OfficeLink Updates™

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

aetna®

DECEMBER 2021

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90-day notices and important reminders

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

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

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

Office consultation codes payment update

CORRECTION: In September, this article appeared on **Aetna.com** with an incorrect start date of December 1, 2021. The correct start date is March 1, 2022.

Starting March 1, 2022, we will no longer pay office consultation codes 99241, 99242, 99243, 99244 and 99245.

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

Colorado providers — notice of material change to contract

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

- **Clinical payment and coding policy changes**

Changes to commercial drug lists begin on April 1

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

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

Ways to request a drug prior authorization

- Submit your completed request form through our **Availity provider portal**.*
- For requests for nonspecialty drugs, call **1-800-294-5979 (TTY: 711)**. Or fax your completed **prior authorization request form (PDF)** to **1-888-836-0730**.
- For requests for drugs on the Aetna Specialty Drug List, call **1-866-814-5506** or fax your completed **prior authorization request form (PDF)** to **1-866-249-6155**.

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

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

Important pharmacy updates

Medicare

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

Commercial — notice of changes to prior authorization requirements

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

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

Coding update effective March 1, 2022

Codes	Provider types affected	What's changing
Q5116–Q5118	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be assigned to DEFALLDRUGS effective March 1, 2022 The codes will remain assigned to the following service groupings: • ALLDRUGS • ALLDRUGSWCS • DIALYSDRUG • DRUGS • DRUGCJSQ • HCDHPALL • HCDHPALLWCS • HCDHPCHEMCS • HCDHPCHEMO • OPCHEMODRUG If the contract contains a DEFALLDRUGS, or one of the service groupings noted above, the applicable service grouping rate will be applied. If the contract contains none of these provisions, the relevant terms of the contract will rule.

Note: The material in the chart is subject to regulatory review and separate notification in Washington state.

Third Party Claim and Code Review Program

Beginning March 1, 2022, you may see new claim edits. These are part of our Third Party Claim and Code Review Program. These edits support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. You can view these edits on the **Availity provider portal**.

For coding changes, go to:

1. Aetna Payer Space
2. Resources
3. Expanded Claim Edits

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

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

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

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Important reminders

eviCore healthcare Site of Care medical necessity requirement

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

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

- the individual is under 18 years of age
- obstetrical observation is required
- perinatology services are required
- there are imaging needs related to transplant services at an approved transplant facility
- there is a known contrast allergy, and use of that contrast agent is planned
- there is a known chronic disease for which prior high-tech imaging procedures have been used for the diagnosis, management or ongoing surveillance of the disease at the hospital-affiliated imaging department
- there is an active coronavirus disease 2019 (COVID-19) diagnosis after positive test for SARS-CoV-2
- there are no other appropriate alternative sites for the individual to undergo the imaging procedure for any of the following reasons:
    1. the surgery or procedure is being performed at the hospital, and preoperative/procedural or postoperative/procedural imaging is an integral component of the care

2. the imaging procedure requires general anesthesia or moderate or deep sedation, and a freestanding facility capable of providing such sedation is not available
3. the equipment needed to accommodate the size of the individual is available only at a hospital-affiliated imaging facility
4. the individual has a documented diagnosis of claustrophobia requiring open magnetic resonance imaging, which is not available in a freestanding facility
5. imaging outside the hospital-affiliated imaging department or facility is expected to adversely impact or delay care

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

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

Verify whether your patients have other coverage

Routinely verifying whether your patients have other coverage is critical. Without that information, your claim payments could be denied or delayed.

If a patient has other coverage, we need the following information on the claim submission:

- The other plan's name
- The other plan's policy number (if applicable)
- The other employer's name (if applicable)

If a patient has no other coverage, please ensure that the above three fields are blank.

Having this information will ensure that we can process the claim accurately and timely.

News for you

New webinar on submitting drug prior authorization requests on Novologix®

This webinar is for anyone who submits specialty drug prior authorizations for your practice or facility. We'll show you how to:

- Use the Novologix portal (accessed through Availity®)* to submit a specialty drug prior authorization
- Initiate a National Comprehensive Cancer Network® (NCCN®) regimen
- Check the status of a pending request

How to attend

This course is offered on the second Thursday of every month from 1 PM to 2 PM ET.

Register for an upcoming session.

We're here for you

For assistance regarding drug prior authorization requests, contact Aetna's Specialty Prior Authorization team at **1-866-752-7021 (TTY: 711)** (commercial) or **1-866-503-0857 (TTY: 711)** (Medicare).

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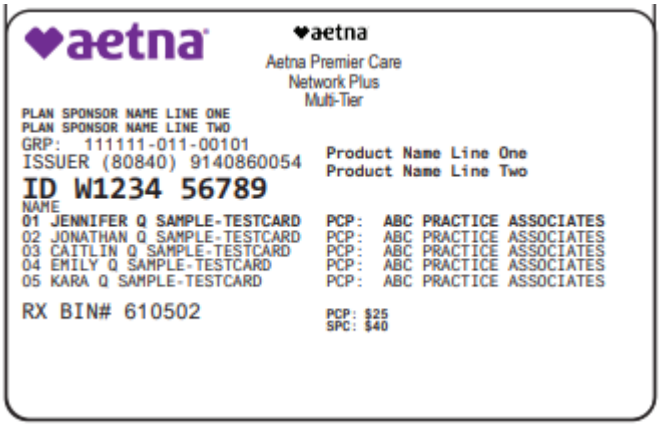
The Aetna Premier Care Network Plus program is now multi-tiered

Starting January 1, some of your patients might be in our new Aetna Premier Care Network Plus Multi-Tier program. This program is a new national performance network offering. Multi-tiered programs sort doctors and facilities into tiers based on their performance and ability to save money. The highest performing and most efficient doctors and facilities are in Tier 1.

How to identify patients who in the multi-tier program

The member ID card will say "Aetna Premier Care Network Plus Multi-Tier."



Find out whether you participate and what tier you are in

To check your participation and tier status, visit our **provider referral directory**. If a hospital or provider does not participate with Aetna®, it will not appear in the search results.

You can also find out whether you are participating or not participating by looking at the "limitations" section of a transaction.

Tier 1 participation

- Tier 1 hospitals and providers will see “maximum savings” displayed.
- This tier is the APCN Plus network, which is covered at the highest benefits level.

