OfficeLink Updates™

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

aetna™

December 2020

Inside this issue

90-day notices and important reminders

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.

A reminder about Healthcare Common Procedure Coding System (HCPCS) code V2790

As of March 1, 2021, we will treat HCPCS code V2790 as a supply. This is the code for amniotic membrane for surgical reconstruction. We will not allow separate payment as an implant. This service does not meet our definition of an implant.

We do not pay for items deemed incidental to the overall care, such as:

- Supplies
- Materials (sutures or suture substitutes, dressings, syringes, gauze, catheters, guidewires, etc.)
- Equipment (stationary parenteral infusion pumps, etc.)

A reminder: Facilities must only use revenue codes 275 and 278 to bill for implants. We do not reimburse for supplies and materials billed under these codes.

Changes to our National Precertification List (NPL)

New-to-market drugs that require precertification:

- Avsola™ (infliximab-axxq) — precertification required, effective August 1, 2020. This drug is part of the immunologic agent category.
- Darzalex Faspro™ (daratumumab and hyaluronidase-fihj) — precertification required, effective August 6, 2020.
- Jelmyto™ (mitomycin) — precertification required, effective August 7, 2020.
- Herzuma® (trastuzumab-pkrb) — precertification required, effective August 11, 2020. This drug is part of the HER2 receptor targeted drugs category.
- Ontruzant® (trastuzumab-dttb) — precertification required, effective August 11, 2020. This drug is part of the HER2 receptor targeted drugs category.

As of September 1, 2020, the following new-to-market drugs require precertification:

- Bynfezia™ (octreotide acetate)
- Uplizna™ (inebilizumab-cdon) — precertification needed for both the drug and site of care.

As of October 1, 2020, the following new-to-market drugs require precertification:

- Phesgo™ (pertuzumab/trastuzumab/hyaluronidase-zzxf)
- Bafiertam™ (monomethyl fumarate)
- Evrysdi™ (risdiplam)

As of November 1, 2020, the following new-to-market drugs require precertification:

- Tecartus™ (brexucabtagene autoleucel)
- Monjuvi™ (tafasitamab-cxix)

Submitting precertification requests

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

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

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

Not registered for Availity?

Go to **Availity.com** and click on "Register" where you will be guided through the registration process.

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

Home infusion therapy limits

Starting March 1, 2021, we will limit the following per diem Healthcare Common Procedure Coding System (HCPCS) codes to one unit per date of service:

S5497, S5498, S5501, S5502, S9342, S9343, and S9364–S9368.

Surgical procedures performed in the emergency room by an emergency physician billed without modifier 54

Effective March 1, 2021, we will pay for surgical procedures performed by an emergency room specialty provider in the emergency room and billed with or without modifier 54 (surgical care only) at 75% of the contracted surgery rate.

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

Third-Party Claim and Code Review Program

Beginning March 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. You can view these edits on our provider website.

We may ask for medical records for certain claims, such as high-dollar claims, implants and bundled services claims. This will 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. Then, go to Aetna Payer Space > Applications > Code Edit Lookup Tools. You'll need to know your Aetna® provider ID number (PIN) to get access.

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

Important update about service codes

Individual service codes are being reassigned within contract service groups. Changes to an individual provider's compensation depends on the presence or absence of specific service groupings in their contract. These changes are shown below.

Unless noted, all updates are effective **March 1, 2021**.

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

Codes	Provider types affected	What's changing
0001U, 0002U, 0003U, 0018U, 0019U, 0021U, 0022U, 0023U, 0045U, 0046U, 0047U, 0048U, 0049U 0050U, 0051U, 0052U, 0053U, 0054U, 0055U, 0056U, 0058U, 0059U, 0060U, 0061U, 0062U, 0063U 0064U, 0065U, 0066U, 0067U, 0068U, 0069U, 0070U, 0071U, 0072U, 0073U, 0074U, 0075U, 0076U 0077U, 0078U, 0084U, 0086U, 0087U, 0088U, 0089U, 0090U, 0091U, 0092U, 0093U, 0094U, 0095U 0096U, 0097U, 0098U, 0099U, 0100U, 0101U, 0102U, 0103U, 0105U, 0106U, 0107U, 0108U, 0109U 0110U, 0112U, 0113U, 0114U, 0115U, 0116U, 0117U, 0118U, 0119U, 0120U, 0121U, 0122U, 0123U 0129U, 0130U, 0131U, 0132U, 0133U, 0134U, 0135U, 0136U, 0137U, 0138U, 0202U, 0223U, 0224U	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be ADDED to the Laboratory Services (LAB) • If the contract has a Laboratory Services rate, then this rate will be applied. If the contract does not have a Laboratory Services rate, the All Other Outpatient Default rate will continue to apply.

0225U, 0226U, G0499, G0659		
0001U, 0002U, 0003U, 0005U, 0007U, 0008U, 0009U, 0010U, 0011U, 0012U, 0013U, 0014U, 0016U, 0017U, 0080U, 0082U, 0083U, 0105U, 0106U, 0107U, 0108U, 0109U, 0110U, 0112U, 0113U, 0114U, 0115U, 0116U, 0117U, 0118U, 0119U, 0120U, 0121U, 0122U, 0123U, 0129U, 0130U, 0131U, 0139U, 0140U, 0141U, 0142U, 0143U, 0144U, 0145U, 0146U, 0147U, 0148U, 0149U, 0150U, 0151U, 0152U, 0153U, 0154U, 0155U, 0156U, 0157U, 0158U, 0159U, 0160U, 0161U, 0162U, 0202U, 0223U, 0224U, 0225U, 0226U, G0499, G0659	Physicians, specialists, primary care, group physicians	Will be ADDED to the Laboratory/Pathology (LABPRO) • If the contract has Hospital Based Physician services for LAB, then we will deny the physician claim with these codes. If the contract does not have Hospital Based Physician services for LAB, then we will allow the physician claim with these codes. There is no change in compensation.
27369	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be ADDED to the Ambulatory Surgery: Default Rate (DEFAULTSUR) Code will remain assigned to Ambulatory Surgery – Aetna Enhanced Grouper: Category 1 (AEG1)

		• 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.

