OfficeLink Updates™

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

aetna™

March 2021

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.

Changes to our National Precertification List (NPL)

As of **July 1, 2021**, these precertification changes apply:

- We'll require precertification for:
  - Cataract surgery
  - Sacroiliac joint fusion surgery
  - Knee arthroscopy with meniscectomy
  - Vertebral corpectomy procedures
  - Additional lower limb prosthetic codes including select foot, ankle and vacuum pump components
- Spinraza® (nusinersen) — precertification required for both the drug and site of care.

Submitting requests

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

To save time, you can make your request 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 drug prior authorization on a specialty drug for a commercial or Medicare member? Then submit your request through NovoLogix®, also available on Availity®.

Not registered for Availity?

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

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

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

Third Party Claim and Code Review Program

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

For procedures considered incidental to another procedure or service, we may not allow modifier 59 to allow the incidental service.

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

To find out if our modifier 59 changes will apply to your claim, go to Aetna Payer Space > Applications > Code Edit Lookup Tools.

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

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

Services related to a denied primary surgical procedure

As of **June 1, 2021**, we will deny all other services billed on an outpatient facility claim when we deny the primary surgical code billed with revenue codes 360, 361 or 369 as experimental and investigational, cosmetic or not medically necessary.
Examples of these other services include, but are not limited to:

- Anesthesia
- Labs
- Medical supplies
- Pharmacy
- Radiology procedures

Billing for allergy testing

Effective **June 1, 2021**, when you bill allergy testing (95004-95079) with rapid desensitization (95180) we will consider allergy testing mutually exclusive to rapid desensitization.

North Carolina providers - 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 **June 1, 2021**.

Codes	**Provider types affected**	**What's changing**
90739	Physicians, specialists, primary care physicians, group physicians	Will be *added* to the immunization schedule called IMMVAC

New Jersey providers — edits activated for billing modifiers 58, 78 and 79

As of **June 1, 2021**, we'll be activating edits for billing modifiers 58, 78 and 79 in New Jersey for fully insured and self-insured membership claims. We may request medical records for these services as provided to your New Jersey fully insured patient claims.*

These edits are an expansion of the edits, communicated in September 2020, that were reactivated for modifiers 25, 59 and the X series. Those edits became effective on December 1, 2020.

The medical records review program will not apply to self-insured membership claims. These new edits are part of our Third Party Claim and Code Review Program. They'll apply prior to finalizing claims for professional services and outpatient facilities.

We may request medical records for professional services provided to New Jersey fully insured patients* and billed with modifiers:

- 25, 59 and X series: effective **December 1, 2020**
- 58, 78 and 79: effective **June 1, 2021**

The new edits do not constitute a clinical review. Any edit applied will be based on industry-recognized coding guidelines. We will review the service, service history, changes in condition, diagnostic tests and the medical chart to determine if these services require separate payment. We allow charges for covered services not subject to the coding review.

- You can send medical records with your initial claim submissions for services provided to New Jersey fully insured patients.*
- If medical records are not provided and needed, Aetna® will request them.
- If a medical chart is requested but not submitted within 45 days, then the charges for the service billed with one of the modifiers listed above will be denied.

Keep in mind:

- We follow both New Jersey claims processing timelines, and appeal rights apply to any denied charges.
- You can submit medical records/notes via the following:
    - Fax number or address on the Explanation of Benefits (EOB) statement
    - The "Claim Status — Send Attachments" functionality through our provider portal on **Availity**.
- This program applies to certain claims for charges $25 or greater and billed with one of the modifiers listed above.

To find out if our new claims edits will apply to your claim, log in to the provider portal. Then, go to Aetna Payer Space > Application > Code Edit Look-up Tools. You'll need to know your Aetna® provider ID number (PIN) to gain access.

*New Jersey member ID cards indicate whether the member is covered under a fully insured plan or under a self-funded plan.

Changes to commercial drug lists begin on July 1, 2021

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

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

Ways to request a drug prior authorization

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

Important reminders

Reminder — experimental and investigational labs

We consider certain laboratory tests to be experimental and investigational. These noncovered laboratory tests are not covered by most of our plans. This means your patient may be responsible for the full cost of these laboratory tests.

There are several tests that Aetna® may not cover, but the most common are:

- Lyme Disease (CPB #0215)
- Vitamin D Assay (CPB #0945)
- Lipoprotein Cholesterol Test (CPB #0381)
- Homocysteine Test (CPB #0381)

Information you should share with patients

It is important that your patients understand that they are financially responsible for these tests, as they are noncovered services. Please remind your patients at the time you order the test that they are responsible for the full cost of laboratory tests.