Tier 2 participation

- Tier 2 hospitals and providers will see “standard savings” but could see both “maximum savings” and “standard savings if both a hospital and doctors are included under the same tax ID (this is referred to as having a “mixed participation” status).
- This tier is Aetna’s broad network of providers and is covered at a reduced benefits level. Most doctors and hospitals not designated as Tier 1 but contracted with Aetna’s broad network will be covered at the Tier 2 benefits level.

Out of network

- If a hospital or provider is out of the network, the system will display this: “We are unable to determine your participation status . . . . Services rendered by providers that are not part of the patient’s network are not covered.”
- A member might still be covered for out-of-network benefits.

Questions?

Call the Provider Service Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)**.

Aetna Premier Care Network and Aetna Premier Care Network Plus 2022 updates

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

Aetna Premier Care Network Plus (APCN Plus) includes a combination of performance networks across the country, but also includes accountable care organizations (ACO) and joint ventures (JV) in certain areas. Members in these networks will have APCN Plus and the name of the ACO/JV on their ID card for identification.

New 2022 network configurations

We did not perform a designation review of provider performance for 2022; however, in some markets we changed the underlying network configuration — for example, converting a broad network to an Aetna Whole Health® (AWH) arrangement.

The following list is a list of states and their new 2022 configurations:

- Cleveland, Ohio: Cleveland Clinic Aetna Whole Health℠
- Toledo and Cincinnati, Ohio: Broad Network

- Fort Meyers and Tampa, Florida: Southwest Florida Aetna Whole Health℠
- El Paso, Texas: Tenet Healthcare Aetna Whole Health℠
- Rio Grande, Texas: Baptist Valley Aetna Whole Health℠
- Boise, Idaho: Broad Network
- Iowa; Southern Illinois; Rock Island/Henry, Illinois: Unity Point Aetna Whole Health℠

Check your Aetna Premier Care Network status

Now is a good time to check our **provider referral directory** to see if you're participating in our Aetna Premier Care Network (APCN)/Aetna Premier Care Network Plus (APCN Plus) programs for 2022.

Questions?

Call the Provider Service Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)**.

Aetna One Advocate (A1A) card color change to platinum

A1A is an Aetna top-tier service offering. It has over 1 million members, and it offers a total population health solution for them.

Effective November 12, 2021, A1A will change the color of some of its ID cards to platinum. Currently, all the cards are white.

Is anything else changing?

The color of some of the cards is the only thing that is changing. The plan is still an Aetna® plan, and nothing about the plan is changing. Treat this card the same way you would treat any other Aetna ID card.

Provider Onboarding Center update

The **Provider Onboarding Center** is a centralized web portal for onboarding information and requests. Users can request to join the Aetna® network, update information for an existing participating provider and much more. The Provider Onboarding Center is supported by Chrome (version 90 or above) and Safari. The Center is updated regularly with new functions to simplify and streamline the onboarding experience.

Requests for Participation

As of August 19, 2021, all Requests for Participation must be submitted via the Provider Onboarding Center. Other Aetna sites that previously supported application submission will redirect to the Provider Onboarding Center.

New Request for Participation save function

Users can now save a Request for Participation. Once a Request ID is assigned, users may return to the Provider Onboarding Center to complete the application at any point within 30 days.

To continue working on a saved application, select "I want to go to a saved Request for Participation" from the Provider Onboarding Center homepage. Then, enter the Request ID, TIN, and NPI associated with the application. If you have not completed the application within 10 days of the expiration date, the submitter will receive an email reminder to complete the application.

New provider manual — state supplement

This document replaces the four regional manuals and is organized by state to make it easier for you to find information to support you in providing care, managing your practice and working with our teams.

Check out the new manual.

Coming soon: a standard electronic solution for receiving supporting documentation

We're creating a new secure solution for receiving supporting documentation electronically to process your claims. Currently, you can upload claim-support documentation and authorization requests on our **Availity provider portal**.* Our new solution will follow the same industry standards that other payers use, making the process easier for you.

We'll introduce the new solution early next year. We'll start by accepting claims-support documentation. Later, we'll start accepting supporting documentation for pre-authorization requests.

We'll use these four clearinghouses to help us receive your documents:

- Availity®
- Change Healthcare
- PNT Data
- Waystar

Learn more about our electronic transaction vendors.

The benefits of the new solution

Sending electronic supporting documentation:

- Reduces claim denials
- Reduces the amount of time to finalize claims
- Eliminates requests from us for supporting documentation
- Eliminates the need to mail or fax us supporting documentation

While you're waiting for our new solution, you can continue to use our existing feature on our Availity provider portal.

We'll update you on our progress in future newsletters.

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Labcorp offers Resolution ctDx Lung™ liquid biopsy for Next Generation Sequencing in Non-Small Cell Lung Cancer

The Resolution ctDx Lung assay provides clinicians with information that can inform treatment decisions in patients with Non-Small Cell Lung Cancer (NSCLC). It includes actionable genes for targeted FDA-approved therapies or therapies in clinical trials.

Resolution ctDx Lung liquid biopsy benefits

- It focuses only on genes implicated in lung cancer.
- A liquid biopsy can offer a complete picture of tumor heterogeneity.
- It's useful when tissue biopsies are limited or unobtainable from the patient.
- It's a non-invasive method with testing performed on a blood sample.
- It has a faster turnaround time compared to tissue NGS profiling.[1]

Clinical response rate data

In a prospective clinical study, the Resolution ctDx Lung assay demonstrated the following performance:[1]

Somatic mutations detected in 64% (135/210) of patients:

- 97% (34/35) of patients who received plasma-directed therapy had a clinical and radiological response to the matched targeted therapy
- 46% (96/210) of patients had an oncogenic driver alteration detected, including actionable mutations in EGFR, ALK, MET, BRAF, ROS1 and RET
- 90% (60/67) positive concordance between plasma and tissue NGS testing. Sub-analysis demonstrated.
- 96% (49/51) positive concordance within NCCN® oncogenic recognized driver alterations in lung cancer

Ordering information

Resolution ctDx-Lung Assay™ (Liquid Biopsy)

- Integrated Oncology Liquid Biopsy kit (PS#127647)
- Integrated Oncology Gene Profiling Assays test request form (ONC-793)

If you have a Labcorp Oncology account, **complete the test requisition form**.

If you do not have a Labcorp Oncology account, call us at **1-800-710-1800** to set one up.