Changes to commercial drug lists begin on April 1, 2021

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

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

Ways to request a drug prior authorization

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

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

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

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

Important pharmacy updates

Medicare

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

Commercial — Notice of changes to prior authorization requirements

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

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

Provider data management on Availity

Just a friendly reminder that as of November 1, 2020, you need to use Availity to update your information.*

It's easy to make changes!

Just log in to the Availity portal. Go to My Providers > Provider Data Management. You can then verify your information or make updates to your address, appointment phone number, office hours, etc. Availity will display quarterly notifications reminding you to verify your information.

What are the benefits of updating with Availity?

Availity helps our members find and connect with you for care by providing us with accurate information about your practice. And you'll benefit because you'll:

- Stay listed in our provider directories
- Avoid potential claims payment delays
- Make sure we can contact you with important information when needed

In addition to keeping your directory information up to date, the Availity portal:

- Allows you to share information with other payers, reducing phone calls to your office
- Shows you pre-populated information that payers are listing in their directories, making it easier for you to check or correct

An easy process with helpful tools.

On the Availity portal, you have one efficient workflow to communicate with payers. You can also:

- Validate eligibility and benefits
- Submit claims, send supporting documentation and check claim status
- View remittances and EOB statements, request authorizations and referrals

* Medicare and Commercial providers in New York and Masaachusetts should continue to use CAQH to submit updates.

1199SEIU benefits and pension funds information

To help ensure that our members receive medically necessary care, we are implementing a new policy that will cover vitamin D testing only when clinically appropriate.

Effective September 1, 2020, the Benefit Funds will pay claims for vitamin D testing only when ordered for the following indications:

- Medical diagnosis associated with vitamin D deficiency
- Documented vitamin D deficiency
- Known or suspected excessive vitamin D blood levels

All other indications, including testing for routine preventive screening, will be considered not medically necessary. Claims for vitamin D testing billed without one of the above indications as a diagnosis will be denied.

The Benefit Funds accept procedure codes used to report vitamin D testing as follows:

- **82306 – vitamin D; 25 hydroxy, includes fraction(s), if performed**
- **82652 – vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed**

Note: Claims submitted for vitamin D testing billed with both 82306 and 82652 in combination will be considered not medically necessary. In addition, procedure code 0038U is currently not covered.

If you have any questions about this policy, please do not hesitate to contact your provider relations representative or call our Provider Relations Call Center at **646-473-7160**, Monday through Friday, from 9:00 AM to 5:00 PM.

News for you

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

New provider onboarding webinar for providers and their staff

New to Aetna®? Or do you simply want to see what's new? Awesome! Join us on a tour through the provider onboarding welcome page. You'll discover tools 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 polices
- Access online transactions such as those related to eligibility, benefits, precertifications and claims
- 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

The new provider onboarding webinar is offered on the second and third Tuesday of every month, from 1 PM to 2 PM ET. Visit **Aetna.com/webinars** to register for an upcoming session.

Questions?
Just email us at **NewProviderTraining@Aetna.com** with any questions that you may have. We look forward to seeing you in an upcoming session.

Update your information — here's why

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

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

We need your current information, such as:

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

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

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

Important message for Massachusetts and New York Commercial and Medicare providers

Please continue to use CAQH to update and validate your demographic information quarterly. This process helps us improve the accuracy of our respective Massachusetts and New York provider directories

Enhancement Clinical Review update for MR and CT authorizations

Starting January 1, 2021, our claim system will require an exact CPT code match between the submitted claims and eviCore Healthcare's authorizations for CT and MR studies. This involves commercial members who need to get pre-authorization with the Enhanced Clinical Review program.

In addition to the specific type of imaging study, eviCore Healthcare will be making medical necessity determinations about the correct use of contrast for MR and CT procedures. Other recommendations will be offered for requests that are not appropriate based on the contrast component of the imaging procedure. We will deny claims billed with CPT codes that do not match the ones that were authorized.

Note that the specific HCPCS codes for these contrast agents are not included in the eviCore Healthcare program. You can find more information about coverage of specific contrast material in Aetna® Clinical Policy Bulletins.

New HMO plans in North Carolina, South Carolina and Tennessee – beginning January 1

We are expanding our 2021 **Aetna Medicare Value℠ Plan (HMO)** and **Aetna Medicare Value Plus Plan (HMO)** to North Carolina, South Carolina and Tennessee.

Starting in 2021, the MidSouth Medicare plans below will require PCP selection. But they will **not require referrals**. Member ID cards will have a note on the back under the key phone numbers, as shown below.

Aetna Medicare NC, SC, and TN Individual Medicare Plans - 2021

North Carolina (NC)
- H3146-001
- H3146-004
- H3146-005
- H3146-006
- H3146-007
- H3146-010

South Carolina (SC)
- H3146-011

Tennessee (TN)
- H3146-012
- H3146-013

Supplemental Benefits (not included in all plans)
- **Dental** (preventive and comprehensive)
- **Over-the-counter (OTC)**
- **Hearing Aids**
- **Post hospital discharge meal delivery**
- **Telehealth**

Other important information
- All members must select a primary care physician.
- There is no referral requirement for specialty care.
- Participating providers can submit pre-authorization requests through our provider portal. They can also fax the request or call it in to the Provider Service Center.
- These plans include pharmacy Part D coverage.

- No out-of-network benefits exist for these plans unless the member follows the approval process. They can start this process by contacting Member Services directly.
- View our HMO plan information by checking our **provider manual page**.

To verify eligibility
Visit **AetnaMedicare.com** to verify member and provider eligibility, view claims submissions and access our websites.