News for you

New drug testing policy and reimbursement terms from 1199SEIU Benefit Funds

On November 1, 2020, 1199SEIU Benefit and Pension Funds issued a new drug testing policy. Under the policy, they will pay for medically necessary presumptive and definitive toxicology testing services when:

- Clinically appropriate
- Performed in a physician-supervised treatment setting
- Clinical records support the medical necessity for testing

Read more about the 1199SEIU Benefit Funds new drug testing policy and reimbursement terms.

Our policy for hip and knee arthroplasty

We consider computer-assisted navigation (CAN) for hip/knee arthroplasty (e.g., MAKOplasty) and the required preoperative advanced imaging to be experimental and investigational. This is because there isn't enough evidence to show that it improves outcomes. Therefore, we don't cover CAN or the related imaging. eviCore healthcare only reviews for the medical necessity of the arthroplasty.

Read more about our policy.

Preventing a million heart attacks and strokes

Million Hearts® 2022 is a national effort of the Centers for Disease Control and Prevention (CDC) and the **Centers for Medicare & Medicaid Services (CMS)**. The goal is to prevent a million heart attacks and strokes in the next five years.

How does the program improve health outcomes?
Million Hearts 2022 seeks strong and specific commitments to improve heart health for all. It focuses on a small set of priorities that can reduce heart disease, stroke and related conditions.

What does Million Hearts 2022 do?
The **CDC** offers support. It works with CMS, sets priorities and leads the communications, partnership development, research and evaluation efforts.

A call to action
Urge your patients to explore **heart disease and stroke risks**, and **tips for prevention**.

Affirmative statement for financial incentives

Visit us online to view a copy of your **provider manual** as well as information on:

Coverage determinations and utilization management (UM)
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.

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.

Improving patients' quality of life: the Chronic Condition Improvement Program (CCIP)

Every year, our National Quality Management Department carries out a Chronic Condition Improvement Program. We do this in accordance with Centers for Medicare & Medicaid Services (CMS) requirements. The CCIP is a clinical effort designed to improve your patients' quality of life.

What does the CCIP do?

The CCIP helps promote effective management of chronic diseases over a three-year period. The expected outcomes are to:

- Slow disease progression
- Prevent complications
- Inhibit development of comorbidities
- Reduce preventable emergency room (ER) encounters
- Decrease inpatient stays
- Improve the health of a specific group of enrollees with chronic conditions

How does the CCIP improve health outcomes?

The quality improvement model we use is based on the Plan-Do-Study-Act (PDSA) quality improvement model. In accordance with the CMS CCIP resource document, PDSA is cyclical in nature and includes planning, implementing, studying a change and acting on the result of that change. Care and Case Management incorporate the PDSA model and are CCIP interventions.

Call to action

Urge your patients to take part in the program so we may help manage their chronic diseases.

Learn more about our initiatives on our **care management page** and in our **provider manual**.

Consider cultural competency when caring for patients

Recognizing that members have diverse views is critical to meeting their needs. The cultural factors that will likely impact your relationships with them include age, gender identity, language, religion and values, to name a few. It's important to respect and respond to members' distinct values, beliefs, behaviors and needs when caring for them.

Our commitment

We're committed to meeting all the National Committee for Quality Assurance (NCQA) standards. Doing so will ensure that members' access to care is satisfactory. Each year, we measure our members' perspectives via the Consumer Assessment of Health Care Provider and Systems

(CAHPS®) Health Plan Survey. Survey responses help us learn about network providers' ability to meet our members' needs. We use this data to monitor, track and improve member experiences.

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

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

Sign up to receive patient payments electronically

We're working with Change Healthcare to offer their National Payments Connector™ solution. It offers patients a convenient way to pay their bills online. By enrolling in the solution, you can:

- Reduce payment lags by receiving electronic payments from patients directly deposited into your account
- Lower administrative costs
- Reduce or eliminate paper billing statements by using a digital process to efficiently manage patient payments and Explanation of Benefits (EOB) statements online
- Enhance your patients' financial experiences
- Help expedite patient payments and help reduce bad debt risk

Call Change Healthcare at **1-866-943-9579** to learn more and to get a unique registration ID. Then, you can use that ID to **enroll online**.