[1]Sabari JK, Offin M, Stephens D, et al. **A prospective study of circulating tumor DNA to guide matched targeted therapy in lung cancers**. Journal of the National Cancer Institute. June 1, 2019; 111 (6): 575–583.

Help improve the health care transition for adolescents and young adults

We know that adolescents and young adults are a vulnerable population with evolving health conditions, high rates of behavioral health risks, and low use of health care services. Health care clinicians play a crucial role in supporting the transition from pediatric to adult health care. For optimal health outcomes, transitioning adolescents need supportive primary care providers and specialists.

We're here to help

To support our youth and help facilitate an effective transition, we provide resources you can use when you talk with your patients:

- The health plan's website to learn more about available plan benefits and special programs
- The Aetna Health℠ app, so you can keep a safe and handy health record online
- The Health Risk Assessment, which helps provide personalized health results that can be shared with clinicians confidentially
- Access to Aetna® nurses, who can help navigate the health care system and find needed resources
- Access to behavioral health counselors to help arrange mental health or substance use disorder care and connections to community resources
- Access to telehealth services, which offer flexible ways to get care

We're introducing a standard acupuncture benefit in 2022

Aetna® will add acupuncture as a standard benefit in new and renewing commercial health plans in 2022 as part of our goal to increase access to complementary health treatments. Providing this coverage gives you and our members more treatment options for chronic pain relief.

Medical literature supports acupuncture as a treatment option

Acupuncture has been shown to reduce chronic pain, such as low-back pain, neck pain and osteoarthritis (knee) pain.[1] It may also help reduce tension headaches and prevent migraines.[1]

The American Pain Society and the American College of Physicians both endorse acupuncture as a nondrug approach for patients who have chronic low-back pain who do not respond to self-care.[1]

More information

This new coverage is based on **Aetna Clinical Policy Bulletin 135**.

[1]National Institutes of Health, National Center for Complementary and Integrative Health. **Acupuncture: in depth**. January 2016. Accessed October 7, 2021.

How to contact us about utilization management issues

Our staff members, including medical directors, are available 24 hours a day for specific utilization management issues. You can call us during and after business hours via toll-free numbers.

Contact us by:

- Visiting our **website**
- Calling Provider Services at **1-800-624-0756 (TTY: 711)**
- Calling the patient management and precertification staff using the Member Services number on the member's ID card.

Health care providers may contact us during normal business hours (8 AM to 5 PM, Monday through Friday) by calling the toll-free precertification number on the member ID card. When only a Member Services number is on the card, you'll be directed to the Precertification Unit through a phone prompt or a Member Services representative.

Update your information in the provider directory — here's why

Good health starts with good provider–patient relationships. Our members are diverse, so when they have the option to connect with providers who share their identity, they might feel more comfortable talking about their health.

According to the Journal of the American Medical Association, health disparities and inequities are linked to a lack of racial and ethnic similarity or shared identity between providers and patients.[1] For this reason, we encourage all providers to self-identify.

It's easy

The provider data management (PDM) tool on Availity® allows you to update information about your business and providers. Keeping your information current and accurate helps our members connect with you for care.

Making updates in the PDM tool allows you to share information with Aetna® and other payers, reducing phone calls to your office. Some other benefits include:

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

Updating your information is easy. Simply log on to our **Availity provider portal**.* Navigate to My Provider and then to Provider Data Management. Update the languages you speak and your race. That's it!

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

[1]Takeshita J, Wang S, Loren A, et al. **Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings**. JAMA Network Open. November 9, 2020; 3(11). Accessed September 15, 2021.

The No Surprises Act requires providers to update their directory information

Changes are coming

Effective January 1, 2022, federal legislation will require all providers to verify and update their profile information in order to remain listed in online provider directories. Please make sure you update or confirm that your information is accurate for all providers in your practice. Doing so will also ensure that your panel status is updated.

Updating your information is consistent with your provider participation agreement, which requires you to update your demographic information when there are changes.

We will provide details about the 2022 online provider directory information requirements soon.

How to update your information

You can update your information in several ways, including:

- Using our **Availity provider portal**.* Go to My Providers > Provider Data Management. Changes you can submit include adding a new service location to an existing contracted Tax Identification Number (TIN) and any change to your appointment phone number, address, whether you are accepting new patients, office hours, specialty, hospital affiliations, language, name, gender, email, fax, telemedicine indicator and board certification.
- Filling out the **Request Changes to Provider Data Submission Form**.
- Sending your changes to your contracted group's administrator. You can choose this option if you are a delegated, custom, NAP, Rental, Dental or EyeMed provider. The administrator will include these updates in the organization's roster submission process.

Confirm that your information is correct

We ask that you review your current directory information found under **Directories and Resources**. If all information is correct, you can attest to the accuracy of your information using **Availity**. If you need to make updates, please use any of the submission methods available to you. We will handle your updates in a timely manner.

Questions?

We're here to help. Call the Provider Services Center at **1-800-624-0756 (TTY: 711)**.

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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 NCQA® standards. Doing so will ensure that members' access to care is satisfactory. Each year, we measure our members' perspectives via the Consumer Assessment of Healthcare Provider and Systems (CAHPS®) health plan survey. Survey responses help us learn about network providers' ability to meet our members' needs. We use this data to monitor, track and improve member experiences.

Do you have the tools you need?

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

Want to learn more?

View this short **cultural competency video and presentation**.

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

Starting in September 2021 through 2022, we're phasing out paper Explanation of Benefits (EOB) statements and checks. Sign up before it's your turn. If you don't enroll to receive direct deposit payments, you may receive future payments by virtual credit card. Keep reading to learn more.

Get EOB statements from Availity®

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

Sign up for direct deposit payments

Sign up for direct deposit payments at **Payer Enrollment Services**. We stopped using EnrollHub® on September 1. Even if you're already enrolled to receive direct deposit payments (or electronic remittance advice), use the new portal to make changes.

Visit **Aetna Paperless Office** to learn more about your options.

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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**.

If you don't have Internet access, call our Provider Service Center for a paper copy of the manual 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 more
- 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 (available in the Office Manual for Health Care Professionals), which is a detailed list of elements we require to be documented in a patient's medical record
- 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.

Behavioral Health updates

Working together to save lives

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

Partnering with Psych Hub

Our behavioral health providers can have a meaningful impact on our members. That's why we're partnering with **Psych Hub**, the world's largest online platform for mental health education. Psych Hub offers access to **best-in-class behavioral health resources** on evidence-based interventions, built with the provider and their patients in mind.