HEDIS® highlight: follow-up care for substance use disorder

Alcohol and other drug (AOD) misuse is a serious public health issue and is increasing as a result of the COVID-19 pandemic. A June 2020 study[1] showed that adults in the United States reported elevated levels of adverse mental health conditions, substance use and suicidal ideation. About one in ten reported that they started or increased substance use because of COVID-19.[1]
According to the National Survey on Drug Use and Health[2] in 2018, approximately 20.3 million people age 12 or older had a substance use disorder (SUD) related to their use of alcohol or illicit drugs in the past year, including 14.8 million people who had an alcohol use disorder and 8.1 million people who struggled with an illicit drug use disorder.[2] With such a large number of people experiencing AOD, the use of emergency department (ED) services has become common. This is an urgent concern for this population.

The **Follow-Up after ED visit for Alcohol or Other Drug Abuse or Dependence (FUA)** HEDIS* measure includes the percentage of ED visits for members age 13 or older with a primary diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence with a primary care physician (PCP) *or* mental health practitioner.

What you can do:

- Identify patients who had an ED visit with a primary diagnosis of alcohol or other drug abuse or dependence.
- Assist in scheduling follow-up appointments with the patient as soon as possible after the ED visit — one within 7 days and one within 30 days.
- Develop outreach systems or assign case managers to encourage patients with recent ED visits for AOD to keep their follow-up appointments or reschedule missed appointments.
- Educate these patients on the importance of follow-up appointments to reduce future ED visits.
- Facilitate referrals for counseling and/or Medication Assisted Treatment (MAT).
- Encourage the use of virtual therapy/telehealth for follow-up visits when appropriate.

[1]Czeisler ME, Lane RI, Petrosky E, et al. **Mental health, substance use and suicidal ideation during the COVID-19 pandemic — United States, June 24–30, 2020**. Morbidity and Mortality Weekly Report. August 14, 2020; 69 (32): 1049–1057. Accessed August 28, 2020.
[2]Substance Abuse and Mental Health Services Administration. **Key substance use and mental health indicators in the United States: results from the 2018 National Survey on Drug Use and Health**. 2018. Accessed August 28, 2020.

AOD misuse can have serious, irreversible effects on patient health and well-being. Studies show that substance abuse treatment immediately following an ED visit has been linked to a reduction in substance use, future ED use, hospital admissions and bed stays.[3,4,5]

Resources

- **Screening, Brief Intervention and Referral to Treatment (SBIRT)**
- **Alcohol and substance use disorder clinical practice guidelines**
- **Medication for the Treatment of Alcohol Use Disorder guide**
- **Medication Assisted Treatment Implementation checklist**

*Healthcare Effectiveness Data and Information Set (HEDIS) is the measurement tool used by the nation's health plans to evaluate their clinical-quality performance.

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[3]Kunz FM, French MT, Bazargan-Hejazi S. Cost-effectiveness analysis of a brief intervention delivered to problem drinkers presenting at an inner-city hospital emergency department. Journal of Studies on Alcohol and Drugs. 2004; 65: 363–370. 2004.

[4]Mancuso D, Nordlund DJ, Felver B. Reducing emergency room visits through chemical dependency treatment: focus on frequent emergency room visitors. Olympia, Wash: Washington State Department of Social and Health Services, Research and Data Analysis Division. 2004.

[5]Parthasarathy S, Weisner C, Hu TW, Moore C. Association of outpatient alcohol and drug treatment with health care utilization and cost: revisiting the offset hypothesis. Journal of Studies on Alcohol and Drugs. 2001; 62: 89–97.

Integrating medical and behavioral health care

Evidence shows that behavioral interventions can be helpful in caring for people who have a number of medical disorders. Yet the boundary between medical and behavioral interventions remains largely unmoved. Big reasons for this division come from narrow training models and the structure of the health care system. It's rare to find behavioral providers included in medical settings. And payors who know the value of integration still largely silo the two operations.

Benefits of integration

For many disorders, educating patients and helping change their attitudes and later behaviors can produce multiple benefits, including improved health status and reduced cost for care. In fact, a **2017 Milliman research report** shows potential savings from $38 billion to $68 billion annually.

Managing the emotional aspects of a medical disorder can help relieve primary and specialty care physicians. Integrated, collaborative relationships among providers bring a wider range of resources to total patient care.

Payment methods to support integration

Cost savings are a clear benefit, but fee-for-service models deter medical providers from integrating. Payment methods need to adjust if we are to experience the savings that integration produces.

Value-based contracting and payment for care coordination, which we provide, are steps in the right direction. But building these payment models is complex. This is where payors, with actuarial knowledge, need to lead the way with proposals that aim at a win-win with providers. Or, where possible, foster the integration of service delivery systems.

For now, no matter what side of the medical/behavior divide you're on, be sure to practice in a way that helps raise the quality of your patients' outcomes. It just makes sense.

Resources

- **Screening, Brief Intervention and Referral to Treatment (SBIRT)**
- **Integration Primary Behavioral Health Program**
- **Value-Based Care**

Reimbursement for care coordination

Care coordination is reimbursed with no cost share to members. With a behavioral health diagnosis (required), care coordination includes communication between:

- Behavioral health providers (such as a therapist and a psychiatrist)
- Behavioral health and medical providers (such as a psychiatrist and a primary care provider)

Exceptions:

- All Medicare plans
- Any high-deductible health plan with a health savings account, until members meet the deductible

CPT codes for collaboration: 99484, 99492, 99493 and 99494

For more information:

- HMO: **1-800-624-0756 (TTY: 711)**
- PPO and indemnity: **1-888-632-3862 (TTY: 711)**

Nippon Life Benefits will require prior authorization beginning January 1, 2021

Beginning January 1, 2021, Nippon Life Benefits will be expanding our requirement for prior authorization to include a variety of outpatient procedures. For more information, providers can visit the **Member Service page** and select the "Prior Authorization" tab. There, they can find things like a detailed list of services, frequently asked questions, and provider and member instructions.

To conduct prior authorization or for more information, reach out to Nippon Life Benefits. You can contact them by phone or fax at the number on the member ID card.

