna medical benefits can provide this service and be reimbursed. Go to **Aetna.com** to learn more.

Get started today

The SBIRT app is now available as a **free download** from the Apple® App Store® online.*

The app provides questions to screen patients for alcohol, drug and tobacco use. A screening tool is provided to further evaluate the specific substance use. The app also provides steps to complete a brief intervention and/or referral to treatment for the patient, based on motivational interviewing.

*The Apple® App Store® is a trademark of Apple Inc., registered in the U.S. and other countries.

Depression in primary care

An estimated 17.3 million adults in the United States (about 7.1%) had at least one major depressive episode in 2017.[1] Depression is an important health problem often seen in primary care. More than 8 million doctor visits each year in the U.S. are for depression, and more than half of these are in the primary care setting. Despite this, **a national study** found that only about 4% of adults were screened for depression in primary care settings. Primary care physicians serve as the entry point to the health care system for many patients and play a critical role in recognizing and treating symptoms of depression. The **Aetna Depression in Primary Care Program** is designed to support the screening for and treatment of depression at the primary care level.

Program benefits

- Access to a tool to screen for depression as well as monitored response to treatment
- Reimbursement for depression screening and follow-up monitoring
- **Patient health questionnaire (PHQ-9)** — specifically developed for use in primary care
- Quick and easy self-administration
- Specific for depression
- Materials available in English and Spanish
- PHQ-9 reimbursement — submit claim with the following billing combination: CPT® code 96127 (brief emotional/behavioral assessment) or G0444 (annual screening for depression) in conjunction with diagnosis code Z13.13 (screening for depression)

To get started, you simply need to:

- Be a participating provider
- Use the **PHQ-9** tool to screen and monitor your patients

[1]Substance Abuse and Mental Health Services Administration (SAMHSA). **Key substance use and mental health indicators in the United States: results from the 2017 national survey on drug use and health**. September 2018. Accessed January 19, 2021.

- Submit your claims using the combination coding

Learn more about the Depression in Primary Care Program.

Behavioral health clinical practice guidelines

Clinical practice guidelines from nationally recognized sources promote consistent application of evidence-based treatment methods. This helps provide the right care at the right time. For this reason, we make them available to you to help improve health care.

These guidelines are for informational purposes only. They aren't meant to direct individual treatment decisions. And they don't dictate or control your clinical judgement about the right treatment for a patient in any given case. All patient care and related decisions are the sole responsibility of providers.

Adopted guidelines

- **American Academy of Pediatrics (AAP) Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents**
- **American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Major Depressive Disorder**
- **APA Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder**
- **APA Practice Guideline for the Treatment of Patients with Substance Use Disorders**
- **Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain**

More resources

- **SAMHSA Treatment Improvement Protocol (TIP) Series**
    - **TIP 45: Detoxification and Substance Abuse Treatment**
    - **TIP 63: Medications for Opioid Use Disorder**
- **American Society of Addiction Medicine (ASAM) Criteria**
- **National Institute on Alcohol Abuse and Alcoholism (NIAAA)**
- **National Institute on Drug Abuse (NIDA)**

Opioid overdose risk screening program

Our behavioral health clinicians screen members to identify patients at risk for an opioid overdose. Any patient receiving a diagnosis of opioid dependence may be at risk. Learn more about the **opioid epidemic.**

How you can help

Consider naloxone for patients at risk for an opioid overdose. Naloxone reverses the effects of an opioid overdose. Giving naloxone kits to laypeople reduces overdose deaths, is safe and is cost effective. You can also tell patients and their families and support networks about the signs of overdose and about how to administer medication.

Coverage of naloxone varies by individual plan. Call the number on the member's ID card for more information on coverage. We waive copays for the naloxone rescue medication Narcan® for fully insured commercial members.

Resources for you and your patients

- **Aetna opioid resources**
- **Naloxone: The Opioid Reversal Drug that Saves Lives**
- **SAMHSA: Opioid Overdose Prevention Toolkit**
- **Seeking treatment for opioid use disorder (Aetna video)**
- **Our opioid response (CVS Health and Aetna)**

Depression screening for pregnant and postpartum women

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

Program elements

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

How to contact us

- Members and providers can call **1-800-272-3531 (TTY: 771)** to verify eligibility or register for the program. Members can enroll in the Aetna Maternity Program with a representative at this number.
- Members can also enroll through **Aetna.com** by logging in to their member website and searching under the "Stay Healthy" section.