What you'll receive

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

"Cognitive Behavioral Therapy Foundations"
Case conceptualization, behavioral action planning, coping techniques and measurement-based care

"CBT for Depression"
Behavior activation and ABCDE methodology for symptom reduction

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

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

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

The courses include:

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

You can earn national Continuing Education (CE) credits and Continuing Medical Education (CME) credits for these courses.

When can I start?

This offering is now available to commercial behavioral health providers. **Sign up for suicide prevention courses**.

Pharmacy updates

Changes to commercial drug lists begin on April 1

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

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

Ways to request a drug prior authorization

- Submit your completed request form through our **Availity provider portal**.*
- For requests for nonspecialty drugs, call **1-800-294-5979 (TTY: 711)**. Or fax your completed **prior authorization request form (PDF)** to **1-888-836-0730**.
- For requests for drugs on the Aetna Specialty Drug List, call **1-866-814-5506**. Or fax your completed **prior authorization request form (PDF)** to **1-866-249-6155**.

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

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Important pharmacy updates

Medicare

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

Commercial — notice of changes to prior authorization requirements

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

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

State-specific updates

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

Colorado providers — notice of material change to contract

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

- **Clinical payment and coding policy changes**

KY, OH and MO providers — expanded Aetna Medicare Advantage program for home health services starting January 1, 2022

Our Aetna Medicare Advantage program works with **myNEXUS**, a technology-enabled care management company, to manage the network, claims payment and precertification/prior authorization program for home health services. This program has been in several states since August 1, 2021. We are now expanding it into Kentucky, Ohio and Missouri.

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

Pre-approval changes

Starting January 1, 2022, myNEXUS will require advance approval for all home-health-related requests for in-home skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social work. Aetna Medicare Advantage members who are in Kentucky, Ohio and/or Missouri and who need to receive services administered in a home or residence will need pre-approval from myNEXUS for those services before they can begin.

View the **Aetna home health care pre-approval list**.

Claims payment changes

Starting January 1, 2022, myNEXUS will pay claims for covered home health services filed with an authorization issued on or after January 1, 2022, for Kentucky, Ohio and/or Missouri Medicare Advantage members under the rates and terms of your myNEXUS contract.

This change applies only to home health care services for:

- Aetna Medicare Advantage members
- Members residing in the states of Kentucky, Ohio and/or Missouri
- Aetna Medicare DSNP members in Kentucky, Ohio and/or Missouri

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

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

Pre-approval requests

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

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

Texas providers: Aetna Medicare Select HMO in Houston

Starting January 1, 2022, we'll have a new Medicare HMO product in Houston. Participating providers can identify this product by viewing the member's ID card, which will list the plan name as Aetna Medicare Select HMO. The bottom right-hand corner of the card will list the plan ID as H8332-003.

The network for this plan consists of a subset of our broader HMO networks to include specific provider partners and systems. This plan requires members to select a PCP. Referrals are also required.

For more information on this plan, please contact our dedicated Provider Services Center at **1-800-624-0756 (TTY: 711)**.

Texas providers: Aetna Medicare Value HMO in El Paso

Starting January 1, 2022, we'll have a new Medicare HMO product in El Paso. Participating providers can identify this product by viewing the member's ID card, which will list the plan name as Aetna Medicare Value HMO. The bottom right-hand corner of the ID card will list the plan ID as H8332-004.

The network for this plan consists of a subset of our broader HMO networks to include specific provider partners and systems. This plan requires members to select a PCP. Referrals are not required.

For more information on this plan, please contact our dedicated Provider Services Center at **1-800-624-0756 (TTY: 711)**.

Washington, Oregon, Nevada, Alaska and California providers — Employee Painters moved utilization management to Aetna®

The move took effect on August 1, 2021.

Employee Painters provides coverage for more than 14,000 members in Washington, Oregon, Nevada, Alaska and California. Precertification is now administered through Aetna and is subject to the Aetna National Precertification List (NPL) and benefits coverage.

Network arrangement and claims management

Employee Painters wants the third party administrator (TPA) to work in tandem with Aetna. Providers should begin working with Aetna in accordance with their usual precertification process. Members should be directed to the TPA when they have questions or eligibility issues. The network product is Managed Choice® II (CPII product).

What you need to know

- For precertification, providers should call **1-888-632-3862 (TTY: 711)**, option 3.
- You can identify the plan sponsor by referring to the member's ID card. The ID card will show group number 863875.
- Precertification requirements were previously outsourced to Innovation Care Management (ICM). Benefits and eligibility should continue to be verified following your normal process.

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.

How to find out who participates

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

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

Questions?

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)**.

Washington, DC providers — notice of non-disclosure of minor-initiated vaccination

Pursuant to 22-B DCMR § 600.9, minors, 11 years of age or older, may consent to receive a vaccine if the minor is able to comprehend the need for, the nature of, and any significant risks ordinarily inherent in the medical care. The vaccine also must be recommended by the United States Advisory Committee on Immunization Practices (ACIP) and be provided in accordance with ACIP's recommended immunization schedule.

Health care providers who treat these minor children must discuss and agree that it is in the minor's best interest not to involve the parent(s)/guardian(s) in the decision to be vaccinated. The vaccination information is to be kept confidential.

A copy of the fully executed **DC Notice of Non-Disclosure of Minor-Initiated Vaccination form** should be submitted to the address included on the form prior to submission of the electronic claim. This document requires that both the minor and the treating health care provider execute the document. Withdrawal of the non-disclosure notice may be made at any time by the completion of a new executed form indicating the withdrawal date.

To ensure that we keep the minor's EOB confidential, be sure to submit this form prior to seeking reimbursement.

Ohio and Pennsylvania — important reimbursement changes regarding hospice patients

We understand that members requiring hospice services may need special care and support. Starting on January 1, 2022, as part of our expanded coverage on select Medicare Advantage plans in Ohio and Pennsylvania, Aetna® will be responsible both for members' full medical coverage and their hospice services.

Aetna Compassionate Care℠ program participants

Members who participate in the Aetna Compassionate Care program and use select hospice providers will also have access to supplemental benefits to support their end-of-life journey. In addition, these members will receive continued transitional concurrent care, like treatment for terminal illnesses and their related conditions, extra transportation, additional meals, reduced prescription costs, in-home respite care and access to a personal emergency response system (PERS).