Providers can encourage members to refer to the list of procedures to be certain if prior authorization is required or not.

New enrollment for Aetna Signature Administrators®

The Aetna Signature Administrators network was recently awarded the Hobby Lobby account starting January 1, 2021. This account has 15,525 employees enrolled in their health plan nationwide.

Hobby Lobby is the largest privately-owned arts and crafts retailer in the world. It's based in Oklahoma City, Oklahoma, where they use their own local network. They'll use the Aetna® preferred provider organization (PPO) network for employees in all other states. They continue to grow and open new stores all over the country; currently, they are located in almost every state.

WebTPA, based in Irving, Texas, is the current third party administrator for Hobby Lobby. All claims will be sent to WebTPA for repricing and claims processing. They'll also handle all customer service calls.

Appointment availability surveys

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 various state regulations.

You'll find the access standards we measure in the Office Manual for Health Care Professionals.

Cultural competency

Knowing that members have diverse viewpoints 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 accordingly to members' distinct values, beliefs, behaviors and needs when delivering care to them.

Our commitment

We're committed to meeting all the National Commission for Quality Assurance (NCQA) standards and making sure members' access to care is satisfactory. We do this by annually measuring our members' perspectives through the Consumer Assessment of Health Care Provider and Systems

(CAHPS®) Health Plan Survey. This helps us learn about in-network providers' ability to meet our members' needs. The information collected is used to monitor, track and improve their experiences.

In addition, we conduct an annual physician satisfaction survey to make sure we give you tools and resources to meet members' cultural needs.

Want to learn more?

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

Two new plans to debut in January 2021

Two new commercial medical plans have been announced for 2021: the Aetna Flexible Five Plan™ and the Aetna Upfront Advantage™ plan.

The Aetna Upfront Advantage plan

- The plan pays 100% for Everyday Care, in-network visits, prior to the normal member cost-sharing amount, up to $500 (individual) and $1,000 (family).
- Everyday Care visits include:
  - PCP and behavioral health office visits
  - Telemedicine visits for medical and behavioral health
  - Diagnostic lab work and X-rays from freestanding and non-hospital-based locations
  - Urgent care visits and visits to walk-in clinics
  - Generic drugs (requires a pharmacy plan)
- Once the Upfront Advantage dollar limits have been met, normal member cost sharing applies for the remainder of the year.
- All other plan benefits follow normal member cost sharing.

The Aetna Flexible Five Plan

- The plan covers, for each member and each dependent, 100% of the first five common, in-network visits.
- Once the five-visit limit is met, normal member cost sharing applies for these benefits for the remainder of the year.
- The common, in-network visits/services include the following:
  - PCP and behavioral health office visits
  - Telemedicine visits for medical and behavioral health
  - Diagnostic lab work and X-rays from freestanding and non-hospital-based locations
  - Urgent care visits and visits to walk-in clinics
  - Short-term rehab (physical, speech and occupational therapy)
- All other plan benefits follow normal member cost sharing.

* Aetna Upfront Advantage dollar limits can vary by plan sponsor or state (California $750 individual / $1500 family).

Working together to reduce suicides

Suicide is one of the top causes of death in the U.S. But the right screening and support can help prevent it. We're here to help you identify patients who may be in need and start that important conversation.

Screening and assessment tools
Identifying risk plays a key role in preventing suicide. In fact, the greatest impact may come from screening patients who don't present with obvious symptoms. Over 80% of those who died by suicide saw a professional in the prior year. Most did not have a mental health diagnosis.

Consider a minimum risk assessment for all your patients, whether there is a clear risk of self-harm or not. Then re-administer when it's clinically appropriate.

Helping patients make a prevention plan
Helping your at-risk patients make a prevention plan is key. Safety planning is not just filling out a form. It should be an ongoing thoughtful conversation and intervention — from the first assessment through transitions of care and beyond discharge. Making this plan together engages and empowers your patients by giving them a leading role in prevention.

Resources for you and your patients
As a clinical professional, taking care of your mental well-being helps you take care of others. Go to **Aetna.com** to find support resources.

Also, please remind your patients that they're not alone. You can refer them to:

- The National Suicide Preventive Lifeline: call **1-800-273-TALK (8255)**
- The Crisis Text Line: text **TALK** to **741741**

Source: National Action Alliance for Suicide Prevention

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 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**.
- 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.

Help stamp out influenza this flu season. Ensure patients are vaccinated.

The COVID-19 virus continues to circulate in communities as the flu season arrives. This complicates the diagnosis of what used to be flu -- cough, fever and shortness of breath.

Diagnosing your patient's condition now poses a new challenge when they haven't received a flu vaccine. Is it COVID-19 or influenza? Or both?

A flu vaccine takes away some of the guess work. Then consider the clinical impact of co-infection with both viruses in the unvaccinated.

We cover flu vaccines given at your office, pharmacies and MinuteClinics®. Some plans may cover flu shots given at an urgent center. (Check with your patient's health plan to be sure.)

CDC recommendation
The CDC recommends continuing to vaccinate throughout the flu season. So encourage your patients to get immunized if they haven't yet had a flu shot.

People at high risk for flu complications are the same ones vulnerable to COVID-19. These include your patients who:

- Are 65 years or older
- Have asthma
- Have cardiovascular disease, diabetes or kidney disease, or
- Have had a stroke

Other at-risk groups are young children, women who are pregnant and those who have immunocompromised conditions.

We all realize the flu vaccine doesn't eliminate the risk of the flu. But it can lessen the symptoms. And that can mean reducing the need for outpatient medical care, hospitalization and ED visits, according to data from the CDC over the last three flu seasons.

You can find CDC recommendations for type of vaccine and dosage at **CDC.gov/flu/professionals/index.htm**.

If your patient does get the flu, refer to the Infectious Disease Society of America. They offer antiviral treatment and antiviral chemoprophylaxis advice.[1] You may also refer to the American Thoracic Society ATS-IDSA Adult CAP Guidelines.[2]

Your advice matters to your patients
Your advice is a powerful influence on your patient's behavior. Don't miss this chance to urge them to get a flu shot. Thank you for protecting their health.

