

September 2023

OfficeLink Updates™



Welcome to the latest edition of OfficeLink Updates (OLU). As always, we provide you with relevant news for your office.



HIGHLIGHTS IN THIS ISSUE

[Referral requirements for DSNPs](#)

Find out how to use Availity® to get DSNP referrals, how to get trained, how to refer members to participating providers and which DSNPs require referrals.

[Telemedicine coverage update](#)

You can view the procedures and modifiers that we will no longer cover as of December 1, 2023, on our [Availity provider portal](#). Go to Aetna Payer Space > Resources > Claim Resources > Telemedicine liberalized codes no longer covered effective 12.1.23.

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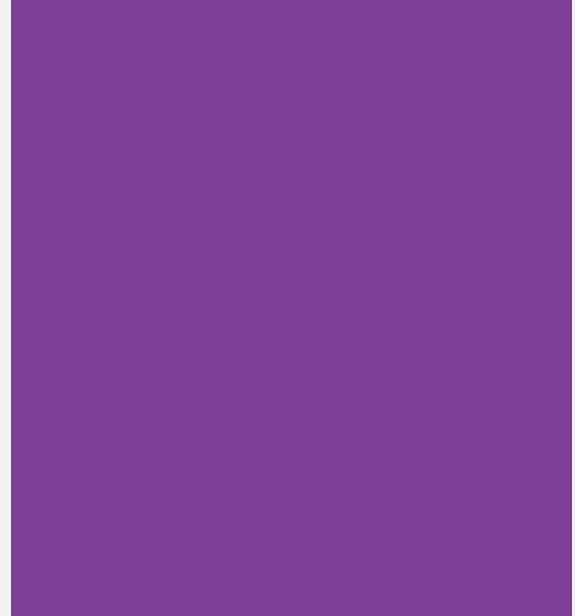
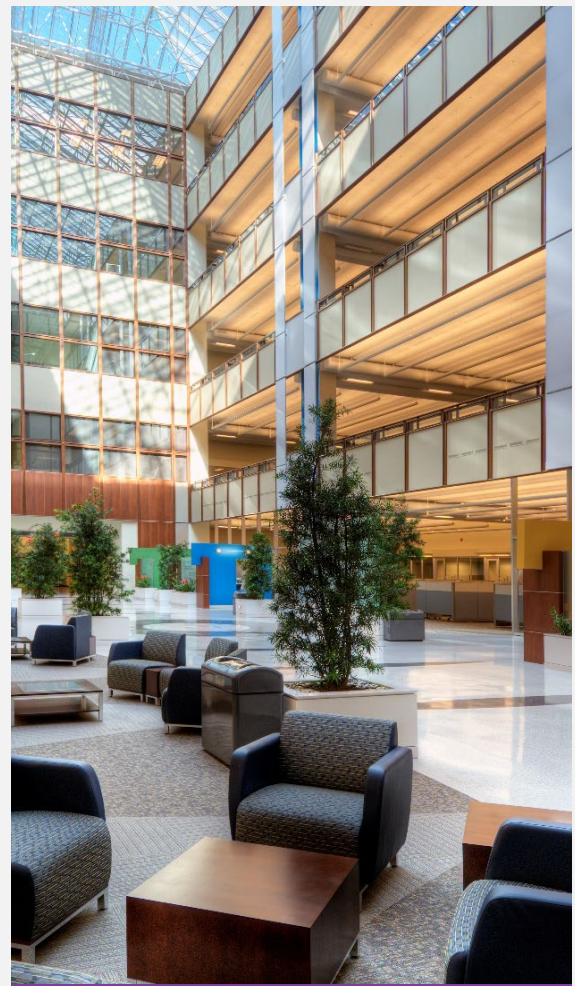
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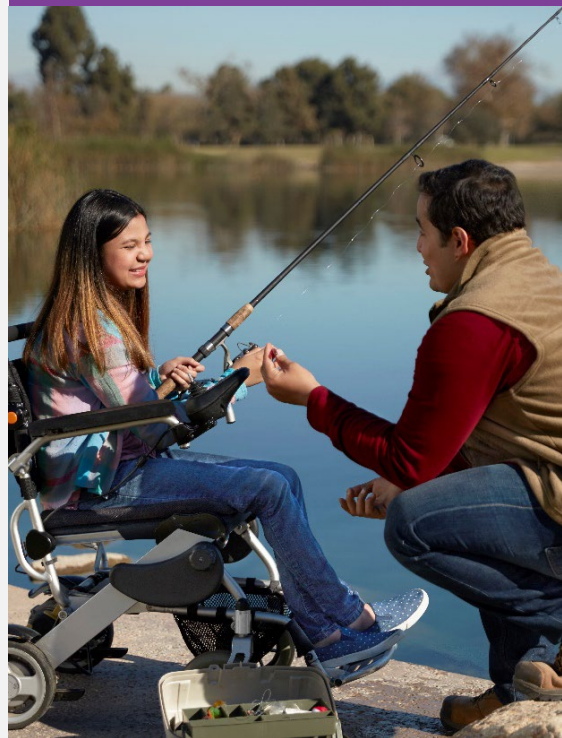
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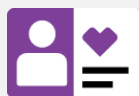
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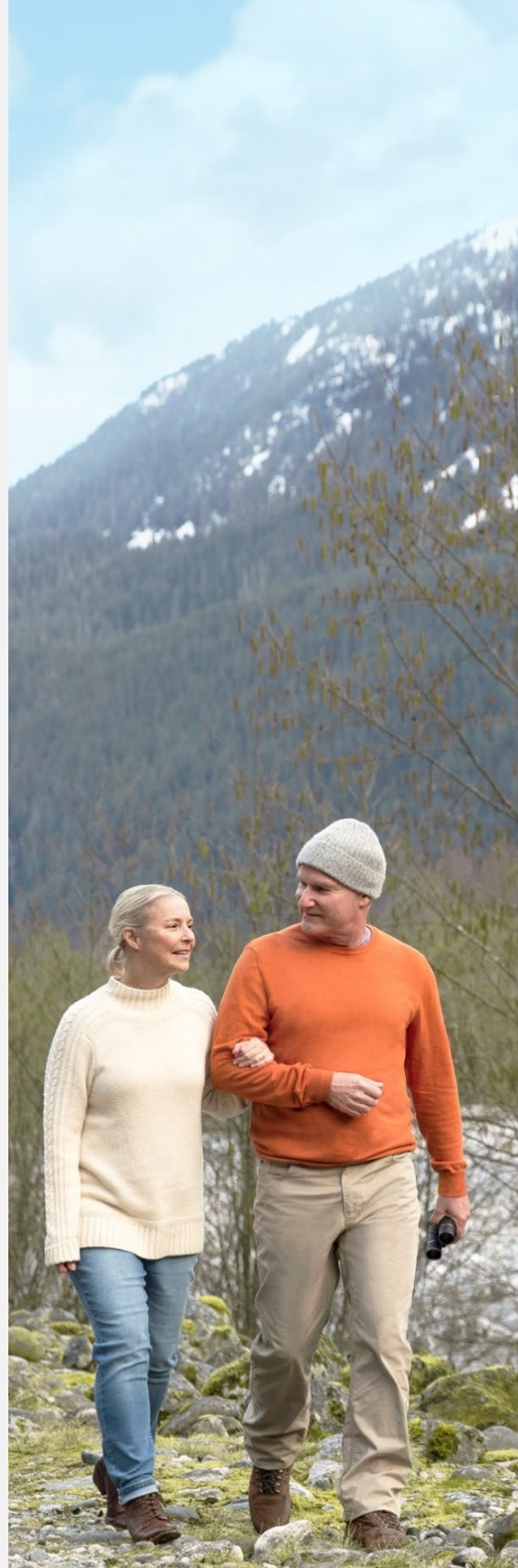
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90-day notices and related reminders