We will provide more information in the coming months.

New pre-approval requirements for Alabama, Arkansas, Louisiana and Mississippi commercial members

Our Enhanced Clinical Review program with eviCore healthcare will require pre-approval for certain procedures. The program will start on November 1, 2021. It affects Alabama, Arkansas, Louisiana, and Mississippi members in our fully insured and self-insured commercial HMO/PPO Aetna® products.

Services that require pre-approval

- High-tech outpatient diagnostic imaging procedures such as MRI/MRA, nuclear cardiology, and PET scan and CT scan, including CTA
- Nonemergent outpatient stress echocardiography
- Nonemergent outpatient diagnostic left and right heart catheterization
- Insertion, removal and upgrade of elective implantable cardioverter defibrillator, cardiac resynchronization therapy defibrillator and implantable pacemaker
- Polysomnography (attended sleep studies)
- Interventional pain management
- Radiation therapy services (for fully insured members only) — these include complex and 3D conformal; Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT); brachytherapy; hyperthermia; Intensity-Modulated Radiation Therapy (IMRT)/Image Guided Radiation Therapy (IGRT); proton beam therapy; neutron beam therapy; and radiopharmaceuticals

Services that won't require pre-approval

- Emergency department services
- Inpatient radiology services
- Outpatient radiology services other than those listed above

For a complete list of procedures requiring pre-approval, visit **eviCore healthcare**.

The requested services are reviewed in accordance with applicable National Coverage Determinations and Local Coverage Determinations, nationally recognized clinical and billing guidelines of the American College of Radiology (ACR), American College of Radiation Oncology, American Society of Radiation Oncology, guidelines from other recognized medical societies, any state regulations or mandates, and Aetna Clinical Policy Bulletins (CPBs).

Submitting authorization requests

Before members receive services, eviCore healthcare's board-certified physicians will review authorization requests for medical necessity. For you to get paid for services, you must send authorization requests before providing services.

If treatment starts before November 1, 2021, and you haven't already called Aetna®, contact eviCore healthcare to request continuity-of-care authorization. This will allow claims for dates of service after November 1, 2021, to be considered.

To review our CPBs, visit **Aetna.com** and look under the Resources section.

Ask eviCore healthcare for approval

Do any of the following:

- Go to **eviCore.com**.
- Call **1-888-693-3211 (TTY: 711)** (7 AM to 8 PM CT, Monday through Friday).
- Fax a request form (available online) to **1-844-822-3862**.

Ask eviCore healthcare for radiation therapy services

Do any of the following:

- Go to **eviCore.com** (after logging in, choose the "CareCore National" tab).
- Call **1-888-622-7329 (TTY: 711)** (7 AM to 8 PM CT, Monday through Friday).
- Fax a request form (available online) to **1-888-693-3210**.

Urgent requests

If a member needs services in less than 48 hours due to medically urgent conditions, please call eviCore healthcare for a fast review. Tell the representative the request is for urgent care.

What you should know

- We recommend that ordering physicians get authorizations and share the approval numbers with the facility performing the procedure when it is scheduled.
- eviCore healthcare will fax their approval decision to the ordering physicians and requested facilities.
- Approvals have authorization numbers, and one or more CPT codes specific to the approved services.
- If the service you ask for differs from what eviCore healthcare approves, the facility must contact eviCore healthcare for review and approval before submitting claims.
- If you perform services without approval, we may deny payment.
- We'll determine coverage under the applicable policy in accordance with the policy's terms and conditions and with our policies and procedures.

We're here to help

If you have questions, call eviCore healthcare at **1-888-693-3211 (TTY: 711)**. Or you can call Provider Services at:

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

You can also see eviCore healthcare's criteria and get request forms at **eviCore.com**.

Pennsylvania providers — Aetna® Medicare payment card for the Keystone market

How does the card work?

Starting January 1, we load the card every quarter with $100. Members can use the card to pay for in-network copayments when visiting a primary care physician (PCP) office, a specialist office, and offices that perform certain other types of services.

If your office accepts Mastercard®, the member can swipe the card as a debit card (with or without a PIN) to pay the copayment amount. The member can pay the full amount in this way. Or, if your office allows the use of more than one payment method, the member can opt to pay a portion of the amount with the card and use a different payment method for the rest of the amount.

What if the member forgets to bring their card or does not have enough money on the card?

The member should pay the copayment in some other way and then request a manual reimbursement. Or, if the member knows their card balance, your office can do a split payment, whereby the member can pay a portion of the amount with the card and use a different payment method for the rest of the amount.

What if the card doesn't work or is declined?

- Make sure the member is using the card only for a copayment.
- The card hasn't been activated. The member can activate their card by calling the number on their activation sticker. That number is **1-877-261-9951 (TTY: 711)**. The member should call that number to activate the card and then try to pay again.
- The expense might not be considered eligible under their plan. The member should refer to their Explanation of Coverage (EOC) document.
- The member might not be in an eligible plan. Eligible plans are Keystone market plans H3959-001, H3959-002, H3959-010, H3959-011, H3959-037, H3959-041, H3959-047, H3959-051, H3959-053, H5521-261 and H5522-018.

Florida, Georgia, Missouri, Texas and North Carolina providers — Aetna® to enter the individual exchange market

Florida, Georgia, Missouri, Texas and North Carolina will see the new Aetna CVS Health™ Affordable Care Act (ACA) insurance product (subject to regulatory approval) on

the individual exchange market starting January 1. Look for “QHP” (qualified health plan) on member ID cards.

The product

The new insurance product gives members access to a high-quality network of health care providers and telemedicine services, and it provides members with convenient and affordable health care offerings at MinuteClinic®, CVS® HealthHUB™ and CVS Pharmacy® locations across the country.

The plan uses the reach of CVS Health® — its health insurance, pharmacy benefits, retail-based health services, mental well-being programs, telehealth services, digital capabilities and more — to provide greater value for individual consumers.

How members can enroll

Enrollment begins on November 1. Interested members can go to the **Aetna CVS Health page** to enroll. And they can visit **HealthCare.gov** for more information about the individual exchange and how to qualify for plan credits and discounts.

Check your participation status for this product

Go to the **provider referral directory** to check your status.

Aetna®, CVS Pharmacy® and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic®-branded walk-in clinics) are part of the CVS Health® family of companies.