[1] Am J Respir Crit Care Med. 2019 Oct 1;200(7):e45-e67)
[2] Clin Infect Dis. 2019 Mar 5;68(6):895-902

How our lab partners are responding to the COVID-19 crisis

What Quest Diagnostics® is doing

Quest Diagnostics is responding to COVID-19's impact on medical practices with its Back to Patient Care program. The program offers supports and suggestions for reopening your practice so patients can get the care they need.

A recent survey showed a 49% drop in primary care visits.[1] Deferment of patient care makes it even more important to get your patients back to a regular course of care, which includes important routine testing.

The Back to Patient Care program can help you:

- Make informed decisions for your practice and how to staff it
- Get back to the office setting
- Minimize risk of exposure in your work environment
- Treat patients in the office, as appropriate
- Continue to optimize telehealth models
- Use our Patient Service Centers for routine testing

Quest's program can help your patients and staff take steps toward managing their COVID-19 exposure and get the care and treatment they need.

Meeting your testing needs

Quest's network of 2,250 patient service centers supports Back to Care. They remain open as an essential service and are putting your patients' care first each day.

Quest's Peace of Mind program reserves the first hour of operations for VIP service for immunocompromised and vulnerable patients.

SARS-CoV-2 (COVID-19) molecular active infection testing

Quest is working with Walmart Neighborhood Markets to provide drive-thru testing. It's for any patient who meets the guidelines of the Centers for Disease Control and Prevention.

SARS-CoV-2 (COVID-19) IgG antibody testing

Quest Patient Service Centers also offer COVID-19 antibody testing. Staff and patients with a physician's order can set up an antibody test at **QuestDiagnostics.com/Appointment**.

Learn more about how Quest can help.

[1]Mehrotra A, Chernew M, Linetsky D, et al. **The impact of the COVID-19 pandemic on outpatient visits: a rebound emerges**. The Commonwealth Fund. May 19, 2020. Accessed on October 29, 2020.

What LabCorp is doing

From the early days of the pandemic, LabCorp has played an essential role in diagnostics, drug development and vaccine research. Now, we're working with our partners on a range of initiatives to help COVID-19 and non-COVID-19 patients get the care they need.

Stop Medical Distancing campaign

Many people responded to COVID-19 by pausing medical appointments, diagnostics and treatment. To encourage patients to return to health care, even if it is through telemedicine, LabCorp helped found the Keep Social Distancing, Stop Medical Distancing campaign. This is an essential call to

action for people who have delayed needed health care. Please join the campaign. The more we get the word out, the more patients will return to health care.

Patient service center (PSC) initiatives to protect communities

We've set aside the first business hour each day to serve people who are 65 or older and those with serious underlying medical conditions.

We also offer the "Wait Where You're Comfortable" program. Patients can check in from their mobile device or by using the LabCorp Express tablet and then wait in their car or anywhere else they are comfortable. They get a text message when it's their turn at the PSC.

The Fight is in Us – convalescent plasma program

LabCorp is part of a united effort to promote the donation of convalescent plasma. We believe plasma from recovered COVID-19 patients could be a key part of the fight against the virus.

COVID-19 Clinical Trial Connect program

Our online screening survey connects people to COVID-19 clinical research studies across the United States. These studies range from symptom tracking to investigating the body's immune response to researching vaccines and treatments.

LabCorp launches the first combined test for COVID-19, flu and RSV

In advance of flu season, LabCorp developed the first testing method to detect COVID-19, influenza A/B and respiratory syncytial virus (RSV) at the same time. The single-panel test uses a short nasal swab to detect multiple types of infections. It can help doctors diagnose patients and make decisions about care. The test is available through doctors, hospitals and other authorized health care providers.

Pixel by LabCorp™ makes testing easy

LabCorp's COVID-19 home test kit has everything patients need to collect a nasal swab sample. Then they can send it back to our lab for testing. It's for anyone who meets the screening criteria for COVID-19 testing. Visit **Pixel.LabCorp.com/covid-19** for more information.

Ready to help

Go to **LabCorp.com/coronavirus-disease-covid-19** to find out more.

Quick tips for using the Authorization transaction on Availity®

With our migration to Availity as our provider portal, we're sharing some tips on using the Authorization (Precertification) transaction.

Tips when submitting an Authorization request

- If you need to enter more than five diagnosis or procedure codes, enter them in the "Notes" section.
- Select a "Level of Service" — it's optional (but recommended) for an Outpatient request:
  - **Emergency**: when a patient is admitted to the facility after services were rendered in the Emergency Department
  - **Urgent**: when care for services is needed within 24 to 72 hours from the time of the request
  - **Elective**: all nonemergent, nonurgent or routine care

Tips when submitting an Authorization inquiry

- If you can't find an Authorization, check the "Show Optional Fields" box. Scroll to the third section labeled "Service Information" and enter the Authorization number in the "Authorization or Referral Number" field.
- After you get the event details, click the "Pin to Dashboard" button to "pin" the event to your dashboard.

Register for Availity if you haven't already. Or use any of our **other participating vendors** to submit precertifications. Functionality may vary.

Pharmacy updates

Here you'll find pharmacy updates including changes to commercial drug lists and formulary information at your fingertips.