An ounce of prevention is worth a pound of cure — encourage a colorectal cancer screening

Colon cancer can be treated and cured if caught early. That's why we suggest encouraging your patients to get a colorectal cancer screening. The screening is noninvasive. And your patient can do it within the privacy and comfort of their own home.

Who should get a colorectal cancer screening?
The American Cancer Society® recommends colorectal screenings for men and women who are 50 years of age or older. This preventive screening can find and treat growths before they turn into tumors. The screening tools are:

- Cost effective
- Patient friendly
- Easy to interpret
- Accurate — resulting in less false positives

This means you can spend less time going over test results and more time caring for your patients.

Help your patients save by using nationally preferred labs
We know you want to help your patients save. So do we. By using in-network labs, your patients can pay a lot less. That's why we suggest using our national preferred lab network. Quest Diagnostics® and LabCorp are our two nationally preferred labs. For more information, visit **Quest Diagnostics** or **LabCorp**.

Texas DSNP claims — there's no cost share for members

Some of our members have been getting invoices from providers after receiving services.
We want to remind you that Aetna DSNP members are fully protected, and they don't have to pay a cost share. Providers should not send these members an invoice.

Aetna® is responsible for paying all Texas DSNP claims. This is part of Aetna's agreement with the Texas Health and Human Services Commission (HHSC).

Aetna adjudicates all Texas DSNP claims according to the contract. And the Explanation of Payments (EOP) documents sent to the providers are considered final.

Reminder
Send all DSNP claims only to Aetna. If you have any questions, you can call your network representative.

We appreciate your cooperation and thank you for being part of the Aetna network.

Aetna Signature Administrators® and Government Employees Health Association (GEHA) are expanding their relationship

Starting **January 1, 2021**, GEHA members living in the following states will be able to access the Aetna Signature Administrators PPO program and medical network nationally.

- Colorado
- Ohio

GEHA is a national health association serving federal employees and their families, providing health benefits plans to members worldwide.
Reminder: GEHA members in the states listed below can currently and will be able to continue to access Aetna Signature Administrators nationally.

- Alaska

- Arizona
- California
- Connecticut
- Georgia
- Maine
- Massachusetts
- Michigan
- Nevada
- New Hampshire
- New York
- New Jersey
- Oregon
- Pennsylvania
- Kentucky
- Rhode Island
- Vermont
- Washington

Contact your local Aetna® network account manager if you have any questions.

Social determinants of health

There has been increased recognition that improving health and achieving health equity require broader approaches that address the social, economic and environmental factors that influence health.

According to **HealthyPeople.gov**, social determinants can have a bigger impact on a person's health than clinical care can. Only 20% of a person's health and well-being is related to access to clinical health care and quality of services. 80% is tied to their physical environment, social determinants and behavioral factors.

Providers can use a "social needs" screening tool to update a patient's treatment plan and make referrals to community services. Assign codes describing the social determinants of health using the patient's self-reported information if approved by the provider and incorporated into the medical record.

Some examples of ICD-10 codes that describe social determinants of health include:

- Z55 — problems related to education and literacy
- Z56 — problems related to employment and unemployment
- Z57 — occupational exposure to risk factors
- Z59 — problems related to housing and economic circumstances
- Z60 — problems related to social environment
- Z62 — problems related to upbringing
- Z63 — other problems related to primary support group, including family circumstances
- Z64 — problems related to certain psychosocial circumstances

- Z65 — problems related to other psychosocial circumstances
- Z71 — persons encountering health services for other counseling and medical advice, not elsewhere classified
- Z72 — problems related to lifestyle
- Z73 — problems related to life management difficulty

Our nurse educator plays an important role by working to ensure that providers accurately document conditions. For additional information about our American Academy of Professional Coders™ (AAPC) *Continuing Education* Units (*CEUs*) webinars or private, non-CEU education sessions, email us at **RiskAdjustment@aetna.com**

Upload clinical information electronically at any time

You can use our provider portal on Availity® to upload clinical information, such as additional information forms, at any time. It's best if you include the form with your initial authorization request right away. You don't have to wait for us to ask you for it.

Just go to our **forms library**. Save it to your favorites. Download a new form each time you need it and follow the instructions on the form. Save the completed form to your computer and upload it during the final step of the authorization request. We'll get your authorization request and match it with your uploaded information.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

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

Screen and refer your patients
Use of the SBIRT model is encouraged by the Institute of Medicine recommendation that calls for community-based screening for health risk behaviors, including alcohol and substance use. Our participating practitioners who treat patients who have Aetna medical benefits can provide this service and be reimbursed. Go to **Aetna.com** to learn more.