Pharmacy updates

Changes to commercial drug lists

On **October 1, 2021,** we'll update our pharmacy drug lists.

You'll be able to view the changes as early as August 1, 2021. They'll be available on our **Formularies & Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug prior authorization

- Submit your request through our **provider portal on Availity**.
- For requests for nonspecialty drugs on Aetna Funding Advantage℠, Premier, Premier Plus, Small Group ACA and Value Plus plans, call the Precertification Unit at **1-855-240-0535 (TTY: 711)**. Or fax your completed **prior authorization request form** to **1-877-269-9916**.
- For requests for nonspecialty drugs on the Advanced Control, Advanced Control — Aetna, Standard Opt Out, Standard Opt Out — Aetna, Standard Opt Out with ACSF, Aetna Health Exchange and High Value formulary plans, call the Precertification Unit at **1-800-294-5979 (TTY: 711)**. Or fax your completed **prior authorization request form** to **1-888-836-0730**.
- For requests for drugs on the Aetna Specialty Drug List, call the Precertification Unit at **1-866-814-5506**. Or fax your completed **prior authorization request form** to **1-866-249-6155**.

These changes will affect all drug lists, precertification, quantity limits and step-therapy programs.

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

Important pharmacy updates

Medicare
See the **Medicare Drug List** to view the most current Medicare plan formularies (drug lists). We update these lists at least once a year.

Commercial — notice of changes to prior authorization requirements
Visit our **Formularies & Pharmacy Clinical Policy Bulletins** page to view:

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

State-specific updates

Here you'll find state-specific updates on policies and regulations.

Arkansas providers - Notice of Material Amendment to Healthcare Contract

Arkansas providers: the articles published below are your notice of Material Amendment to Healthcare Contract. It is being sent pursuant to Ark. Code Ann. § 23-99-1205(a) and "shall apply to all Provider, Physician, Ancillary, Facility and Hospital healthcare contract(s)."

- Diagnosis-related group (DRG) transfer expansion
- Incidental supplies, materials and equipment
- Technical-component-only codes
- Pay percent reductions of multiple endoscopies
- Changes to our National Precertification List (NPL)
- Third-Party Claim and Code Review Program
- Important update about service codes
- Medicare Advantage plan: acupuncture coverage for chronic lower back pain
- Changes to commercial drug list

California providers - How to access your fee schedule

In accordance with the regulations issued pursuant to the Claims Settlement Practices and Dispute Mechanism Act of 2000 (CA AB1455 for HMO) and to the expansion of the Health Care Providers Bill of Rights (under CA SB 634 for indemnity and PPO products), we're providing you with information about how to access your fee schedule.

- If you're affiliated with an Independent Practice Association (IPA), contact your IPA for a copy of your fee schedule.
- If you're directly contracted with Aetna®, you can call our Provider Service Center for help with up to ten Current Procedural Terminology® (CPT®) codes. For requests of eleven or more codes, you can enter the codes on an Excel® spreadsheet (include tax ID, contact telephone number, CPT codes and modifier) and use the **FeeSchedule@Aetna.com** email address to send it to us.
- If your hospital is reimbursed through Medicare Groupers, visit the **Medicare website** for your fee schedule information.

Colorado providers - Notice of material change to contract

For important information that may affect your payment, compensation or administrative procedures, see the following articles in this edition:

- **Updates to our National Precertification List**
- **Clinical payment and coding policy changes**

Maryland providers - How to ID providers no longer in the network

Maryland Insurance Code 15-112 — Provider Panels requires Aetna® to notify primary care physicians of the termination of a specialty referral services provider. To comply, we offer access to the Maryland Provider Terminations (Quarterly Report). This report lists specialists in HMO-based plans whose participation in the Aetna network terminated during the specified time frame.

You can find this **report** in the **Southeast Regional section** of our **Office Manual for Health Care Professionals**. Review the report periodically to see which providers no longer participate with us.

To view a current listing of providers who participate in our network, go to our **provider referral directory**. Referring your Aetna members to in-network providers helps them control their out-of-pocket costs.

If you have questions about the Aetna network or making specialty referrals to in-network providers, please contact our Provider Service Center at **1-800-624-0756 (TTY: 771)**.

State of Nevada Public Employees' Benefits Program (PEBP) members can use the Aetna Signature Administrators® program and network

Starting July 1, State of Nevada PEBP members can use the Aetna Signature Administrators preferred provider organization program and medical network.