Changes to commercial drug lists begin on April 1, 2021

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

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

Ways to request a drug prior authorization

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

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

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

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

Important pharmacy updates

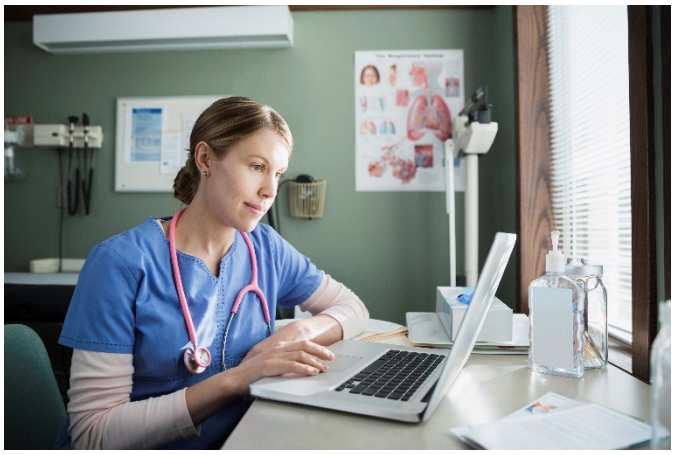
Medicare

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

Commercial — Notice of changes to prior authorization requirements

Visit our **Formularies & Pharmacy Clinical Policy Bulletins** 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



Medicare updates

Get Medicare-related information, reminders and guidelines.

Upcoming changes to Part B step therapy requirements

A few changes are planned for step therapy requirements for certain Part B drugs for our Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MAPD) plans. These changes below take effect January 1, 2021. Please keep in mind that:

- Before covering a nonpreferred drug, your patient must try a preferred drug
- These new rules do not apply to patients who have had treatment with the nonpreferred drug in the past 365 days

Visit **Aetna.com/partb-step** for more details. You'll find the full list of preferred and nonpreferred drugs there.

These therapeutic categories have both preferred and nonpreferred products.

- Bone resorption inhibitors
- Botulinum toxins
- Colony stimulating factors — leukocyte growth factors
- Erythropoiesis stimulating agents
- Immunologics
- IVIG/SQIG
- Multiple sclerosis
- Oncology
- Ophthalmic disorders
- Pulmonary arterial hypertension (PAH)
- Viscosupplements

News about Avastin®

Avastin for oncology use was added to the National Precertification List on July 1, 2020. There is no step therapy requirement for Avastin for oncology use. For ophthalmic use, code C9257 will not require prior authorization. If other codes are used, a prior authorization for indication will be required.

We're here to help

If you have questions, call us at **1-800-624-0756 (TTY: 711)** from 8 AM to 6 PM, Monday to Friday in all continental U.S. time zones. Or you can visit our provider website at **Aetna.com/partb-step**.

Free OneTouch Verio Reflect® meter for Aetna Medicare Advantage Prescription Drug (MAPD) plan members

Introducing the OneTouch Verio Reflect meter! This new high-tech, high-touch product is available to Aetna MAPD members at no cost from LifeScan, our exclusive provider of diabetes meters and supplies. These members are eligible for one free meter per year. Now may be a good time for members to upgrade their diabetes meter.

The OneTouch Verio Reflect meter:

- Takes less blood to obtain accurate readings
- Has a user-friendly backlit display, featuring glucose readings on a range to indicate near-high or near-low blood sugar levels
- Is the only meter to provide real-time messaging with guidance, insight and encouragement based on blood glucose results
- Allows the option to connect to the free OneTouch Reveal® mobile app via Bluetooth® technology, making it easy to share and discuss results with family and health care providers. Members can sync data seamlessly from the OneTouch Verio Reflect meter to their smartphone to view patterns identified in blood glucose summaries.

If you have questions or if you'd like to know how Aetna Medicare Advantage plan members can order a OneTouch Verio Reflect system kit at no additional cost, visit **OneTouch.OrderPoints.com** and input brochure code 123AET200. Or call LifeScan at **1-877-764-5390** and provide brochure code 123AET200.

A new year means new Medicare plans — verify your Medicare patients' eligibility

Some of your patients may have new plans. Or their plans may have changed from last year with different financial obligations or a new ID number. Remember to verify their eligibility as the new year approaches.

Ask your patients for their current ID card. If they don't have one, you can still verify their eligibility using their full first and last names and date of birth on our **Availity provider portal**. You can also print an electronic copy of their ID card, if you need it. Make sure what we have listed matches your patient's information. And be sure to use their current ID number when submitting claims, precertifications or referrals.

While it is a good idea to verify their eligibility at the beginning of the year, we recommend verifying their eligibility before every visit.

Reminder to California and Illinois Independent Physician Associations (IPA):
Data file exchange formats and capitation payment reporting will be changing. Refer to the IPA Capitation and Eligibility Bulletins for additional information.

NationsHearing to manage services for some of our Medicare members

As of January 1, 2021, NationsHearing will administer all **routine** hearing-related services for some* of our Medicare members. These services include:

- The hearing exam used to assess hearing aid candidacy
- All hearing aid benefits

What you need to know

Your patients' hearing benefit is separate from the diagnostic hearing exams and related charges covered by Medicare. You may continue to bill us for hearing tests for a medical condition. If your Aetna Medicare patient needs hearing aids, tell them to call NationsHearing at **1-877-225-0137**. Someone is available to help Monday through Friday, 8 AM to 11 PM ET.

Join the NationsHearing network

To provide hearing aid services to our Medicare Advantage plan members, you must be part of the NationsHearing network. Visit **nationsbenefits.com/providers** to learn more about the network.

For a paper application, call **1-877-226-9158**.

*This benefit is not available to all Aetna Medicare Advantage members. To check eligibility, members should check their Evidence of Coverage (EOC). Providers should verify eligibility through our Provider Service Center.

Don't let your network status change — complete your required Medicare Compliance training by December 31, 2020 to comply with CMS requirements

Participating providers (individual, group, hospital, facility or ancillary, etc.) in our Medicare Advantage (MA), Medicare-Medicaid (MMP) and/or Dual Eligible Special Needs (DSNP) plans must meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related (FDR) entities and/or the DSNP Model of Care (MOC) training and attest **by December 31, 2020**.

How to complete your attestation

Providers contracted for **MA/MMP plans**: You'll find the training resources you need to ensure your compliance on **Aetna.com.** Find "**QUICK LINKS"** (under the picture at the top of the page) then, "**Medicare information.**" Review the Medicare Compliance requirements training (Medicare compliance FDR program guide, FDR frequently asked questions) and complete your attestation.

