OfficeLink Updates™

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

aetna™

SEPTEMBER 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.

eviCore healthcare Site of Care medical necessity requirement

Effective **December 1, 2021**, Aetna® will add a Site of Care medical necessity requirement to the Enhanced Clinical Review program for fully insured commercial members. As part of this change, advanced radiology imaging procedures (MR and CT scans) will be reviewed by eviCore healthcare for applicable medical necessity criteria prior to authorization of services in the hospital outpatient setting.

An advanced imaging procedure at a hospital outpatient site is considered medically necessary when cases involve certain factors. Examples are those where:

- the individual is under 18 years of age
- obstetrical observation is required
- perinatology services are required
- there are imaging needs related to transplant services at an approved transplant facility
- there is a known contrast allergy, and use of that contrast agent is planned
- there is a known chronic disease for which prior high-tech imaging procedures have been used for the diagnosis, management or ongoing surveillance of the disease at the hospital-affiliated imaging department
- there is a COVID-19 diagnosis after positive test for SARS-CoV-2
- there are no other appropriate alternative sites for the individual to undergo the imaging procedure for any of the following reasons:
    - the surgery or procedure is being performed at the hospital, and preoperative/procedural or postoperative/procedural imaging is an integral component of the care
    - moderate or deep sedation or general anesthesia is required for the imaging procedure, and a freestanding facility capable of providing such sedation is not available
    - equipment needed to accommodate the size of the individual is available only at a hospital-affiliated imaging facility
    - the individual has a documented diagnosis of claustrophobia requiring open magnetic resonance imaging, which is not available in a freestanding facility
    - imaging outside the hospital-affiliated imaging department or facility is expected to adversely impact or delay care

All requested advanced radiology procedures that don't meet the required criteria will be considered non-medically necessary unless performed at a freestanding or office location.

This policy will apply to all existing Enhanced Clinical Review program markets.

Pay percent reductions for multiple endoscopies

In the June issue of OLU, we said that, effective September 1, 2021, we would begin adjusting 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. We delayed the policy changes and will begin applying pay percent reductions on **December 1, 2021**.

Site-of-service precertification requirements

Effective **December 1, 2021**, we will implement site-of-service precertification requirements for certain procedures.

We will not require precertification for services performed in an ambulatory surgical facility or an office.

We will require precertification for procedures performed in an outpatient hospital setting. Our goal is to ensure that our members receive quality care at the most appropriate site of service based on individual needs.

We consider the following during the precertification process:

- The need for access to more intensive services or medical support
- The availability of a participating network facility
- Physician privileges
- Other specialty requirements

For a list of procedure codes that require precertification under this policy, go to **our provider portal on Availity**. Once there, go to Aetna's Payer Space > Resources > Site of Service Outpatient Surgical Procedure list.

Changes to our National Precertification List (NPL)

Starting January 1, 2022, the following precertification changes apply:

- We will no longer require precertification for canthoplasty.
- We will no longer require medical precertification for the following oral drugs (precertification may still be required through pharmacy plans):
  - Adcirca® (Alyq™, tadalafil)
  - Adempas® (riociguat)
  - Aubagio® (teriflunomide)
  - Bafiertam™ (monomethyl fumarate)
  - Emflaza® (deflazacort)
  - Gilenya® (fingolimod hydrochloride)
  - Letairis® (ambrisentan)
  - Mavenclad® (cladribine)
  - Mayzent® (siponimod)
  - Olumiant® (baricitinib)
  - Opsumit® (macitentan)
  - Orenitram® (treprostinil diolamine)
  - Otezla® (apremilast)
  - Ponvory™ (ponesimod)
  - Revatio® (sildenafil citrate)
  - Rinvoq™ (upadacitinib)
  - Tecfidera® (dimethylfumarate)
  - Tracleer® (bosentan)
  - Uptravi® (selexipag)
  - Vumerity® (diroximel fumarate)
  - Xeljanz®, Xeljanz XR® (tofacitinib)
  - Zeposia® (ozanimod)

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 another vendor or clearinghouse on our list. Vendor fees may apply.