To check eligibility or verify benefits for the State of Nevada PEBP, call their dedicated phone line at
1-888-7NEVADA (1-888-763-8232). You'll also find the phone number on the member's ID card. Or **log in** to view claims and benefit information. First time log in will require providers to register to obtain a user ID and password.

Our TPA partners handle all claims processing and claims questions. Send claims electronically to HealthSCOPE Benefits payer ID #71063. This number is also on the member's ID card.

Or send paper claims to:
HealthSCOPE PO Box 91603 Lubbock, TX 79490-1603

Please note: Neither Aetna nor ASA is able to verify eligibility or process claims.
To learn more, see this **flyer**.

New Jersey providers - Where to find our appeal process forms

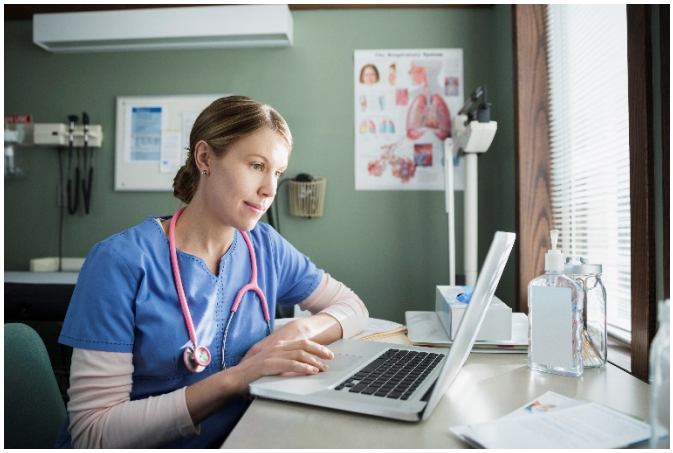
We have updated the information about internal and external **provider appeal processes** on our public website.

If you use the New Jersey **Health Care Provider Application to Appeal a Claims Determination form** when submitting certain claims appeals, you should make sure your claim is eligible. You can find this form and the correct procedures on our public website.

New York providers - Be aware of this PPE guideline

New York prohibits participating providers from charging members of insured health, dental and vision plans for Personal Protective Equipment (PPE). If you've charged our members for PPE, contact your Aetna® network representative or call our service center at **1-888-632-3862**. Doing so will help us ensure that they get refunds.

You can find the latest information on COVID-19 liberalizations on our **provider page**. You can also visit the **New York Department of Financial Services website**.



Medicare updates

Get Medicare-related information, reminders and guidelines.

Medicare Advantage plan: acupuncture coverage for chronic lower back pain

Since January 2020, the Centers for Medicare & Medicaid Services (CMS) covers acupuncture only for Medicare patients with chronic Lower Back Pain (cLBP).

Who may perform acupuncture for cLBP?

- **Physicians**, in accordance with state requirements
- **Physician assistants, nurse practitioners/clinical nurse specialists and auxiliary personnel** who meet all applicable state requirements and have:
  - A master's or doctoral degree in acupuncture or oriental medicine from a school accredited by the Accreditation Commission for Acupuncture and Oriental Medicine
  - A current, full, active and unrestricted license to practice acupuncture in a state, territory or commonwealth of the United States, or in the District of Columbia

Auxiliary personnel furnishing acupuncture must be under supervision of a physician, physician assistant or nurse practitioner/clinical nurse specialist.

Requirements are included in our **provider and facility participation criteria**.

What is covered?
CMS covers up to 12 visits in 90 days for cLBP when the pain:

- Lasts 12 weeks or longer
- Is nonspecific (no identifiable systemic cause; not associated with metastatic, inflammatory or infectious disease)
- Is not associated with surgery or pregnancy

A patient may receive:

- Eight additional sessions improvement
- No more than 20 acupuncture treatments annually
- Treatment must stop if the patient not improving or regresses

New Medicare plan: Aetna Assure Premier Plus (HMO D-SNP) effective January 1, 2021

On January 1, we launched Aetna Assure Premier Plus (HMO D-SNP), a new Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) in these New Jersey counties:

- Bergen
- Camden
- Essex
- Hudson
- Mercer
- Middlesex
- Monmouth
- Ocean
- Passaic
- Union

This is a Medicare Advantage managed care plan option for individuals with Medicare and full NJ FamilyCare/Medicaid coverage.