Providers contracted in **MA & DSNP plans**: In addition to reviewing the FDR materials, you must review the DSNP Model of Care (MOC) and complete the Medicare Compliance FDR & DSNP MOC Combined Attestation.

Where to get more information
If you have attestation-completion or compliance-related questions, please review all supporting materials **noted above**. If you need additional assistance or would like a Quick Tips guide to assist with the attestation, email us at **FDRAttestation@Aetna.com**. You'll find more compliance information in our quarterly **FDR Compliance Newsletter**, too.

Independent Living Systems (Florida only) and GA Foods to manage benefits for some Medicare members

In 2021, Independent Living Systems (Florida only) and GA Foods will provide post-inpatient hospital discharge meals to some of our Medicare members.* This delivery process happens automatically once the hospital discharges the member. The vendor will contact the member to schedule meal delivery.

- Members are eligible for meals delivered to their requested location.
- Meals are guaranteed within 72 hours of the order.

How to make changes to this service
The vendor will send PCPs a fax with more details on this service. The fax will include instructions on how to change the meal content or cancel this service.

*This benefit is not available to all Medicare Advantage members. To check eligibility, members should check their Evidence of Coverage (EOC) document.

Reminder: Medicare Advantage plan members can get one wellness visit per calendar year

Medicare Advantage plan members can get their annual wellness visit once per calendar year instead of once every 366 days. This means even your patients who had their annual wellness visits late in the calendar year can be scheduled early in the next calendar year. This gives patients more time to focus on their health during the year.

In addition, members can get their annual wellness visit (G0438 or G0439) when billed with a routine physical exam.

2021 market expansion: Dual-Eligible Special Needs Plans (DSNPs)

We're excited to announce the expansion of our DSNP program into more markets for 2021.

Am I in the D-SNP network?

The DSNP network is available in limited counties. Check your participation status using the **provider search tool**. In Virginia, check status via the **Aetna Better Health® of Virginia** page. In New Jersey, check status via the **Aetna Assure Premier Plus** page.

Provider policies and procedures

All DSNP plans are required to have an approved Model of Care (MOC). Providers must take the mandatory **Model of Care training** required by the Centers for Medicare & Medicaid Services (CMS) each year.

What members need to know

- Members should show their D-SNP member ID card and their state-issued Medicaid card.
- NJ FIDE-SNP members will have one member ID card for both Medicare and Medicaid.
- Members must select a primary care physician (PCP).
- There are no out-of-network benefits unless the member follows the approval process by contacting Member Services directly.

Provider claims processing

Member cost sharing: Depending on the member's Medicare Savings Program (MSP) eligibility, they may have a cost share responsibility. Providers may not balance bill members who do not have cost share responsibility, including Qualified Medicare Beneficiary (QMB)-only enrollees. For more information, please **check out our cost share grid**.

You can easily find more **D-SNP resources**. Or **contact us** for help.

How to handle telehealth visits

Due to the current public health crisis, Telehealth is currently a benefit for Medicare Advantage members. Here are some tips:

- The visit must be performed in real time, using both audio and video
- Document the visit properly:
  - Indicate the mode of the visit for video conferencing
  - Document the date and duration of the visit
  - Complete documentation as you would for an in-person visit

In this rapidly changing environment, an Aetna® team of clinical and coding certified educators play an important role by working to ensure that providers have access to the most updated information. For additional information, contact us at us at **RiskAdjustment@aetna.com**.

We're expanding our Aetna Medicare Advantage (MA) plans to 115 new counties

We're expanding our MA plans to 115 new counties for 2021. Depending on your contract, you may be listed as a participating provider in our MA networks.* On **Aetna.com**, you can view our **2021 expansion counties**. If you're not currently contracted for our MA plans, please call our Provider Service Center at
1-800-624-0756 (TTY: 711).

The Annual Enrollment Period (AEP) for Medicare is from **October 15, 2020**, through **December 7, 2020**. We believe that Medicare beneficiaries will be interested in our plans because of our healthy Star Ratings. For 2021, our overall enrollment-weighted rating is 4 out of 5 stars (measurement period FY 2019 and early 2020). These ratings reflect the care you give to your patients

Learn more about our MA products

View our **Aetna Medicare Advantage plans quick reference guide**.

Visit our Health Care Professionals page on **Aetna.com** to view the **At a Glance** reference guide.

*Not all plans are offered in all service areas.

State-specific updates

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

Arkansas - Notice of Material Amendment to Healthcare Contract

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

- A reminder about HCPCS code V2790
- Changes to our National Precertification List (NPL)
- Home infusion therapy limits

- Surgical procedures performed in the emergency room by an emergency physician billed without modifier -54
- Third-Party Claim and Code Review Program
- Important update about service codes
- Changes to commercial drug lists begin on April 1, 2021
- Important pharmacy updates
- Upcoming changes to Part B step therapy requirements

California - How to access your fee schedule

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

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

Colorado - 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** (90-day notices & important reminders)

Maryland - How to ID providers no longer in the network

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

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

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

If you have questions about the Aetna network or making specialty referrals to in-network providers, please contact our Provider Service Center at **1-800-624-0756 (TTY: 711)**.

Massachusetts - We cover alternatives to opiates under Massachusetts law

In accordance with Mass. Gen. Laws Ch. 175 §§ 47KK, Aetna® covers medication and nonmedication pain management opiate alternatives ("Opiate Alternatives") that are medically necessary. Generally, Aetna considers an Opiate Alternative to be medically necessary if it is supported by adequate evidence of safety and effectiveness in peer-reviewed, published medical literature. Coverage for an Opiate Alternative that Aetna considers medically necessary is subject to applicable benefits plan limitations and exclusions.