Arizona providers — Banner|Aetna to enter the individual exchange market

Banner|Aetna, a health insurer jointly owned by Banner Health and Aetna®/CVS®, will begin offering Affordable Care Act (ACA) individual and family insurance products in Maricopa, Pinal and Pima counties on the individual exchange market starting January 1, 2022.

The product

The new insurance product uses our Performance Network, which gives members access to a high-quality network of health care providers and telemedicine services, and it provides members with convenient and affordable health care offerings at MinuteClinic®, CVS® HealthHUB™ and CVS Pharmacy® locations.

Banner|Aetna Individual & Family plan features include: no- and low-cost* MinuteClinic® visits, 24/7/365 text-based primary care delivered by board-certified physicians through 98point6, discounts on CVS Health®-brand health products, a quality network of hospitals and health care providers, and one- to two-day Rx delivery through CVS Pharmacy® and specialty medication delivery from Banner Family Pharmacy at no additional cost.

How members can enroll

Enrollment begins on November 1. Interested members can go to the **Banner Aetna page** to enroll. And they can visit **HealthCare.gov** for more information about the individual exchange and how to qualify for plan credits and discounts.

Check your participation status

Go to the **Banner Aetna directory** to check your participation status in the Banner|Aetna Performance Network.

*Includes select MinuteClinic® services. Not all MinuteClinic services are covered. Please consult benefits documents to confirm which services are included. Members enrolled in qualified high-deductible health plans must meet their deductible before receiving covered non-preventive MinuteClinic services at no cost-share. However, such services are covered at negotiated contract rates. This benefit is not available in all states and on indemnity plans.

Health benefits and health insurance plans are offered, underwritten, and/or administered by Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner|Aetna). Banner|Aetna is an affiliate of Banner Health and of Aetna Life Insurance Company and its affiliates (Aetna). Each insurer has sole financial responsibility for its own products. Aetna and Banner Health provide certain management services to Banner|Aetna. Aetna®, CVS Pharmacy® and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic®-branded walk-in clinics) are part of the CVS Health® family of companies.

Access to the 98point6 application is not included in all plans. 98point6 is a registered trademark of 98point6 Inc.

Virginia providers — Aetna® and Innovation Health® to enter the individual exchange market

Aetna CVS Health™ will enter the individual exchange market in Virginia on January 1. As part of the CVS Health® family, Innovation Health will also join the Northern Virginia ACA (Affordable Care Act) individual market.

The product

The new insurance product gives members access to a quality network of health care providers and telemedicine services, and it provides members with convenient and affordable health care offerings at MinuteClinic®, CVS® HealthHUB™ and CVS Pharmacy® locations across the country.

The plans use the reach of Aetna, Innovation Health and CVS Health® — health insurance, pharmacy benefits, retail-based health services, mental well-being programs, telehealth services, digital capabilities and more — to provide greater value for individual consumers.

How members can enroll

Starting November 1, members can **enroll in Aetna CVS Health ACA individual plans** or in **Innovation Health ACA individual plans**. And they can visit **HealthCare.gov** for more information about the individual exchange and how to qualify for plan credits and discounts.

Check your participation status

Aetna providers can go to the **provider referral directory** to check their status. Innovation Health in Northern Virginia providers can check this **provider directory**.

Health plans are offered and/or insured by Innovation Health Plan, Inc. ("Innovation Health"). Innovation Health is the brand name used for products and services provided by Innovation Health Plan, Inc. Innovation Health Plan, Inc. is an affiliate of Inova and Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Innovation Health. Aetna®, CVS Pharmacy® and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic®-branded walk-in clinics) are part of the CVS Health® family of companies.

Nevada providers — Aetna® to enter the individual exchange market

Nevada will see the new Aetna CVS Health™ Affordable Care Act (ACA) insurance product (subject to regulatory approval) on the individual exchange market starting January 1.

- In Clark and Nye counties, Aetna uses the existing Aetna Whole Health Las Vegas network of providers with the addition of University Medical Center.
- In Washoe county, Aetna uses the HMO network.

Look for "QHP" (qualified health plan) on member ID cards.

The product

The new insurance product gives members access to a high-quality network of health care providers and telemedicine services, and it provides members with convenient and affordable health care offerings at MinuteClinic®, CVS® HealthHUB™ and CVS Pharmacy® locations across the country.

The plan uses the reach of CVS Health® — its health insurance, pharmacy benefits, retail-based health services, mental well-being programs, telehealth services, digital capabilities and more — to provide greater value for individual consumers.

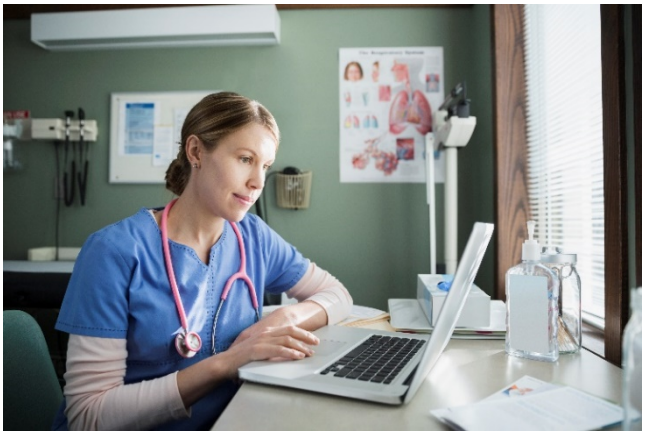
How members can enroll

Enrollment begins on November 1. Interested members can visit **Nevada Health Link** to enroll. And they can visit **HealthCare.gov** for more information about the individual exchange and how to qualify for plan credits and discounts.

Check your participation status

Go to the **provider referral directory** to check your status.

Health plans are offered or underwritten or administered by Aetna Health of Utah Inc. (Aetna). Aetna®, CVS Pharmacy® and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic®-branded walk-in clinics) are part of the CVS Health® family of companies.



Medicare updates

Get Medicare-related information, reminders and guidelines.

Medicare Advantage COVID-19 vaccine and monoclonal antibody products billing update

Beginning January 1, 2022, Aetna® will pay for COVID-19 vaccines (including approved booster doses) and their administration with no member cost share. In addition, Aetna will also pay for administering monoclonal antibody products to treat COVID-19 beginning January 1, 2022. This update applies to your Medicare Advantage patients.