We regularly adjust our clinical, payment and coding policy positions as part of our ongoing policy review processes. Our standard payment policies identify services that may be incidental to other services and, therefore, ineligible for payment.

We're required to notify you of any change that could affect you either financially or administratively at least 90 days before the effective date of the change. These changes may not be considered material changes in all states.

Unless otherwise stated, policy changes apply to both Commercial and Medicare lines of business.

Evaluation & Management (E&M) services update

We won't allow additional payment for E&M services billed by radiology providers.

This change applies to both our commercial and Medicare members.

Starting December 1, 2023, we will not allow additional payment for E&M services when billed by a radiologist. We consider the charges incidental to the test or procedure.

Effective December 1, 2023, we will not allow payment for E&M codes from providers in these areas:

- 207U00000X: Nuclear Medicine
- 207UN0901X: Nuclear Medicine, Nuclear Cardiology
- 207UN0902X: Nuclear Medicine, Nuclear Imaging & Therapy
- 207UN0903X: Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine
- 2085B0100X: Radiology, Body Imaging
- 2085H0002X: Radiology, Hospice and Palliative Medicine
- 2085N0700X: Radiology, Neuroradiology
- 2085N0904X: Radiology, Nuclear Radiology
- 2085R0203X: Radiology, Therapeutic Radiology
- 2085R0205X: Radiology, Radiological Physics
- 2471M2300X: Radiologic Technologist, Mammography
- 2471R0002X: Radiologic Technologist, Radiation Therapy
- 261QM1200X: Clinic/Center, Magnetic Resonance Imaging (MRI)
- 261QR0200X: Clinic/Center, Radiology
- 261QR0208X: Clinic/Center, Radiology, Mobile
- 335V00000X: Portable X-ray and/or Other Portable Diagnostic Imaging Sup

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

Claim and Code Review Program (CCRP) update

We might have new claim edits for our commercial, Medicare and Student Health members. You can view them on [Availity®](#).

This update applies to our commercial, Medicare and Student Health members.

Beginning December 1, 2023, you may see new claim edits. These are part of our CCRP. These edits support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. You can view these edits on our [Availity provider portal](#).*

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

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

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

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

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

Changes to our National Precertification List (NPL)

Note the following drug changes for Medicare members.

The following changes apply only to Medicare members.

Effective January 1, 2024, we'll require precertification for the following drugs:

- Zilretta® (triamcinolone acetonide extended release injectable suspension)
- Pempfexy® (pemetrexed)

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 [Availity provider portal](#).^{*} Or you can use your practice’s Electronic Medical Record (EMR) system if it’s set up for electronic precertification requests. Use our “Search by CPT® code” search function on our [precertification lists](#) page to find out if the code requires precertification.^{**} Learn more about [precertification](#).

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? Go to [Availity](#) to register and learn more.

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Assistant therapy services billing reductions

This update applies to both our commercial and Medicare businesses.

Effective December 1, 2023, we will pay eligible services billed by occupational therapy assistants (OTAs) and physical therapist assistant (PTAs) at 85% of allowed.

- CO: Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
- CQ: Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant

Policy changes

Each policy change described below will apply depending on the type of reimbursement you receive as stipulated in your provider agreement and/or whether you bill for the services or procedures.

Procedure/ revenue codes	Effective date	What's changing
0235T, 0263T, 0264T, 0265T, 0266T, 0267T, 0268T, 0269T, 0270T,	1/1/2024	Will be ADDED to the Ambulatory Surgery: Default Rate (DEFAULTSUR)

0271T, 0274T, 0398T, 0465T, 0546T, 0699T, C2613, C9734, C9776, G0247, G0276, G0428, G0429		
10004, G0516, G0517, G0518	1/1/2024	<p>Will be ADDED to the Ambulatory Surgery: Default Rate (DEFAULTSUR)</p> <p>Code will remain assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 1 (AEG1)</p> <ul style="list-style-type: none"> • If contract has an Ambulatory Surgery — Aetna Enhanced Grouper: Category 1 rate it will apply. If not, then the Ambulatory Surgery Default Rate will apply.
0425T, 0426T, 0427T, 0428T, 0429T, 0430T, 0432T, 0433T	1/1/2024	<p>Will be ADDED to the Ambulatory Surgery: Default Rate (DEFAULTSUR)</p> <p>Code will remain assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 2 (AEG2)</p> <ul style="list-style-type: none"> • If contract has an Ambulatory Surgery — Aetna Enhanced Grouper: Category 2 rate it will apply. If not, then the Ambulatory Surgery Default Rate will apply.
0424T, 0431T	1/1/2024	<p>Will be ADDED to the Ambulatory Surgery: Default Rate (DEFAULTSUR)</p> <p>Code will remain assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 3 (AEG3)</p> <ul style="list-style-type: none"> • If contract has an Ambulatory Surgery — Aetna Enhanced Grouper: Category 3 rate it will apply. If not, then the Ambulatory Surgery Default Rate will apply.
0620T	1/1/2024	<p>Will be ADDED to the Ambulatory Surgery: Default Rate (DEFAULTSUR)</p> <p>Code will remain assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 4 (AEG4)</p> <ul style="list-style-type: none"> • If contract has an Ambulatory Surgery — Aetna Enhanced Grouper: Category 4 rate it will apply. If not, then the Ambulatory Surgery Default Rate will apply.

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

Timely notification of hospital admissions payment policy change

We will be extending the notification period from one day to two days.