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

The app provides questions to screen patients for alcohol, drug and tobacco use. A screening tool is provided to further evaluate the specific substance use. The app also provides steps to

complete a brief intervention and/or referral to treatment for the patient, based on motivational interviewing.

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

Depression in primary care

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

Program benefits

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

To get started, you simply need to:

- Be a participating provider
- Use the **PHQ-9** tool to screen and monitor your patients
- Submit your claims using the combination coding

Learn more.

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

Behavioral health clinical practice guidelines

Clinical practice guidelines from nationally recognized sources promote consistent application of evidence-based treatment methods. This helps provide the right care at the right time. For this reason, we make them available to you to help improve health care.
These guidelines are for informational purposes only. They aren't meant to direct individual treatment decisions. And they don't dictate or control your clinical judgement about the right treatment for a patient in any given case. All patient care and related decisions are the sole responsibility of providers.

Adopted guidelines

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

More resources

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

Opioid overdose risk screening program

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

How you can help

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

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

Resources for you and your patients

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

Depression screening for pregnant and postpartum women

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

Program elements

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

How to contact us

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

Aetna® HEDIS® data collection is underway

You'll be hearing from us soon. Either someone from our staff or from our contracted representatives (CiOx Health or Sharecare) will contact your office to collect medical record information on behalf of our members. We appreciate your understanding and cooperation as we complete this required quality reporting with minimal disruption to your practice.

Why is this necessary?
Healthcare Effectiveness Data and Information Set (HEDIS) data collection is a nationwide, joint effort among employers, health plans and physicians. The goal is to monitor and compare health plan performance as the National Committee for Quality Assurance (NCQA) specifies.

We must regularly send health care quality data to the Centers for Medicare & Medicaid Services (CMS) for our Aetna Medicare Advantage and Coventry Medicare Advantage organizations. We collect most of the data from claims and encounters. We also gather data on services provided and member health status from member medical records.

What we may need from you
When we reach out to you, we'll ask that you give us timely access to our members' medical records. Our contracted representatives will work with you and give you options for sending medical records.

Meeting HIPAA guidelines
Our contracted representatives, like CiOx Health and Sharecare, serve us in a role that the Health Insurance Portability and Accountability Act (HIPAA) defines and covers. As HIPAA defines, Aetna is a "Covered Entity," and our representative's role is as a "Business Associate" of a "Covered Entity." Giving medical record information to us or our contracted representatives meets HIPAA regulations.

We appreciate your help in our data collection efforts.

Reminder: check your Aetna Premier Care Network status

If you haven't already, now is a good time to check our **provider referral directory. Just go to Aetna.com** to see if you're participating in our Aetna Premier Care Network/Aetna Premier Care Network Plus programs for 2021.

For 2021, we did not perform a designation review of provider performance. However, in some markets we have changed the underlying network configuration. For example, we converted a broad network to an Aetna Whole Health℠ arrangement.

If you have questions, call us at **1-888-632-3862**. You can also visit our **provider website** and send us any questions.

Here are some changes for 2021

Aetna Premier Care Network Plus only

Springfield, MO: Cox Health Aetna Whole Health
Kansas City, MO: I-35 Performance Network
Georgia: VHAN ACO expansion into Murray and Whitfield Counties

Aetna Premier Care Network only
Kansas City, MO: Aetna Broad Network

Aetna Premier Care Network and Aetna Premier Care Network Plus
South Carolina: Aetna Broad Network
Utah: Utah Connected Network

Overview of Aetna Premier Care Network
Aetna Premier Care Network 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.

Overview of Aetna Premier Care Network Plus
Aetna Premier Care Network 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 Aetna Premier Care Network Plus and the name of the ACO/JV on their ID card for identification.

Our office manual keeps you informed

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

Visit us online to view a copy of your provider manual (if you don't have Internet access, call our Provider Service Center for a paper copy) as well as information on the following:

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

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

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

Update your information — here's why

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

We need your current information, such as:

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

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

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

Important message for Massachusetts and New York commercial and Medicare providers
Beginning **April 1, 2021**, you must use Availity to update and validate your demographic information.