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)**.

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 on the **Precertification page**.

Changes to commercial drug lists begin on January 1

On **January 1, 2022**, we'll update our pharmacy drug lists. Changes may affect all drug lists, precertification, step therapy and quantity limit programs.

You'll be able to view the changes as early as October 1. 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**.
- For requests for nonspecialty drugs, call **1-800-294-5979 (TTY: 711)**. Or fax your completed **prior authorization request form (PDF)** to **1-888-836-0730**.
- For requests for drugs on the Aetna Specialty Drug List, call **1-866-814-5506**. Or fax your completed **prior authorization request form (PDF)** to **1-866-249-6155**.

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

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

Nonparticipating-provider standard timely filing limit change

We've changed the standard nonparticipating-provider timely filing limit from 27 months to 12 months for traditional medical claims.

The updated limit will:

- Start on **January 1, 2022**
- Maintain dental limits at 27 months
- Match Centers for Medicare & Medicaid Services (CMS) standards

Providers will begin seeing denials in 2023. All policy exceptions to timely filing today will apply after this change and will be supported as they are today.

Third Party Claim and Code Review Program

Beginning **December 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 portal**.

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

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**. Once there, go to Aetna's Payer Space > Applications > Code Edit Lookup Tools. You'll need to know your Aetna® provider ID number (PIN) to use the tools.

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.

Introducing the Aetna Institutes™ Gene-Based, Cellular and Other Innovative Therapies (GCIT™) Designated Network program

About the program and how to participate

The GCIT™ Designated Network program is the Aetna® participating network for certain gene therapy services. The program helps patients who have been diagnosed with certain genetic conditions that may be treated with the use of innovative FDA-approved GCIT products.

All fully insured benefits plans, and an increasing number of self-insured benefits plans, now require members to seek GCIT services from a GCIT-designated provider to receive any coverage or maximum in-network coverage for GCIT services. This means that providers who do not contract to be part of the GCIT-designated networks for specific GCIT services may not be able to serve as participating providers for those services in the future.

Current GCIT-designated services include Luxturna, Spinraza and Zolgensma. If you do not provide those GCIT-designated services and wish to be, we invite you to contact Aetna at **GeneTherapyDesignatedCenterRequests@aetna.com** to discuss GCIT network participation.

Additional information on Aetna Institutes programs, including program criteria for GCIT network consideration, can be found at **Aetna Institutes**.

Network selection

The Aetna Institutes GCIT network is selected through a national contracting process. GCIT providers that meet Aetna guidelines and execute a specific GCIT agreement will be designated in the Aetna GCIT network. The GCIT network selection process is an ongoing effort. Any provider who would like to join the Aetna Institutes GCIT network should **submit a request to the Aetna-dedicated gene therapy contracting team mailbox** for consideration.

Aetna retains the sole discretion to determine designation as an Aetna Institutes GCIT-designated provider. We will take into consideration all program criteria, including cost, accessibility and business needs. Satisfaction of the program criteria is not a guarantee of designation.
The list of GCIT-designated services in the section above is subject to change. Not all self-funded plans cover all GCIT services. The terms and conditions of the member's benefits plan will apply.

More information about GCIT-designated services

Luxturna: Aetna Clinical Policy Bulletin (CPB) #927

On December 18, 2017, the U.S. Food and Drug Administration (FDA) approved Luxturna (voretigene neparvovec-rzyl), a gene therapy drug used to treat children and adult patients who have an inherited form of vision loss that may result in blindness. **Read the FDA announcement**.

Spinraza®: Aetna Clinical Policy Bulletin (CPB) #915

On December 23, 2016, the FDA approved Spinraza (nusinersen), an innovative drug used for the treatment of spinal muscular atrophy (SMA) in children and adults. SMA is a rare genetic disease and is often fatal. **Read the FDA announcement**.