This update applies to our commercial and Medicare members.

Currently, all acute medical-surgical hospitals must notify us of all inpatient admissions within one business day of the admission. Starting December 1, 2023, we are extending this period to two business days from the admission date.

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 [Availity provider portal](#).^{*} Or you can use your practice's Electronic Medical Record (EMR) system if it's set up for electronic precertification requests. Use our "Search by CPT[®] code" search function on our [precertification lists](#) page to find out if the code requires precertification.^{**} Learn more about [precertification](#).

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? Go to [Availity](#) to register and learn more.

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Telemedicine: coverage ending for certain services

Check Availity[®] for the procedures/modifiers that we will no longer be covering.

This update applies to our commercial members.

When the public health emergency ended on May 11, 2023, we continued coverage for the liberalized telemedicine procedures/modifiers. Beginning December 1, 2023, we're modifying our policy to no longer cover some of the liberalized telemedicine procedures/modifiers.

You can view the procedures/modifiers that we will no longer cover on our [Availity provider portal](#).* Go to Aetna Payer Space > Resources > Claim Resources > Telemedicine liberalized codes no longer covered effective 12.1.23.

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

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Changes to commercial drug lists begin on January 1

[Find out about drug list changes and how to request drug prior authorizations.](#)

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

You'll be able to view the changes as early as October 1. They'll be on our [Formularies and Pharmacy Clinical Policy Bulletins](#) page.

Ways to request a drug prior authorization

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

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

More information

For more information, refer to the [Contact Aetna](#) page. Open the “By phone” tab to find the pharmacy management phone number.

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Important pharmacy updates

Read the updates for [Medicare, Medicare Part B step therapy and commercial](#).

Medicare

Visit our [Medicare drug list](#) to view the most current Medicare plan formularies (drug lists). We update these formulary documents regularly during the benefits year as we add or update additional coverage each month.

Visit our [Medicare Part B step therapy](#) page to view the most current Preferred Drug Lists for Medicare Advantage (MA) and Medicare Advantage with prescription drug coverage (MAPD) members. These lists are updated regularly throughout the plan year.

Commercial — notice of changes to prior authorization requirements

Visit our [Formularies and Pharmacy Clinical Policy Bulletins](#) page to view:

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

Student Health

Visit our [Aetna Student Health](#) website to view the most current Aetna Student Health plan formularies (drug lists).

- Select your college or university and click “View your school.”
- Select the “Members” link at the top of the page.
 - Click the “Prescriptions” link under Resources for Members.
 - Scroll down to the Aetna Pharmacy Documents section.

Aetna federal employee plans

Visit our [Aetna Federal Plans](#) website to view the most current formularies (drug lists).



State-specific updates

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

Important changes to the SNF concurrent review process for the Aetna MA plan and the DSNP

SNFs that are located in certain states and that admit certain Aetna® members will go back to using Availity.®

Note: This article applies to Connecticut, Delaware, Florida, Georgia, Indiana, Kentucky, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Vermont and West Virginia.

Aetna's partnership with Post Acute Analytics (PAA) to automate the concurrent review process by using their Anna™ software platform will end at midnight on July 31, 2023.

What's changing?

Starting August 1, 2023, all skilled nursing facilities (SNFs) in the above states that admit Aetna Medicare Advantage (MA) and Dual-Eligible Special Needs Plan (DSNP) members who reside in and receive care in those states will return to using Availity* for uploading documents or faxing documents directly to Aetna for the purposes of:

- Notifying Aetna of a member's arrival in the facility (that is, admission verification, for which you should send a face sheet)
- Conducting concurrent review processes, including providing clinical documentation

Does this change affect the precertification and concurrent management process?

It does not affect the precertification process. Aetna will continue to make utilization management decisions and send the appropriate letters and other communications. However, the concurrent management process will no longer use PAA's Anna platform.

Notification and document delivery options

We continue to recommend the use of Availity first, as this allows the fastest response for you and for Aetna members. Communication options are listed below in the preferred order:

- Submit precertification/authorization supporting documentation electronically on [Availity](#).

- Your SNF can provide direct access to your EMR. If interested, please [email Aetna](#).
- Fax to FaxHub at **1-833-596-0339**.
- Call your assigned Utilization Management (UM) nurse.

Questions?

If you have questions about this change, please send an email message to [Post Acute Analytics](#).

If you have questions about Aetna's UM process, you may contact your facility's assigned UM review nurse or visit our [Contact Aetna](#) page.

Thank you in advance for your cooperation with this change.

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California: 2023 Provider Appointment Availability Survey (PAAS)

We might contact your office with our brief survey questions, and we are required to send your responses to the DMHC and the CDI.

California law requires that health plans survey their network providers annually to ensure that they comply with California time-elapsd standards for urgent and non-urgent appointments.

Aetna® has contracted with the Center for the Study of Services (CSS) to administer the PAAS for 2023. Aetna will assess compliance through the PAAS and report the results to the California Department of Managed Health Care (DMHC) and to the California Department of Insurance (CDI).

Please be aware that your office may be contacted via fax, email or phone for the purposes of this assessment. This survey should take only a few minutes of your time and will be conducted during normal business hours. We appreciate your cooperation in complying with this regulation.

Providers to be surveyed

- Primary care physicians (PCPs)
- Specialty physicians
- Psychiatrists
- Non-Physician Mental Health (NPMH) providers and Substance Use Disorder (SUD) providers

- Ancillary providers who offer mammogram appointments and ancillary providers who offer physical therapy appointments

Survey questions

- Urgent appointments: Is the appointment date and time within 48 hours (for a PCP visit request) or within 96 hours (for a specialist/psychiatrist/NPMH or SUD visit request)?
- Non-urgent appointments: Is the appointment date and time within 10 business days (for a PCP/NPMH visit request or a SUD visit request) or within 15 business days (for a specialist/psychiatrist/ancillary visit request)?

Note that both in-person visits and telehealth visits qualify as appointments.

The importance of your response

As a contracted provider, we encourage you to make every effort to respond to the survey. We will report all responses, including non-responses, to the DMHC. Your response should accurately reflect your appointment availability for Aetna members.

California: What you must do to comply with Assembly Bill 133

By January 31, 2024, you must participate in the data exchange program.

The bill

[Assembly Bill \(AB\) 133](#) applies to health care entities, including health plans, medical groups, general acute care hospitals, acute psychiatric hospitals, skilled nursing facilities, and clinical laboratories, which all must participate in the [California statewide data exchange](#).

What you need to do

On or before January 31, 2024, you must exchange health information with other health care entities or provide access to health information in real time for the purpose of treatment, payment or health care operations. You are required to participate in this data exchange as a health care entity as defined by this law. Certain providers have until January 31, 2026, to comply with these requirements; please review the requirements in AB 133 carefully.