Pharmacy updates

Changes to commercial drug lists begin on July 1, 2021

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

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

Ways to request a drug prior authorization

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

State-specific updates

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

Arkansas providers - Notice of Material Amendment to Healthcare Contract

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

- Changes to our National Precertification List
- Important update about service codes
- An important message about technical component only lab services
- Third Party Claim and Code Review Program
- Services related to a denied primary surgical procedure
- Billing for allergy testing
- Changes to commercial drug lists begin on July 1, 2021
- Important pharmacy updates

California providers, how to access your fee schedule

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

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

Colorado providers - Notice of material change to contract

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

- **Updates to our National Precertification List**
- **Clinical payment and coding policy changes (i.e. 90-day notices & important reminders)**

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

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

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

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

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

New Jersey providers - Where to find our appeal process forms

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

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

North Carolina providers - 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 **June 1, 2021**.

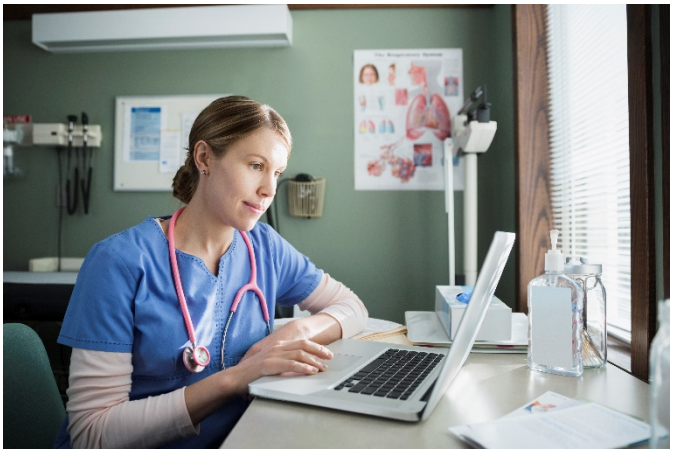
Codes	**Provider types affected**	**What's changing**
90739	Physicians, specialists, primary care physicians, group physicians	Will be *added* to the immunization schedule called IMMVAC

Ohio providers - Cleveland office on the move

The staff of the Aetna® office at 4059 Kinross Lakes Parkway, Richfield, Ohio, has moved. You can now find them at another area Aetna office. Their new address is:

Aetna Better Health of Ohio
7400 West Campus Drive
New Albany, OH 43054

You can still reach them at the same phone numbers and email addresses.



Medicare updates

Get Medicare-related information, reminders and guidelines.

A friendly reminder: You can't balance bill Medicare beneficiaries who have extra benefits

Some dual-eligible Medicare beneficiaries have extra benefits. You can't charge these members for cost sharing.

State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. But by law, states can limit the provider reimbursement amount for Medicare cost sharing under certain conditions.

Dual-eligible individuals may qualify for Medicaid programs that pay Medicare Part A and Part B premiums, deductibles, coinsurance and copays. These programs include:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualified Disabled and Working Individuals (QDWI)
- Qualifying Individual (QI)

Medicare providers must accept the Medicare and Medicaid payment (if any) in full for services given to a beneficiary who is part of one of these Medicare Savings Programs.

What happens if you don't comply?
Your provider agreement stipulates that you must follow billing rules. Failure to follow billing rules may result in sanctions from the Centers for Medicare & Medicaid Services (CMS).

Keep in mind

- All Original Medicare and Medicare Advantage providers — not just those that accept Medicaid — must follow the balance-billing rules.
- Providers can't balance bill members when they cross state lines for care. This is true no matter which state provides the benefit.

Where to go for more information

- **Medicare-Medicaid general information**
- **Additional Dual Eligible Special Needs Plans (DSNPs) resources**

Avoid a network status change — complete your required Medicare Compliance training to comply with CMS requirements by December 31, 2021

Participating providers in our Medicare Advantage (MA), Medicare-Medicaid (MMP) and/or Dual Eligible Special Needs (DSNP) plans, are required to meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related (FDR) entities and if participating in the DSNP plan, the Model of Care (MOC) training. An attestation will be required (when released) by December 31, 2021.

How to complete your Medicare Compliance FDR or FDR/DSNP attestation
The Medicare FDR & MOC Attestation(s) will be released in 2nd/3rd quarter of 2021. In the meantime, review the training resources now to ensure you're in compliance on **Aetna.com**. These include the

Medicare compliance FDR program guide, **FDR frequently asked questions** and also if participating in DSNP, the **DSNP Model of Care (MOC)**.

Where to get more information

If you have attestation-completion or compliance-related questions, please review all supporting materials published on **Aetna.com**. Just email us at **FDRAttestation@Aetna.com** if you don't find the answers you need. You'll find more information in our quarterly **FDR Compliance Newsletter**, too.

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