Zolgensma®: Aetna Clinical Policy Bulletin (CPB) #953

On May 24, 2019, the FDA approved AVXS-101/Zolgensma (onasemnogene abeparvovec-xioi), a gene therapy drug used for the treatment of spinal muscular atrophy (SMA) in infants under two years of age. SMA is a leading genetic cause of infant mortality. **Read the FDA announcement**.

Important reminders

Refer patients to our Complex Case Management program

Our Complex Case Management program is a joint process including Aetna®, the member, the caregiver and the providers.

The Complex Case Management program focuses on the continuum of care, addresses the health care needs of members, and stresses medically appropriate care and member involvement in the health care process. We offer members with complex conditions extra help understanding their health care needs and benefits. We also help them access community services and other resources available to them.

The overall goal and objective of the Complex Case Management program is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner.

We welcome referrals for the program from many sources. These include:

- Primary care physicians
- Specialists
- Facility discharge planners
- Member or caregiver(s)
- Medical management programs
- The member's employer
- Other organization programs or through a vendor or delegate
- The 24-Hour Nurse Line

You can submit a referral through the toll-free phone number on the member's ID card.

Remember, starting August 30, you can 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 that 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 webinar dates and times**, or register for our Authorizations on Availity webinar. Before you join us, **register for Availity**.

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

News for you

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.
- For EODs, the time allowed to submit supporting clinical information as well as a peer-to-peer discussion for adverse determinations is limited.
- EODs should not be requested for cases when the only issue involves a claim for payment for services that the member has already received.

Member access to care

We measure member access to care every year. We do this in many ways. For example, we review:

- Member satisfaction survey results
- Complaint data
- Phone surveys we conduct

The phone surveys include a random sampling of primary care and specialty care providers.

We thank you for taking part in these phone surveys. We do all this to comply with the National Committee for Quality Assurance (NCQA) accreditation standards and with those of various state regulations.

You'll find the access standards we measure in the **Office Manual for Health Care Professionals**. These standards include appointment availability time frames for routine care, urgent matters and after-hours care. State requirements supersede these access standards and are located in the Regional Office Manual Supplements.

We're going paperless! Here's how to get electronic EOB statements and payments

Starting in September through 2022, we're phasing out paper Explanation of Benefits (EOB) statements and checks. Sign up before it's your turn. If you don't enroll to receive direct deposit payments, you may receive future payments by virtual credit card. Keep reading to learn more.

Get EOB statements from Availity®
Register for **our provider portal on Availity**. Get identical copies of your EOB statements from the Availity Remittance Viewer. Then print or save them to your computer. You won't need to wait for them to arrive in the mail.

Sign up for direct deposit payments
Sign up for direct deposit payments using our new portal, Payer Enrollment Services. Just go to **Payer Enroll Services**. We'll stop using EnrollHub® effective September 1. Even if you're already enrolled to receive direct deposit payments (or electronic remittance advice), use the new portal to make changes.

Visit **AetnaPaperlessOffice** to learn more about your options.

BRCA testing made simple with Quest Diagnostics®

You can now order BRCA1 and BRCA2 testing through Quest for commercial members who meet our coverage criteria without completing a precertification request. To ensure a seamless process, you can continue to submit their family history. Just go to the Quest Diagnostics **Know Your History page**, click Get Started, then I'm a Healthcare Provider.

Simplified program
This simplified program is exclusive to Quest. We will provide coverage based on our Clinical Policy Bulletins (CPBs).

Advantages of testing with Quest
- Patients with our commercial plan will have no out-of-pocket costs for the above tests when testing is considered preventive.
- Testing is easier to access, and there's less administrative work for your office.

- BRCA services through a preferred laboratory provider are high quality and cost effective.
- BRCA testing is available for patients who could benefit from genetic testing.

Quest genetic counselors provide ongoing support for test selection and result interpretation. They are available at **1-866-GENE-INFO (1-866-436-3463)**, Monday through Friday, 8:30 AM to 8:00 PM ET.

Visit the **test directory page** for ordering information.

You can learn more about Quest hereditary cancer testing options at **Quest Hereditary Cancer**. For our Medicare members, precertification is still required. You can fax the precertification form to **1-855-422-5181**.