If you have not already done so, please sign the [CalHHS Data Sharing Agreement \(DSA\)](#) to confirm your participation in the Data Exchange Framework.

How to get more information

CalHHS is currently holding data exchange workgroup stakeholder meetings, and we encourage you to participate in them.

Colorado: We're updating our fee schedule

[Read about fee schedule updates for all plans in your market.](#)

Beginning October 15, 2023, we'll adjust our standard fee schedule (the Aetna® Market Fee Schedule, or AMFS) for all plans in the Colorado market. This change affects those services for which we pay you based on the AMFS. You can find these services in the compensation section of your contract.

Please note that if you have a different fee-based schedule, these adjustments apply only to the default.

How we develop fee schedules

- For CPT® codes,* we look at industry-standard methodologies and sources, such as the 2023 Resource-Based Relative Value Scale (RBRVS). These sources include Outpatient Prospective Payment System (OPPS) rates that the Centers for Medicare & Medicaid Services (CMS) establishes (CMS Clinical Laboratory Fee Schedule).
- When we use the RBRVS, we base the fee schedule on a multiplier of 33.8872. We use the 2023 Relative Value Units (RVUs) file that CMS posts on its website.
- For codes using RBRVS, we use the “site-of-service” differential, which CMS defines in transitional RVUs. This differential adjusts payment for certain codes based on where you perform a service. To find code-specific information where we use RBRVS and the 2023 formula for calculating the physician fee schedule, visit the [Centers for Medicare & Medicaid Services \(CMS\)](#).
- For some codes for which we don't use the RBRVS or when information isn't available, we use other sources to develop the fees. These sources include external vendor pricing models, Medicare fee schedules and nationally contracted rates.
- We also adjust fees based on the Colorado Medicare Geographic Price Cost Index (GPCI). We won't apply any other changes that the CMS makes in 2023 except for new codes that Medicare values.

To get the full RBRVS schedule, you can:

- Call the Government Publishing Office at [1-202-512-1800](tel:1-202-512-1800).
- Visit the [Centers for Medicare & Medicaid Services \(CMS\)](#).

How to access the updated fee schedule

You can always check your current fee schedule on our [Availity provider portal](#).** Once you're logged in to Availity®, click on Claims & Payments > Fee Schedule Listing. Note that only contracted physicians can access fee schedules.

If you need your updated fee schedule before October 15, fax your request and the CPT codes to **1-859-455-8650** after October 1.

Questions?

If you have questions, refer to our [Contact Aetna](#) page. You can use the first or second number listed under the By Phone tab.

Thank you for your continued participation in the Aetna network.

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Colorado: Notice of material change to contract

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

Michigan: Register for Availity® to ensure compliance with a new law

The law requires that you request prior authorizations digitally.

Michigan amended a [utilization review law](#) effective June 1, 2023. This law requires insurers and providers to request prior authorizations only via a standard electronic process.

Aetna® uses our [Availity provider portal](#)* to communicate electronically about authorization requests. We encourage you to [register with Availity](#) and use it to ensure compliance with the law and to take advantage of its many other features.

To register, you will need your physical and billing addresses, TIN (tax ID number), NPI (National Provider Identifier) and primary specialty.

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

The Aetna Assure Premier Plus plan

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

About the special needs survey

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

How to take the survey

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



News for you

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

Acute care facilities: Use our provider portal to get real-time status updates for your admitted patients

Starting September 1, we will stop sending you our end-of-day logs. Use the portal to check status and when approved bed days will end. You can also view selected letters in the patient's Inquiry response.

[In our previous issue \(PDF\)](#) (page 25), we told you we'd stop sending end-of-day logs as of September 1. You can get real-time status updates for your admitted patients from our [Availity provider portal](#).* Keep reading to learn more.

How to check status

Use the Authorization Inquiry transaction on Availity® to:

- Check the status of your admission request or when approved bed days will end
- View selected letters within the patient's Inquiry response

All the information you need is right in the Inquiry response. And the response status matches what's in our systems. You don't need to look for letters in the mail.

Learn more

You can learn more about the letters we post on Availity. [Log in to Availity](#), go to the Resources tab on our Payer Space, and read the Digital Authorization Status Letters user guide.

We also offer training on how to use Availity. Go to our [educational webinars](#) page and register for the next Authorizations on Availity live webinar. We suggest registering for Availity before joining our webinar. It's available at no cost to all providers.

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We've introduced new clinical questionnaires

Completing a questionnaire on Availity could help you get immediate decisions.

We've introduced new clinical questionnaires for the following procedures:

- Orthognathic surgery
- Pre-implantation genetic testing
- Frozen embryo transfer

As with our existing clinical questionnaires, you may be invited to complete one when submitting an Authorization Add request on our [Availity provider portal](#).^{*} If you complete the questionnaire on Availity®, you may receive an immediate decision. Visit the [clinical questionnaires](#) page for the full list of clinical questionnaires by specialty.

Share discharge information using our clinical questionnaire

We'd like to remind you that there's an easy way to let us know when you've discharged a patient. Here's how it works:

1. On the patient's last covered bed day, we'll send a notification to your Availity Authorization/Referral Dashboard asking you to act.
2. Click on the event to open the discharge verification clinical questionnaire.
3. Answer just two questions: whether you've discharged the patient and, if so, where you discharged them to.

That's it. Answering a maximum of two simple questions will save you time. No more notification telephone calls.

Let us know what you think about your experience

We're always interested in your opinion, so we'll ask for it after you complete a clinical questionnaire. Tell us about your experience by answering just a few questions and pressing the Submit button. We'll use your feedback to improve our questionnaires.

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New provider onboarding webinar for providers and their staff

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

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

We'll show you how to:

- Locate provider manuals, clinical policy bulletins and payment policies
- Access online transactions such as those related to eligibility, benefits, precertifications, and claim status/disputes
- Register for live instructional webinars
- Access our online forms
- Navigate to our provider referral directory and Medicare directory
- Update your provider data, and much more

Register today

The new provider onboarding webinar — “Doing business with Aetna” — is offered on the [second Tuesday](#) and [third Wednesday](#) of every month, from 1 PM to 2 PM ET.

Questions?

Just [email us](#) with any questions that you may have. We look forward to seeing you in an upcoming session.

Our office manual keeps you informed

Refer to this manual for information about policies, utilization management decisions, medical record documentation, acute care and drug lists.

Visit us online to view a copy of your [Office Manual for Health Care Professionals \(PDF\)](#). The Aetna® office manual applies to the following joint ventures: Allina Health | Aetna, Banner|Aetna, Texas Health Aetna, and Innovation Health.