It covers all Medicare and Medicaid services, including prescription drugs, behavioral health, Managed Long Term Services and Supports (MLTSS) and additional supplemental benefits. It carries a $0 cost share for all members.

As a participating provider in this new plan, you will want to be aware of the following:

- Key plan features:
    - $0 cost sharing for all plan-covered services and prescription drugs
    - One member ID card to access all covered services
    - A dedicated Aetna® care manager for all members
    - No referrals for specialists
    - In-network primary care provider (PCP) selection required

- Using the member's ID number from the plan ID card, you will need to submit *one claim*. Your claims will automatically be processed first under the Medicare benefits and then under the

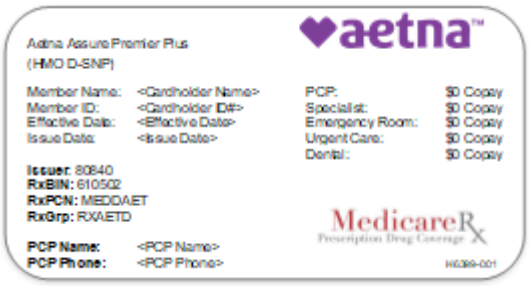
Medicaid benefits. Use submitter ID #46320 when submitting claims. Members should *not* be balanced billed for any covered benefit.

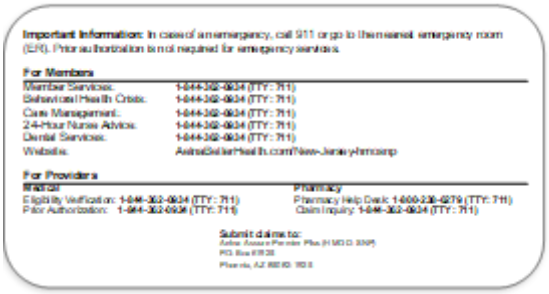
- You can use the provider portal to access eligibility, panel rosters, claims status and much more. Simply use the Medicaid Web Portal or select Aetna Better Health® in Availity® to see all the ways that we support you.

More resources for you and your office staff

- **Aetna Assure Premier Plus (HMO D-SNP) plan website**
- **Provider website**
- **Provider FAQ**
- **Provider orientation**

Member ID card image





If you have any questions, call Aetna Assure Premier Plus (HMO D-SNP) at **1-844-362-0934 (TTY: 711)** Monday to Friday, 8 AM to 5 PM.

New for 2021: Changes to our requirements for Medicare compliance training & DSNP MOC attestation

Participating providers in our Medicare Advantage (MA), Medicare-Medicaid (MMP) and/or Dual Eligible Special Needs (DSNP) plans, are required to meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related entities (FDR). Provider attestation collection for the FDR compliance requirements (except for Delegated Entities) will no longer be required. Delegated entities will receive their attestation directly through Adobe Sign. Completion of DSNP MOC training and the related attestation is still required.

Our Compliance Department completes random audits to ensure compliance on an annual basis. To ensure you're able to meet these requirements review our training materials at **Aetna.com/Medicare**.

If participating in our DSNP network – Annual MOC training & attestation requirements still apply

ıIf we have a valid email address for your practice/organization, you will receive an email from Adobe Sign to review and sign your 2021 attestation. If we do not have an email on file, you will receive postcard to complete your attestation on **Aetna.com/Medicare**.

Please see our **Quick Tips Guide** to address common questions and assist you with the completion of your attestation.

Review our training resources to ensure you're in compliance at **Aetna.com/Medicare**.

- **Medicare compliance FDR program guide**
- **FDR frequently asked questions**
- **DSNP Model of Care (MOC)** – Required only if you are in our DSNP network

Where to get more information
If you have questions related to meeting FDR compliance or the MOC attestation, email us at **FDRAttestation@aetna.com**. For more information, view our quarterly **FDR Compliance Newsletters**.

ABNs aren't valid for Medicare Advantage members

Providers should be aware that an Advance Beneficiary Notice of Noncoverage (ABN) is not a valid form of denial notice for a Medicare Advantage member. The Original Medicare program uses ABNs — 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 is and isn't covered

Providers in the Medicare program should know what 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 to verify coverage or if you have questions.

Providers in a Medicare Advantage plan can't charge a Medicare Advantage member for a service not covered under their plan unless that member gets a preservice organization determination (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.

But 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. 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.

Holding members responsible

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

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

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