HIPAA and release of information

Most health care professionals are familiar with the Health Insurance Portability and Accountability Act, most commonly known as **HIPAA**, and the importance of upholding its requirements. In short, HIPAA works to protect the confidentiality of people receiving medical and behavioral health treatment.

At Aetna®, we work to support your efforts to coordinate care among our medical and behavioral health providers. It's important to follow HIPAA and relevant federal and state privacy laws to safeguard personally identifiable information (PII) and protected health information (PHI).

Helpful tips

- There is a difference between how behavioral health practitioners share information with medical providers and how medical providers share information among themselves.
- For behavioral health information such as general progress reporting and sharing of details like medication lists, a signed release may be required by relevant federal or state law. This release may be required even if the medical provider seeking the information is also the one that referred the member to the behavioral health provider. State and/or other laws may apply. Learn more about **mental health HIPAA requirements** and **substance use disorder requirements**.
- Psychotherapy notes that contain the content of conversations are not covered under a general release. Psychotherapy notes **require a separate release of information**.
- Confidentiality laws govern what and how information can be shared, and they vary by state. We encourage both behavioral health and medical providers to **find out about and follow their state regulations**.
- To enhance coordination of care, obtaining a release of information from your patient is one way to facilitate information sharing with other providers and practitioners.

Legal disclaimer

The information in this article does not, and is not intended to, constitute legal advice; instead, all information, content and materials are for general informational purposes only. Information may not constitute the most up-to-date legal or other information. Links are provided only for the convenience of the reader, and Aetna does not recommend or endorse the contents of third-party sites.

Readers should contact their attorney to obtain advice with respect to any particular legal matter. No reader should act or refrain from acting on the basis of information contained in this article without first seeking legal advice from counsel in the relevant jurisdiction. Only your individual attorney can provide assurances that the information contained in this article — and your interpretation of it — is applicable or appropriate to your particular situation.

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, view **this short video and presentation**.

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

The provider data management (PDM) tool on Availity® allows you to update information about your business and providers. Keeping your information current and accurate helps our members find and connect with you for care. Making updates in the PDM tool allows you to share information with Aetna® and other payers, reducing phone calls to your office. Some other benefits include:

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

Make sure we have the right contacts so we can provide you with important information, such as our OfficeLink Updates™ newsletter, changes on the provider portal and policy updates.

By using the PDM tool, you can simply verify what we already have on file for you or make updates to information about your business, provider directory and key staff members. Many updates are pushed right to the Aetna database. Some will route to other Aetna workflows for updating. Either way, your changes will get made significantly faster than they would by reaching out to us by phone or in writing.

Give it a try. Once logged in to Availity, go to My Provider > Provider Data Management.

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.

Major depressive disorder (MDD)

Major depressive disorder, also known as clinical depression, is a common but serious mood disorder. To be diagnosed with depression, persistent feelings of sadness, hopelessness and loss of interest in activities must be present for at least two weeks.

Major depressive disorder is found in the following ICD-10 category
F32 — Major Depressive Disorder, single episode
F33 — Major Depressive Disorder, recurrent

Documentation tips

- Include depression screening results with encounter notes (coders cannot code directly from depression screenings).
- Document the episode as single or recurrent.
- Indicate the severity as either mild, moderate or severe.
- Indicate whether psychosis symptoms are present or absent.
- If the person is in remission, document whether the remission is partial (up to two months, symptom free) or full (greater than two months symptom free).
- Do not use "history of" to describe a current or active diagnosis of MDD.
- Document a treatment plan.

The overarching focus of our nurse educators is to ensure that providers keep accurate and current documentation and that they properly code and submit member diagnoses and conditions. Email **Risk Adjustment** for additional information and scheduling education.

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 (PDF)**. 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**, a **parent training program**, **counseling services**, **stress-management techniques**, and **emotional well-being resources**.