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

What's in the manual

The manual contains information on the following:

- Policies and procedures
- Patient management and acute care
- Our complex case management program and how to refer members
- Additional health management programs, including disease management, the Aetna Maternity Program, Healthy Lifestyle Coaching and others
- Member rights and responsibilities
- How we make utilization management decisions, which are based on coverage and appropriateness of care, and include our policy against financial compensation for denials of coverage

- Medical Record Criteria, which is a detailed list of elements we require to be documented in a patient’s medical record and is available in the [Office Manual for Health Care Professionals \(PDF\)](#)
- The most up-to-date [Aetna Medicare Preferred Drug Lists](#), [Commercial \(non-Medicare\) Preferred Drug Lists](#) and [Consumer Business Preferred Drug List](#), also known as our formularies.

How to reach us

Contact us by visiting our [Contact Aetna](#) page, calling the Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** and selecting the “precertification” phone prompt, or calling patient management and precertification staff using the Member Services number on the member’s ID card. Our medical directors are available 24 hours a day for specific utilization management issues.

More information

Visit us online for information on how our quality management program can help you and your patients. We integrate quality management and metrics into all that we do, and we encourage you to take a look at the program goals.

PacificSource Health Plans is a new Aetna Signature Administrators® (ASA) payer partner

[Find out how to check eligibility and send claims.](#)

New member access

On June 1, 2023, PacificSource members started to use the ASA preferred provider organization program and medical network outside of Oregon, Washington, Montana and Idaho.

Checking eligibility and additional support

To check eligibility or verify benefits for PacificSource members, call the PacificSource dedicated phone number at [1-800-624-6052](#). You’ll also find the phone number on the member’s ID card.

You can log in to InTouch for Providers to view claims and benefits information. The first time you log in, you will need to register. For help, consult the PacificSource InTouch for Providers system [resources guide \(PDF\)](#).

How to send claims

Our payer partners handle all claims processing and claims questions. Send claims electronically to PacificSource Health Plans payer ID number 93029 for fully insured members, and payer ID number 93031 for self-insured members. Or send paper claims to:

P.O. Box 7068
Springfield, OR 97475-0068

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

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

More information

To learn more, see our [ASA flyer \(PDF\)](#).

Check your Aetna Premier Care Network (APCN) status

Now is a good time to check our [provider referral directory](#) to see if you're participating in our APCN/APCN Plus programs for 2024. If you have questions, visit our [Contact Aetna](#) page.

Notable 2024 changes

- Northern California: market withdrawal of APCN
- Central Valley, California: network expansion
- Council Bluffs, Iowa: new market
- Omaha, Nebraska: new market
- Kansas City, Kansas/Missouri: network name change from I-35 Preferred to KC Care Net Plus
- Winston-Salem, North Carolina: Wake Forest Baptist Aetna Whole HealthSM (AWH) merged with Atrium Health AWH
- Chattanooga, Tennessee: new market
- Connecticut: network expansion

Overview of APCN/APCN Plus

APCN is a performance network for businesses with employees in locations across the country. With this network, employers can offer a single benefits design and simplified communications to all employees, regardless of their location.

APCN Plus includes a combination of performance networks across the country, but also includes Accountable Care Organizations (ACOs) and joint ventures (JVs) in certain areas. Members in these networks will have APCN Plus and the name of the ACO/JV on their ID card.

Referrals to our Complex Case Management program

[Read about how the program works and how to send referrals.](#)

Program goal

Our Complex Case Management program is a collaborative process of assessment, planning, facilitation, care coordination, monitoring, evaluation and advocacy for options and services to meet an individual's and caregiver's comprehensive health care needs. The program assesses population needs and uses evidence-based practices in managing complex illnesses and chronic conditions. We help members understand their health care needs, benefits and how to access available community resources for which the member may be eligible.

How it works

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.

Referrals

Referrals for the program may come from the following sources:

- 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

Referrals can be submitted through the toll-free phone number on the member's ID card.

Aetna Smart Compare™ designation program annual update

Updates include an orthopedics and spine surgery expansion.

What is Aetna Smart Compare?

Aetna Smart Compare is a program designed to help members find high-quality, effective providers. We use an industry standard methodology to give members personalized recommendations that they can easily access through our secure member portals.

We identify efficient and high-quality physician practices and publish designations for the following specialties for our commercial membership:

- Cardiology
- Endocrinology
- Pulmonology
- Primary care physicians (PCPs)
- Neurosurgeon
- Obstetrics and Gynecology (OB/GYN)
- Orthopedic

These designations do not affect practice network status or reimbursement. Members do not receive different benefits based on Aetna Smart Compare.

What are the updates?

- We screen for quality as an initial step in the evaluation process. After that, physician practices must surpass the program effectiveness criteria.
- We expanded orthopedics from hip and knee to include all services provided by physicians under this specialty.
- We expanded spine surgery to include procedures for the central nervous system treated by neurosurgeons.

Updates to come in 2024

We will be expanding our specialties to include the following:

- General surgery
- Medical oncology
- Vascular surgery physicians

We will continue to publish Aetna Smart Compare Medicare PCP designations.

Designation notification

Physician practices will receive notification by November 2023 regarding their designation. We exclude physicians who see few or no Aetna® members.

In California and Texas, commercial Aetna Smart Compare designations are for self-insured plans.

More information

Visit our [Aetna Smart Compare](#) page, where you can find guides for the designation measures. You can email [Aetna Smart Compare](#) if you have questions or want to provide feedback.

Now available: Use our virtual assistant to check precertification status

[By calling the phone numbers you already use, you can get details about precertification status.](#)

We're pleased to announce that our virtual assistant, which you can use to check precertification status, is now available. You can find it when calling any Provider Services telephone number. Keep reading for more information about the virtual assistant and its features.

Save time by getting real-time precertification status

Here's what you can do using our virtual assistant:

- Check precertification status for commercial, Medicare, and Individual and Family Plans members.
- For pended requests, we'll give you reasons, as applicable, and detailed status remarks as the request moves through our process.
- Speak your inputs or use your telephone's keypad.
- Share your feedback at the end of your call.

It's easy to find and use

Just call any Provider Services telephone number you already use. Then say "precert," then "precert status" when asked. Use the reference number to get the status. And you can check status for multiple members in the same call.

Coming soon: Check whether precertification is required

We're working on a feature where you can use our virtual assistant to find out if precertification is required for specific services for specific members. We'll even let you know when there are special arrangements for services.

We'll make an announcement in a future newsletter regarding when you can start using our virtual assistant to check whether precertification is required.