- To check whether Aetna considers a nonmedication Opiate Alternative to be medically necessary, please refer to our Clinical Policy Bulletins (CPBs). Relevant CPBs may include acupuncture (#0135), biofeedback (#0132), physical therapy (#0325) and chiropractic services (#0107). Coverage for a nonmedication Opiate Alternative, even if medically necessary, is subject to applicable benefits plan limitations and exclusions.
- To check whether a medication Opiate Alternative is covered by an Aetna formulary, please refer to our Find a Medication page. Relevant medications may include acetaminophen, NSAIDs, muscle relaxants, anticonvulsants, antidepressants, topical analgesics and corticosteroids. Coverage for an Opiate Alternative medication is subject to applicable benefits plan limitations and exclusions.

New Jersey - Where to find our appeal process forms

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

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

North Carolina - expansion of Dual Eligible Special Needs plans (DSNPs) begins January 1

Since the DSNP network is available only in limited counties, check your participation status using the **provider search tool**.

Supplemental benefits included:

- Dental (preventive and comprehensive)
- Healthy food card
- In-home personal care support
- Over-the-counter (OTC)
- Hearing aids
- Transportation
- Eyewear
- Post-hospital-discharge meal delivery

DSNP members should show these cards at each office visit

- DSNP member ID card
- State-issued Medicaid (or MSP) card *(this can vary by state and month of eligibility)*

Other important information

- All members *must* choose a primary care physician.
- There is no referral requirement for specialty care.
- Participating providers can submit pre-authorization requests through our provider portal. They can also fax or call the Provider Service Center with such requests.
- Pharmacy Part D coverage is part of our DSNP plans.
- No out-of-network benefits exist for these plans unless the member follows the approval process. They can start this process by contacting Member Services directly.
- View our DSNP information by checking our **provider manual**.

To verify eligibility

To verify member and provider eligibility, view claims and access our websites, check our 2021 DSNP Medicare Advantage HMO plans. You can also find a phone number to speak to a representative.

Ohio - Preventive mammogram coverage

When a member is eligible for a preventive mammogram under their benefits plan, we consider the first mammogram billed in the calendar/plan year as preventive. For dates of service beginning on January 1, 2021, we will apply the mandated screening mammography rate to this service for fully insured members residing in Ohio.

An Aetna Whole Health℠ plan is coming to Northeast Ohio

We're launching a new accountable care product in Cleveland/Northeast Ohio during fall of 2020. The product is called **Aetna Whole Health℠ — Cleveland Clinic**. The following counties are included: Cuyahoga, Lorain, Medina, Summit, Portage, Geauga, Lake, Ashtabula, Stark and Tuscarawas.

The Aetna Whole Health — Cleveland Clinic network

Providers for the Aetna Whole Health — Cleveland Clinic network include Cleveland Clinic Quality Alliance providers. This network is a subset of our current networks. The same policies and procedures that apply to our commercial business also apply to this plan. Please check on your participation in this product and verify member eligibility before you see members with the ID cards shown below.

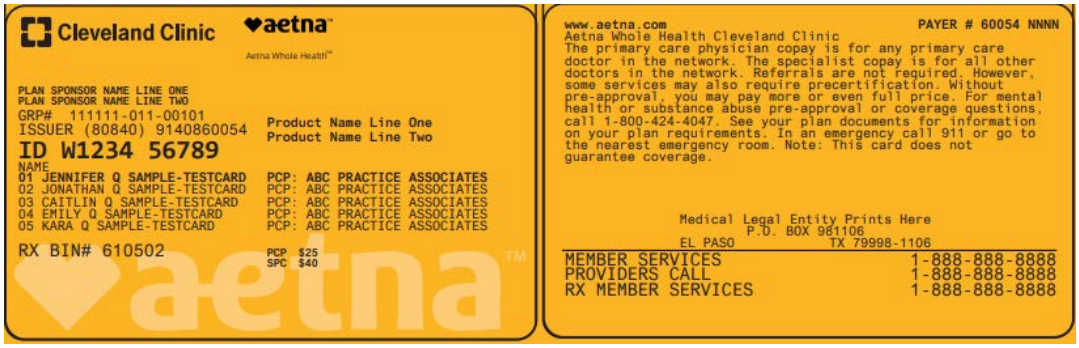
Finding an in-network provider is easy

Simply visit **the provider search page** and:

- Select the **(OH) Aetna Whole Health — Cleveland Clinic** plan from the drop-down menu.
- Choose a doctor or facility listed under "Best Results for Your Plan." (These providers are also indicated with "Aetna Whole Health — Cleveland Clinic." That's how you'll know who's in the network.)

We're here to help

Questions? Just call our Provider Service Center at **1-888-MD AETNA** (**1-888-632-3862**). Here's a sample member identification card:



Pennsylvania - Pittsburgh office on the move

The staff of the Aetna® office at 11 Stanwix Street, Pittsburgh, has moved. You can now find them at another area Aetna office. Their new address is:

730 Holiday Drive
Suite 140
Pittsburgh, PA 15220

Washington - PURMS moves to Aetna®

Public Utility Risk Management Services (PURMS) moves to Aetna effective January 1, 2021. The pool provides coverage for over 2,200 members in Washington State. Under this new agreement with Aetna, prior authorization requirements have been waived. Please contact Aetna provider services at **1-888-632-3862 (TTY: 711)** to verify benefits.

Network arrangement and claims management

This plan sponsor has elected that the Third Party Administrator (TPA) work in tandem with Aetna. Providers should continue to work with Aetna in accordance with their usual process, and members who have questions or eligibility issues should be redirected to the TPA. The network product is Managed Choice II (CPII Product).

What you need to know

- The move becomes effective January 1, 2021.
- The plan sponsor can be identified by referring to the member's ID card. The ID card will reflect group number 891042.
- Please note that prior authorization requirements have been waived for the 2021 plan year. Benefits and eligibility should continue to be verified following your normal process.

Looking ahead

The plan sponsor is composed of multiple public utility departments with different benefits arrangements. Aetna continues to be in discussions with those departments regarding the upcoming benefits change. We will provide any updates in the upcoming quarterly newsletter

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