LOCUS® and CALOCUS/CASII® are here

Aetna® is beginning to use 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 replace the Level of Care Assessment Tool (LOCAT) for behavioral health reviews.

These person-centered approaches aim to best match individual needs and behavioral health services. LOCUS and CALOCUS/CASII help identify the array of services that best meet the needs of a population.

Currently, these guidelines are effective for commercial patients in California. Starting Q2 2021, these guidelines will be effective for all patients with commercial plans. Any reviews that took place in the past using LOCAT (before the required use of LOCUS and CALOCUS/CASII) are acceptable.
And for your patients in Medicare Advantage plans, the Centers for Medicare & Medicaid Services (CMS) criteria will continue to be used for all Organizational Determinations. LOCUS will be used in all other cases.

Guidelines and resources

- LOCUS evaluation parameters (PDF)
- LOCUS levels of care descriptions (PDF)
- LOCUS guide for patients and families (PDF)
- CALOCUS/CASII levels of care descriptions (PDF)
- CALOCUS/CASII anchor points (PDF)

For more information about LOCUS, visit the **American Association for Community Psychiatry** website. For more information about the CALOCUS/CASII, visit the **American Academy of Child and Adolescent Psychiatry** website.

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

[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.

- 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 Z13.31 (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
- 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 (PDF)

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 (PDF)

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 (PDF)
- 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.

Better health outcomes for substance use disorders

Patients with alcohol and substance use disorders are more likely to have better outcomes with patient education, early treatment and follow-up care. You can make a difference. Schedule follow-up treatment each time you diagnose a new episode of alcohol or other drug (AOD) dependence.

Improving outcomes

- **Screen your patients** for at-risk alcohol and substance use. You can be reimbursed for this screening.
- Educate your patients about at-risk alcohol and substance use.
- Educate your patients about their **diagnosis**.
- Discuss the importance of follow-up care and attending all appointments.
- Involve your patients' support system and help those supports understand how they can help.

Managing appointments for success

- Schedule the initial AOD dependence treatment within 14 days of diagnosis. Treatment may include:
    - **Telehealth** or **medication assisted treatment** (MAT)
    - An outpatient visit
    - An intensive outpatient visit
    - Inpatient admission
    - Partial hospitalization
- Arrange two additional visits within 34 days of the initial visit.
- Use appropriate **diagnosis codes (PDF)**.
- Use the diagnosis of AOD judiciously. For example, if your adolescent patient receives an AOD dependence diagnosis, they should receive follow-up care.
- Ensure that all claims contain a place of service, procedure code (as applicable in your contract) and an AOD dependence diagnosis.

Refer patients to a behavioral health professional

We're here to support the care you give your patients. Just call the Member Services number on their ID card. We can help connect them to a behavioral health provider.

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 Psych Hub
Our behavioral health providers can have a meaningful impact on our members. That's why we're partnering with **Psych Hub**, the world's largest online platform for mental health education.

Psych Hub 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 courses you can take to earn an **eLearning certification in suicide prevention (video)** developed by leading experts at Columbia, the University of Pennsylvania and Harvard. Course titles and descriptions are as follows:

"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 courses 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 can I start?
This offering is now available to commercial behavioral health providers. **Sign up today**.

Pharmacy updates

Changes to commercial drug lists begin on January 1

On **January 1, 2022**, we'll update our pharmacy drug lists. Changes may affect all drug lists, precertification, step therapy and quantity limit programs.

You'll be able to view the changes as early as October 1. 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**.
- For requests for nonspecialty drugs, call **1-800-294-5979 (TTY: 711)**. Or fax your completed **prior authorization request form (PDF)** to **1-888-836-0730**.
- For requests for drugs on the Aetna Specialty Drug List, call **1-866-814-5506**. Or fax your completed **prior authorization request form (PDF)** to **1-866-249-6155**.

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

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 referred to below are your Notice of Material Amendment to Healthcare Contract. They are 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)."