Connect patients to your profile by keeping your directory data current

It's easy to update by using our [quick reference guide](#).

Help members find you when they need you

Our member directories play a key role in connecting patients with providers. We want to ensure that your information is correct and available to our members when they need care.

Accurate and up-to-date contact details in your provider profile helps:

- **Patients easily find you when searching for care.** Your provider profile information is the first thing a patient will see and learn about you when choosing a provider.
- **Ensure seamless communications and appointment scheduling.** Address, email, phone number and telehealth status are essential details patients need to connect with you.
- **Facilitate referrals and care coordination.** Other providers use our directories to easily search and access your profile information in order to make referrals.
- **Keep you in better touch with us.** We use your provider profile contact details to communicate essential updates via email, fax and mail.
- **Reduce phone calls to your office.** When you make regular updates, Aetna® won't need to connect with you as frequently to verify your profile information.

Update the easy way

Simply use our new [quick reference guide \(PDF\)](#) to make updates in our Availity® provider portal.*

First, log in to our [Availity provider portal](#). Next, navigate to My Providers in the top navigation and then select Provider Data Management (PDM). There, you can update your:

- Email address
- Service location
- Appointment phone number
- Telehealth status
- NPI number

Availity now includes enhanced race and ethnicity choices for providers, giving you more options if you choose to self-identify. You'll find these choices in the PDM tool under Managing Type 1 Providers General Information.

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

Affirmative statement for financial incentives

[Here's how we make coverage decisions and help members access eligible services.](#)

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

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

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

How we help members access services

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

- We don't pay or reward practitioners or individuals for denying coverage or care.
- We base our decisions entirely on appropriateness of care and service and the existence of coverage.
- Our review staff focuses on the risks of underutilization and overutilization of services.

Questions?

Participating physicians may ask for a hard copy of the criteria that were used to make a determination by contacting our Provider Contact Center at [1-888-MD AETNA \(1-888-632-3862\)](tel:1-888-MD-AETNA) (TTY: [711](tel:711)).

Visit us online to view a copy of your [provider manual \(PDF\)](#).

Provider manual updates for July 2023 and January 2024

July 2023 updates

These updates apply to our commercial, Medicare and Student Health providers.

We have made updates to your provider manual, including but not limited to, the sections listed below:

- Page 5 “Your provider resource”
- Page 6 “Health Equity”
- Page 7 “Medicare and commercial providers”
- Page 8 “Roster fields”
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- Page 15 “Health care professionals”
- Page 16 “Accessibility standards and participation criteria”
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- Page 17 Note for the term “medical necessary”
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- Page 30–33 “Medical records”
- Page 34–35 “Referrals”
- Page 38–41 “Member programs and resources”
- Page 42–46 “Pharmacy management and drug formulary”
- Page 48–49 “Clinical medical management”
- Page 52–72 “Medicare”

We do not believe these edits are material changes according to your agreement with us. If you have any questions, please reach out to your Aetna® contact.

January 2024 updates

This update applies to our commercial, Medicare and student health providers.

To streamline content and remove redundancy, we will archive the behavioral health provider manual. We will include any applicable information for behavioral health providers in the Office Manual for Health Care Professionals.

Review your updated provider manual

Go to our [Provider Manuals](#) page to review recent and future updates.

Venipuncture policy update

We will add two CPT® codes to the venipuncture policy starting October 1, 2023.

This update applies to both our commercial and Medicare members.

We are updating our venipuncture policy to state that venipuncture is:

- The process of collecting blood from a vein, including traditional venipuncture, venous device, and peripherally inserted central catheter (PICC) line; most often used for laboratory testing.

Effective October 1, 2023, we will be adding CPT® codes 36591 and 36592 to the venipuncture policy found under policy L001: Laboratory, Pathology and Blood Procedures Payment Policy.*

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

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

Your patients can save money by using in-network labs

They should use one of our three preferred labs.

You can advise patients to get lab work done at one of our three preferred national labs: Quest Diagnostics®, Labcorp and BioReference®. Or you can refer them to one of the hundreds of other labs in our network.

How in-network costs compare to out-of-network costs*

	Quest, Labcorp and BioReference	In-network independent lab	In- network hospital lab	Out-of- network lab
	\$	\$\$	\$\$\$	\$\$\$\$
Lab test price	\$30	\$45	\$120	\$300
Patient's coinsurance or copayment	20%	20%	20%	40%
Patient pays	\$6	\$9	\$24	\$120

*This chart is for illustrative purposes only. These prices reflect an example of a routine lab test. Information is based on 2021 commercial Aetna claims. Actual test prices will vary according to the test ordered, and patient payment amounts vary in accordance with a patient's benefits plan. There are some local hospitals in our lab network that are cost-effective.

Process change for Diagnosis-Related Group (DRG) assignment appeals reconsideration

We will no longer send disputes through the reconsideration process.

Beginning November 1, 2023, if you disagree with a DRG assignment decision, you may submit an appeal request. We will no longer send these disputes through the reconsideration process.

To submit an appeal, forward the medical records supporting your DRG assignment and any relevant information to the following address: Aetna, Attn: Provider Resolution Team, P.O. Box 14020, Lexington, KY 40512.



Behavioral health

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

New appointment wait time standards coming in January 2024

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

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

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

What are the new requirements?

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

New appointment wait time standards (“access to care”)	Primary care physicians (PCPs)	Behavioral health (BH) providers
Emergency and urgently needed services	Immediately (or referred to the emergency room, as appropriate)	Immediately (or referred to the emergency room, urgent care/crisis center, as appropriate)
Non-emergency/Non-urgent; but requires medical attention	Within 7 business days	Within 7 business days
Routine and preventive care	Within 30 business days	Within 10 business days
Follow-up care	As appropriate, if needed	<ul style="list-style-type: none"> Non-prescribers of medication: within 3 weeks Prescribers of medication: within 5 weeks
24/7 answering service	Must have reliable 24 hours per day, 7 days per week (24/7) answering service or machine with notification system for call backs.	Must have a reliable live answering service or voicemail system in place 24 hours per day, 7 days per week (24/7).

	<ul style="list-style-type: none"> • PCPs must have appropriate backup for absences. • A recorded message or answering service that refers members to emergency rooms is not acceptable. 	<ul style="list-style-type: none"> • Prescribing providers are required to have a designated provider backup and/or an answering service and/or a machine with a beeper/paging system in place 24/7. • Non-prescribing providers are required to have a voicemail greeting which provides contact information for a licensed BH provider who is available 24/7; and/or direction to go to the nearest emergency department; and/or direction to call 911/988 in a crisis.
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Note: State requirements supersede the above standards and are in the [Provider Manual State Supplement \(PDF\)](#).