Currently, the government pays for the vaccine and its administration, and for monoclonal antibody therapy. Starting January 1, you should bill us, not Medicare.

Aetna Individual Medicare Advantage (MA) plan expansion to 83 new counties

We're expanding our Individual MA plans to 83 new counties for 2022. Depending on your contract, you may be listed as a participating provider in our MA networks.*

What are the new counties?

On **Aetna.com**, you can view our **2022 expansion counties**.

MA plans have high ratings

The Annual Enrollment Period (AEP) for Medicare is from October 15, 2021, through December 7, 2021. We believe that Medicare beneficiaries will be interested in our plans because of our healthy Star Ratings. For 2022, our overall enrollment-weighted rating is 4.29 out of 5 stars (measurement period FY 2020 and early 2021). These ratings reflect the care you give to your patients.

More about our MA products

- View our **Aetna Medicare Advantage plans quick reference guide (PDF)**.
- Visit our Health Care Professionals page on **Aetna.com** to view the **At a Glance reference guide (PDF)**.
- How to **verify your patients' eligibility**.

How to get contracted for MA plans

If you're not currently contracted for our MA plans, please call our Provider Service Center at **1-800-624-0756 (TTY: 711)**.

*Not all plans are offered in all service areas.

Aetna Medicare Select HMO in Houston

Starting January 1, 2022, we'll have a new Medicare HMO product in Houston. Participating providers can identify this product by viewing the member's ID card, which will list the plan name as Aetna Medicare Select HMO. The bottom right-hand corner of the card will list the plan ID as H8332-003.

The network for this plan consists of a subset of our broader HMO networks to include specific provider partners and systems. This plan requires members to select a PCP. Referrals are also required.

For more information on this plan, please contact our dedicated Provider Services Center at **1-800-624-0756 (TTY: 711)**.

Aetna Medicare Value HMO in El Paso

Starting January 1, 2022, we'll have a new Medicare HMO product in El Paso. Participating providers can identify this product by viewing the member's ID card, which will list the plan name as Aetna Medicare Value HMO. The bottom right-hand corner of the ID card will list the plan ID as H8332-004.

The network for this plan consists of a subset of our broader HMO networks to include specific provider partners and systems. This plan requires members to select a PCP. Referrals are not required.

For more information on this plan, please contact our dedicated Provider Services Center at **1-800-624-0756 (TTY: 711)**.

Important reimbursement changes regarding hospice patients

We understand that members requiring hospice services may need special care and support. Starting on January 1, 2022, as part of our expanded coverage on select Medicare Advantage plans in Ohio and Pennsylvania, Aetna® will be responsible both for members' full medical coverage and their hospice services.

Aetna Compassionate Care℠ program participants

Members who participate in the Aetna Compassionate Care program and use select hospice providers will also have access to supplemental benefits to support their end-of-life journey. In addition, these members will receive continued transitional concurrent care, like treatment for terminal illnesses and their related conditions, extra transportation, additional meals, reduced prescription costs, in-home respite care and access to a personal emergency response system (PERS).

We will provide more information in the coming months.

Part B step therapy updates for January 1, 2022

Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MAPD) plan step therapy updates begin on January 1, 2022.

Existing categories that have preferred drug changes

- Bone resorption inhibitors
- Erythropoiesis-stimulating agents
- Immunologics
- Multiple sclerosis
- Ophthalmic disorders
- Long-acting granulocyte colony stimulating factors (G-CSFs)
- Viscosupplements

New categories

- Acromegaly
- Alpha-1 antitrypsin deficiency
- Intravenous iron
- Multiple myeloma
- Myelodysplastic syndromes
- Prostate cancer
- Rituximab
- Severe asthma

The new categories contain preferred and nonpreferred drugs. **Review the updated drug list** to find out more about preferred drug changes and the new categories.

Not everything is changing

Step therapy rules and regulations have not changed.

- Before covering a nonpreferred drug, your patient must first try a preferred drug.
- These rules do not apply to patients who have received the nonpreferred drug in the past 365 days.

Visit the **requirements for Part B drugs** page for preferred drug lists, clinical policy bulletins and precertification fax forms (for the forms, click on "Preferred therapies" or "Nonpreferred therapies").

We're here to help

If you have questions, call us at **1-800-624-0756 (TTY: 711)**, 8 AM to 6 PM, Monday through Friday, in all continental U.S. time zones. Or you can visit our **Provider Services website**.

Proper coding of sepsis

Coding guidance for streptococcal and other sepsis

Streptococcal sepsis classifies to category A40, Chapter 1, of ICD-10-CM. Other sepsis classifies to category A41, Chapter 1, of ICD-10-CM.

Coding guidance for systemic inflammatory response syndrome (SIRS)

In order to code for SIRS, you must first determine whether the SIRS has an infectious origin.

- If yes, assign a code for sepsis (if organ dysfunction is present, you'll need to include a code from R65.2-, severe sepsis).
- If no, assign a code first for the underlying cause of the SIRS, followed by R65.1- for SIRS of noninfectious origin.
- For SIRS of noninfectious origin (R65.1-), the 5th character* is needed for with/without acute organ failure.

Coding guidance for severe sepsis and septic shock

Severe sepsis

Coding severe sepsis requires a minimum of two codes: a code for the underlying systemic infection followed by a code from subcategory R65.2 (severe sepsis). If the causal organism is not documented, assign code A41.9. Additional codes for the associated acute organ dysfunction are also required.

Septic shock

Septic shock generally refers to circulatory failure associated with severe sepsis; it represents a type of acute organ dysfunction. The code for the systemic infection should be sequenced first, followed by R65.21 (severe sepsis with septic shock) or T81.12 (postprocedural septic shock). Any additional codes for other acute organ dysfunction are also required.

- For severe sepsis (R65.2-), the 5th character* is needed for with/without septic shock (the code for septic shock cannot be sequenced as the principal diagnosis).

Get in touch

Please reach out to your Aetna Nurse Educator or **send a message to Risk Adjustment** for further information on sepsis and on our AAPC CEU webinars and other education sessions.

*Refer to the ICD-10-CM manual for any needed 5th or 6th characters and for important "Code First" and "Excludes 1" notes.

Pennsylvania providers — Aetna® Medicare payment card for the Keystone market

How does the card work?

Starting January 1, we load the card every quarter with $100. Members can use the card to pay for in-network copayments when visiting a primary care physician (PCP) office, a specialist office, and offices that perform certain other types of services.