- Pay percent reductions for multiple endoscopies
- Site-of-service precertification requirements
- Changes to our National Precertification List (NPL)

- Third Party Claim and Code Review Program
- Introducing the Aetna InstitutesTM Gene-Based, Cellular and Other Innovative Therapies (GCITTM) Designated Network program
- eviCore healthcare Site of Care medical necessity requirement
- Changes to commercial drug lists

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 **email 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 the **Maryland Provider Terminations (Quarterly Report) (PDF)** in the **Office Manual for Health Care Professionals — Southeast Regional section (PDF)**. Review the report periodically to see which providers no longer participate with us.

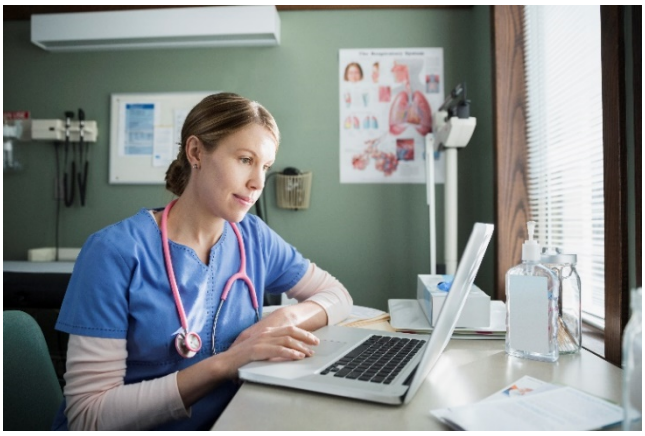
To view a current listing of providers who participate in our network, go to our **provider referral directory**. Referring your Aetna members to in-network providers helps them control their out-of-pocket costs.

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)**.

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 (PDF)** 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.



Medicare updates

Get Medicare-related information, reminders and guidelines.

It's time to verify your patients' eligibility

Important member ID card changes for those with Medicare Advantage plans

The following changes begin on January 1, 2022:

- All Aetna Medicare Advantage plan members will have 12-digit member ID numbers beginning with "10." We will no longer use the "ME" prefix for Medicare Advantage plans after that date. Consol Energy will transition from ID numbers beginning with "ME" to those beginning with "10" on April 1, 2022.

- "Group #" will be known as "Plan #." Please use the plan number in the way that you have previously used the group number in your transactions.

When checking your patients' eligibility and benefits, use our **provider portal on Availity** or another vendor or clearinghouse on our list. Vendor fees may apply.

Note when services were performed:
- For services performed on or before December 31, 2021, use the member's prior ID number.
- For services performed on or after January 1, 2022 (April 1, 2022, for Consol Energy), use the member's 2022 MA plan ID number. You can use this number to verify coverage, request an authorization/precertification, issue referrals and submit claims.

Ask your patients for their current member ID card. If they don't have one, you can verify their eligibility using their full first and last name and date of birth. In addition, you can print an electronic copy of a patient's ID card, if needed. Make sure that eligibility details match the patient's information.

While it's a good idea to verify patient eligibility at the beginning of the year, it's best to verify their eligibility before every visit.

A new year means new plans
Some of your patients may have a new Aetna Medicare Advantage plan for 2022 that has different financial obligations or a new member ID number. Use the Eligibility and Benefits Inquiry transaction to get details on their 2022 plan.

Always use the correct ID number (for the corresponding year) when submitting claims, authorizations/precertifications or referrals.

Expanded Aetna Medicare Advantage program starting August 1, 2021

Our Aetna Medicare Advantage program works with **myNEXUS, a technology-enabled care management company**, to manage the network, claims payment and precertification/prior authorization program for home health services. This program has been in Texas since March 1, 2020, and now we are expanding it to DSNP members in Texas and to Georgia, Virginia and Oklahoma.

We have also made important changes regarding pre-approval and claims payments.

Pre-approval changes
Starting August 1, 2021, all home-health-related requests for in-home skilled nursing, physical therapy, occupational therapy, speech therapy, home health aides and medical social work will require advance approval from myNEXUS. Services administered in a home or residence for Aetna Medicare Advantage members in Georgia, Virginia, and/or Oklahoma will need pre-approval from myNEXUS before they can commence. **View the Aetna home health care pre-approval list**.