Participation criteria

You can find our participation criteria in our [Provider and Facility Participation Criteria handbook \(PDF\)](#).

Definitions

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

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

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

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

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

Routine and preventive care

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

Follow-up care

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

2023 Aetna® behavioral health quality management program summary

[Read about what we've achieved and what's on the horizon.](#)

Quality management and improvement efforts

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

Behavioral health initiatives

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

Highlights from 2022

- The Aetna Managed Behavioral Health Organization (MBHO) achieved full National Committee for Quality Assurance (NCQA) re-accreditation for Commercial, Medicare and Exchange lines of business.
- We continued our Caring Contacts program to provide resources and support to Aetna members discharged from an inpatient setting after a suicide attempt. We also saw a 17.3% decrease in suicide attempts for adult Aetna Commercial members through October 2022.
- We launched multiple suicide prevention strategies in 2022, with a focus on preventing adolescent suicide attempts.
- We partnered with Psych Hub to provide free provider education on suicide prevention.

- We expanded access to mental health services through partnerships with Array Behavioral Care and Brightline.
- We began working with SafeSide, an organization dedicated to mental health education, to train primary care physicians and medical practices and their staff on identification and early intervention for patients at risk of suicide.
- Aetna and CVS Health® launched multiple initiatives dedicated to improving health equity. Targeted populations included members with disabilities, LGBTQ+ members, and Black and Hispanic members, among others.
- CVS Health Foundation supported expansion of equitable access to mental health care services in underserved communities via grant funding.
- An educational campaign for members who received treatment for substance use disorder resulted in a 21.12% decrease in inpatient admissions for this group. We also launched informational campaigns for members who are taking mental health medications but not participating in therapy, who are dealing with depression in addition to long-term medical conditions, or who are searching for therapy options on our member website.
- Aetna 360™ Behavioral Health established an enhanced partnership with Array Behavioral Care to get discharged members access to quicker follow-up appointments.
- MinuteClinic® hired over 60 providers of mental health counseling and opened new locations across 14 states, enabling broader access to mental health counseling services (virtually and in person).
- MinuteClinic® mental health providers completed over 19,000 counseling sessions.

Plans for 2023

- Focus on behavioral health network expansion with the goal of increasing provider availability and reducing appointment wait times.
- Develop and use a new model to identify members who may benefit from Medicare Behavioral Health Case Management.
- Launch member and caregiver case management satisfaction surveys, with a satisfaction score goal of > 85%.
- Continue to develop robotics expertise and continue to work toward the creation of automated solutions to reduce manual work and data entry.
- Implement the 2023 suicide prevention roadmap to meet or exceed our bold goal for suicide prevention.
- Improve quality of care, achieve strong clinical outcomes and drive patient safety.
- Promote care coordination between medical and behavioral health providers.
- Improve provider network and charitable partnerships.

More information

Find more resources and information on our [behavioral health member site](#).

Aetna is part of the CVS Health® family of companies.

How to document major depressive disorder (MDD)

Read on for tips about how to code and document MDD.

Major depressive disorder, also known as clinical depression, is a common and serious mood disorder. According to the National Institutes of Mental Health, symptoms must be present for at least two weeks, and patients must exhibit five to nine of the symptoms outlined in the Diagnostic and Statistical Manual of Mental Health Disorders V (DSM-V) in order to meet the definition of major depressive disorder.¹

Documentation tips

- Include depression screening results with the appointment notes.
- Documentation should support the episode (single or recurrent); severity (mild, moderate, severe); presence or absence of psychosis; and remission status (partial or full).
- Do not use History Of to describe a current or active diagnosis.
- Document the following in the treatment plan:
 - Medications linked to the condition
 - Therapy
 - Referrals
 - Date of follow-up appointment

Coding guidance

F32	Depressive Episode
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.8_	Other depressive episodes
F32.81	Premenstrual dysphoric disorder
F32.89	Other specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified (includes major depression NOS)
F32.A	Depression, unspecified (includes depression NOS and depressive disorder NOS)

F33	Major Depressive Disorder, recurrent
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent, severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic features
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission, unspecified
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified

¹Jessica Truschel. [Depression definition and DSM-5 diagnostic criteria](#). Psyc.com. August 26, 2022. Accessed on June 8, 2023.

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Review your updated provider manual

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September is Suicide Prevention Awareness Month

Join us in our goal to reduce suicide attempts in our adult, commercial member population by 20% by 2025. Register for the SafeSide Prevention program.

Primary care physicians and staff members may be the first point of contact for suicidal patients, regardless of the presenting concern or the nature of the scheduled visit. Suicide is one of the leading causes of death in the United States,¹ and “about a third of individuals who die by suicide visit a primary care provider in the month before their death.”²

Join us in our goal to reduce suicide attempts in our adult, commercial member population by 20% by 2025.

What is SafeSide Prevention?

[SafeSide Prevention](#) provides primary care physicians and staff members with “a clear framework for responding to suicide concerns within the time and resource constraints of primary care.” All health care providers can create space for a lifesaving practice such as

universal screening. This [SafeSide podcast](#) offers thoughts on how to incorporate universal screenings in a health care setting.

The SafeSide Prevention training program

We're offering the free SafeSide Prevention video-based training program, which consists of:

- Three 50-minute video-based group sessions that can be taken consecutively or independently as schedules permit
- Monthly office hours with clinicians and the SafeSide Prevention team
- Access to tools and refreshers to help you stay current with new practices
- 3 AMA category 1 credits upon completion

How to register

Register by going to the [SafeSide Prevention registration page](#).

¹Centers for Disease Control and Prevention. [Suicide data and statistics](#). May 11, 2023. Accessed on June 20, 2023.

²Pisani AR and Hinkson J. American Foundation for Suicide Prevention. [More than referrals: the role of primary care in suicide prevention](#). April 20, 2020. Accessed on June 20, 2023.

How to get better health outcomes for those with substance use disorders

[Screen patients, use proper coding and work with other providers to improve outcomes.](#)

Patients with alcohol and substance use disorders are more likely to have better outcomes with patient education, early treatment and follow-up care. Despite strong evidence that treatment, including Medication-Assisted Treatment (MAT), along with counseling or other behavior therapies improve patient outcomes, less than 20% of individuals with substance use disorders receive treatment.¹

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

Provide adequate screening and education

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

Managing appointments for success

After diagnosis, treatment should be initiated within 14 days, but the type of treatment can vary based on the severity of the symptoms as well as the member's motivation for treatment. Follow-up care should occur a minimum of 2 times within 34 days of the initial treatment visit. Avoid claims issues by using the appropriate diagnosis codes. Be sure to also include place of service and procedure code (as applicable depending on the terms of your contract).