If your office accepts Mastercard®, the member can swipe the card as a debit card (with or without a PIN) to pay the copayment amount. The member can pay the full amount in this way. Or, if your office allows the use of more than one payment method, the member can opt to pay a portion of the amount with the card and use a different payment method for the rest of the amount.

What if the member forgets to bring their card or does not have enough money on the card?

The member should pay the copayment in some other way and then request a manual reimbursement. Or, if the member knows their card balance, your office can do a split payment, whereby the member can pay a portion of the amount with the card and use a different payment method for the rest of the amount.

What if the card doesn't work or is declined?

- Make sure the member is using the card only for a copayment.

- The card hasn't been activated. The member can activate their card by calling the number on their activation sticker. That number is **1-877-261-9951 (TTY: 711)**. The member should call that number to activate the card and then try to pay again.
- The expense might not be considered eligible under their plan. The member should refer to their Explanation of Coverage (EOC) document.
- The member might not be in an eligible plan. Eligible plans are Keystone market plans H3959-001, H3959-002, H3959-010, H3959-011, H3959-037, H3959-041, H3959-047, H3959-051, H3959-053, H5521-261 and H5522-018.

New address for Aetna Medicare Advantage participating providers' post-service appeals

What's changing

Starting January 1, you need to use a new, Medicare-specific form for your post-service appeals.

As January approaches, you will be able to find this form, which is called the Medicare Provider Complaint and Appeal Request Form, by going to the **forms for health care professionals page** and scrolling to the "Dispute and appeals" drop-down menu.

You will also need to send this form to a new, dedicated mailbox and fax number.

The old mailbox and fax number:

Provider Resolution Team
PO Box 14020
Lexington, KY 40512
Fax: 1-800-624-0756

The new mailbox and fax number:

Medicare Provider Appeals
PO Box 14835
Lexington, KY 40512
Fax: 1-860-900-7995

What's not changing

Continue to use the existing address for **commercial appeals**. The **reconsideration process** is not changing.

It's time to verify your patients' eligibility

Important member ID card changes for those with Aetna Medicare Advantage plans

The following changes begin on January 1, 2022:

- All Aetna Medicare Advantage plan members will have 12-digit member ID numbers beginning with "10." We will no longer use the "ME" prefix for Medicare Advantage plans after that date.
- Consol Energy will transition from ID numbers beginning with "ME" to those beginning with "10" on April 1, 2022.
- "Group #" will be known as "Plan #." Please use the plan number in the way that you have previously used the group number in your transactions.

Checking patient eligibility

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

Note when services were performed:

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

Note that accurate benefits details for 2022 plans will not be returned if an eligibility and benefits submission is made prior to January 1, 2022. Note that if you make an eligibility and benefits submission before January 1, 2022, we will not return accurate benefits details for 2022 plans.

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

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

A new year means new plans

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

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

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

Post-inpatient hospital discharge meals for some Medicare members

In 2022, Independent Living Systems (Florida only), Mom's Meals (Indiana and Louisiana 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 your office can 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 Aetna Medicare Advantage members. To check eligibility, members should check their Evidence of Coverage (EOC) document.

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

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

New for 2021

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

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

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

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

Where to get more information

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

Expanded Aetna Medicare Advantage program starting January 1, 2022

Our Aetna Medicare Advantage program works with **myNEXUS**, a technology-enabled care management company, to manage the network, claims payment and precertification/prior authorization program for home health services. This program has been in several states since August 1, 2021. We are now expanding it into Kentucky, Ohio and Missouri.

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

Pre-approval changes

Starting January 1, 2022, myNEXUS will require advance approval for all home-health-related requests for in-home skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social work. Aetna Medicare Advantage members who are in Kentucky, Ohio and/or Missouri and who need to receive services administered in a home or residence will need pre-approval from myNEXUS for those services before they can begin. Services administered in a home or residence for Aetna Medicare Advantage members in Kentucky, Ohio and/or Missouri will need pre-approval from myNEXUS before they can commence.

View the **Aetna home health care pre-approval list**.

Claims payment changes

Starting January 1, 2022, myNEXUS will pay claims for covered home health services filed with an authorization issued on or after January 1, 2022, for Kentucky, Ohio and/or Missouri Medicare Advantage members under the rates and terms of your myNEXUS contract.

This change applies only to home health care services for:

- Aetna Medicare Advantage members
- Members residing in the states of Kentucky, Ohio and/or Missouri
- Aetna Medicare DSNP members in Kentucky, Ohio and/or Missouri

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

- Medicare members residing outside of the states of Kentucky, Ohio and/or Missouri
- Aetna and Coventry commercial fully insured HMO/POS/PPO plans

- Aetna administrative services only (ASO) self-funded HMO/POS/PPO plans
- Aetna Student Health℠
- Aetna Global Business
- Coventry Workers' Compensation
- Cofinity®
- First Health®, Meritain® Health, Traditional Choice®
- Aetna Signature Administrators®

Pre-approval requests

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

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

2022 Dual Eligible Special Needs Plans (DSNPs) information

We're expanding our DSNP program into more markets for 2022.

What is a DSNP?

A DSNP is a special type of Aetna Medicare Advantage Prescription Drug (MAPD) plan. It provides benefits to members who qualify for Medicare and who receive full Medicaid benefits and/or assistance with Medicare premiums or Medicare Parts A & B cost sharing through one of the Medicare Savings Program (MSP) categories. Members must reside in a county where Aetna Medicare offers a DSNP.

Am I in the DSNP network?

The DSNP network is in limited counties. Check your participation status using the **provider search tool**. If you are in Virginia, check your status by going to the **Aetna Better Health of Virginia provider search page**. If you are in New Jersey, check your status by going to the **Aetna Assure Premier Plus provider search page**.

Required Centers for Medicare & Medicaid Services (CMS) training

All DSNP plans are required to have an approved Model of Care. CMS requires providers to take the **Model of Care training course (PDF)**.

Member eligibility and benefits

Members should note the following:

- Members should show their DSNP 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.

- There are no out-of-network benefits unless the member follows the approval process by contacting Member Services directly.

Provider claims processing

Depending on the member's MSP eligibility, they may have a cost-share responsibility. Providers may not balance bill members who do not have cost-share responsibility (including QMB-only). Visit our **Medicare page** for more DSNP resources, including cost-share information.

How to reach us

If you have questions, visit our **contact us** page.

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