Claims payment changes

Starting August 1, 2021, claims for covered home health services filed with an authorization issued on or after August 1, 2021, for Georgia, Virginia, and/or Oklahoma Medicare Advantage members will be paid by myNEXUS under the rates and terms of your myNEXUS contract.

This change applies only to home health care services for:

- Aetna Medicare Advantage members
- Members residing in the states of Georgia, Virginia and Oklahoma
- Aetna Medicare DSNP members in Georgia and Texas only

This change does not apply to any other plans or members, including, but not limited to:

- Medicare members residing outside of the states of Georgia, Virginia and/or Oklahoma
- Aetna and Coventry commercial fully insured HMO/POS/PPO plan
- Aetna administrative services only (ASO) self-funded HMO/POS/PPO plan
- Aetna Student Health℠
- Aetna Global Business
- Coventry Workers' Compensation
- Cofinity®
- First Health®, Meritain® Health, Traditional Choice®
- Aetna Signature Administrators®

Pre-approval requests

- **Visit the myNEXUS portal** (registration required) to get started.
- Fax the **authorization request form** to **1-866-996-0077**.

If you have questions, call myNEXUS Intake (Monday through Friday, 8 AM to 8 PM ET) at **1-833-585-6262**.

2021 Medicare Member In-Home FIT-Kit campaign

We are pleased to announce the launch of our annual Medicare Member In-Home FIT-Kit campaign. This campaign will offer members a convenient solution for completing their colorectal cancer screening at home. The campaign will be launched in two phases.

Phase I

The Provider Order program will run from June through August 20, 2021. During this time, an online portal will be available for providers to use to order kits for their members with colorectal cancer screening gaps (that is, Medicare members from age 50 to 75 who have not received an appropriate colorectal cancer screening within a designated time frame). Orders will be processed by our vendor, Home Access Health, which will ship kits directly to members. Only members with attributed providers will be eligible.

Phase II

The Direct to Member program will begin in September and will apply to all members with a colorectal cancer screening gap in care. The member eligibility file will be sent directly to Home Access Health. Phase II will not include members who were opted out by their provider.

Test results will be mailed to the member and the member's provider. If the test is positive, Home Access Health will call the member and provider.

2021 Medicare compliance training and DSNP MOC attestation requirements for participating providers

Participating providers in our Medicare Advantage (MA) plans, Medicare-Medicaid Plans (MMPs) and/or Dual Eligible Special Needs Plans (DSNPs) must meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related (FDR) entities identified in the **Medicare compliance FDR program guide (PDF)** and/or **DSNP Model of Care (MOC) (PDF)** training guide.

New for 2021

- MA/MMP: Providers who participate only in our MA/MMP plans no longer need to complete an annual FDR attestation.
- DSNP/FIDE: Providers who also participate in our DSNP/FIDE plans must still complete the annual **DSNP Model of Care (MOC) training (PDF)** and attestation requirements.
- Delegated Entities: Provider attestation collection for the FDR compliance requirements continue to be required for Delegated Entities. Delegated Entities will receive their attestation directly through Adobe Sign. Completion of both the **DSNP Model of Care (MOC) training (PDF)** (if applicable) and attestation is still required.

Notification regarding requirements will be sent directly to providers via Adobe Sign email or postcard notification.

Take a moment to review our training resources on the Aetna Medicare page to ensure you're in compliance. These include the **Medicare compliance FDR program guide (PDF)**, the **DSNP Model of Care (MOC) training guide (PDF)** — required only if you are in our DSNP network — and the **frequently asked questions document (PDF)**.

Note: Our compliance department completes random audits on an annual basis to ensure compliance.

Where to get more information

Have questions on the Medicare FDR compliance or DSNP/FIDE programs? Review the **frequently asked questions document (PDF)** for more information and contacts.
To keep up with compliance news, you can also view our quarterly **FDR Compliance Newsletters**.

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