Common treatment options:

- [Medication assisted treatment](#) (MAT)
- Outpatient counseling
- Intensive outpatient program
- Partial hospitalization
- Inpatient admission
- Residential treatment
- [Telehealth](#)

Enlist help

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

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

- [Shatterproof](#), to learn about addiction and available resources and treatment
- [Alcoholics Anonymous](#), [Narcotics Anonymous](#) or [SMART Recovery](#), for peer support
- [Al-Anon/Alateen](#), for family support

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

¹Substance Abuse and Mental Health Services Administration (SAMHSA). [Key substance use and mental health indicators in the United States: results from the 2019 National Survey on Drug Use and Health](#). Publication number PEP20-07-01-001. September 2020. Accessed June 8, 2023.



Get Medicare-related information, reminders and guidelines.

Complete your required Medicare compliance training by December 31, 2023

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

Participating providers in our Medicare networks are required to meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related entities (FDR) as outlined in the FDR program guide.

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

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

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

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

Training materials and attestations are posted on our [Medicare page](#).

Our training materials

- [FDR Medicare compliance guide \(PDF\)](#)
- [SNPs Model of Care \(MOC\) provider training \(PDF\)](#)
- [Provider and delegate frequently asked questions document \(PDF\)](#)

Where to get more information

If you have questions, please review all supporting materials published on our [Medicare page](#) or review the quarterly [First Tier, Downstream and Related \(FDR\) entities compliance newsletters](#).

Important changes to the SNF concurrent review process for Aetna® MA and DSNP

SNFs that are located in certain states and that admit certain Aetna® members will go back to using Availity.®

This article applies to Connecticut, Delaware, Florida, Georgia, Indiana, Kentucky, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Vermont and West Virginia.

Aetna's partnership with Post Acute Analytics (PAA) to automate the concurrent review process by using their Anna™ software platform will end at midnight on July 31, 2023.

What's changing?

Starting August 1, 2023, all skilled nursing facilities (SNFs) in the above states that admit Aetna Medicare Advantage (MA) and Dual-Eligible Special Needs Plan (DSNP) members who reside in and receive care in those states will return to using Availity* for uploading documents or faxing documents directly to Aetna for the purposes of:

- Notifying Aetna of a member's arrival in the facility (that is, admission verification, for which you should send a face sheet)
- Conducting concurrent review processes, including providing clinical documentation

Does this change affect the precertification and concurrent management process?

It does not affect the precertification process. Aetna will continue to make utilization management decisions and send the appropriate letters and other communications. However, the concurrent management process will no longer use PAA's Anna platform.

Notification and document delivery options

We continue to recommend the use of Availity first, as this allows the fastest response for you and for Aetna members. Communication options are listed below in the preferred order:

- Submit precertification/authorization supporting documentation electronically on [Availity](#).
- Your SNF can provide direct access to your EMR. If interested, please [email Aetna](#).
- Fax to FaxHub at **1-833-596-0339**.
- Call your assigned Utilization Management (UM) nurse.

Questions?

If you have questions about this change, please send an email message to [Post Acute Analytics](#).

If you have questions about Aetna’s UM process, you may contact your facility’s assigned UM review nurse or visit our [Contact Aetna](#) page.

Thank you in advance for your cooperation with this change.

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

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

You can request an electronic referral for any plan that requires it. If a plan requires a referral, it must be issued from the primary care physician (PCP) for all specialist visits, including those services performed in a facility. A referral isn’t a substitute for a service that requires precertification. Visit our website to see if a service requires [precertification](#).

You can find our electronic Referral Add and Inquiry transactions on our [Availity® provider portal](#).* Or find another vendor on [our electronic transaction vendor list](#).

Why use Availity?

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

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

Referrals training

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

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

Other ways to get help

- You can visit the [Electronic Transactions Tools](#) page on **Aetna.com** and click the down arrow next to “Patient Referrals.”

- You can view the [Electronic Transaction Vendor](#) page for information on the vendors and clearinghouses with which Aetna has a relationship.
- For help understanding how to use the National Provider Identifier (NPI) in the Referral transaction, see the Referral Add (278) section of [Using Organizational \(Type 2\) National Provider Identifiers \(NPIs\) in HIPAA standard electronic transactions \(PDF\)](#).
- You can take one of our [live webinar events](#).

Refer members to participating providers

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

DSNPs that require referrals through December 31, 2023

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

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

PCP selection

All DSNPs require PCP selection.

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Keep your data updated in NPPES

[Accurate provider directories help Medicare patients identify and find providers and make health plan choices.](#)

CMS suggests updating NPPES

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

Accurate provider directories help Medicare beneficiaries identify and find providers and make health plan choices.

More information

For more information, refer to this [frequently asked questions document \(PDF\)](#).

New appointment wait time standards coming in January 2024

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

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

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

What are the new requirements?

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

New appointment wait time standards (“access to care”)	Primary care physicians (PCPs)	Behavioral health (BH) providers
Emergency and urgently needed services	Immediately (or referred to the emergency room, as appropriate)	Immediately (or referred to the emergency room, urgent care/crisis center, as appropriate)
Non-emergency/Non-urgent; but requires medical attention	Within 7 business days	Within 7 business days
Routine and preventive care	Within 30 business days	Within 10 business days
Follow-up care	As appropriate, if needed	<ul style="list-style-type: none">• Non-prescribers of medication: within 3 weeks• Prescribers of medication: within 5 weeks
24/7 answering service	Must have reliable 24 hours per day, 7 days per week (24/7) answering service or machine with notification system for call backs. <ul style="list-style-type: none">• PCPs must have appropriate backup for absences.	Must have a reliable live answering service or voicemail system in place 24 hours per day, 7 days per week (24/7). <ul style="list-style-type: none">• Prescribing providers are required to have a designated provider backup and/or an answering service and/or a machine with a

	<ul style="list-style-type: none"> • A recorded message or answering service that refers members to emergency rooms is not acceptable. 	<ul style="list-style-type: none"> • beeper/paging system in place 24/7. • Non-prescribing providers are required to have a voicemail greeting which provides contact information for a licensed BH provider who is available 24/7; and/or direction to go to the nearest emergency department; and/or direction to call 911/988 in a crisis.
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Note: State requirements supersede the above standards and are in the [Provider Manual State Supplement \(PDF\)](#).

Participation criteria

You can find our participation criteria in our [Provider and Facility Participation Criteria handbook \(PDF\)](#).

Definitions

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

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

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

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

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

Routine and preventive care

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

Follow-up care

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