Provider Newsletter

Fall 2025

Aetna Better Health Premier Plan MMAI

Availity

What is Availity?

Availity is a single login, multi-payer provider portal with self-service tools and provider-initiated transactions in one convenient location. Once registered, providers can simply add the Aetna instances to their registration at any time.

Aetna and Availity

Availity operates Aetna's provider portal for multiple lines of business, including Commercial, Medicaid, Medicare, and DSNP/MMP products. There are now two instances of Availity for Aetna products: "Aetna" instance is for Medicare/Commercial, and the "Aetna Better Health" instance is for Medicaid/DSNP/MMP. Providers will need add both instances to their Availity profile to access our entire population. Availity will eventually replace the Aetna Better Health Medicaid Web Portal.

Who can the provider call for assistance?

Call Availity directly at **1-800-AVAILITY (282-4548)**. Monday through Friday from 8 a.m. to 8:00 p.m. ET (excluding holidays). Availity can also be reached through direct messaging when available. Availity should be contacted for any connectivity or account concerns. Any concerns with an Aetna decision or information on Availity should be directed to the respective provider services.

For More information on Availity, please visit our **provider portal**.

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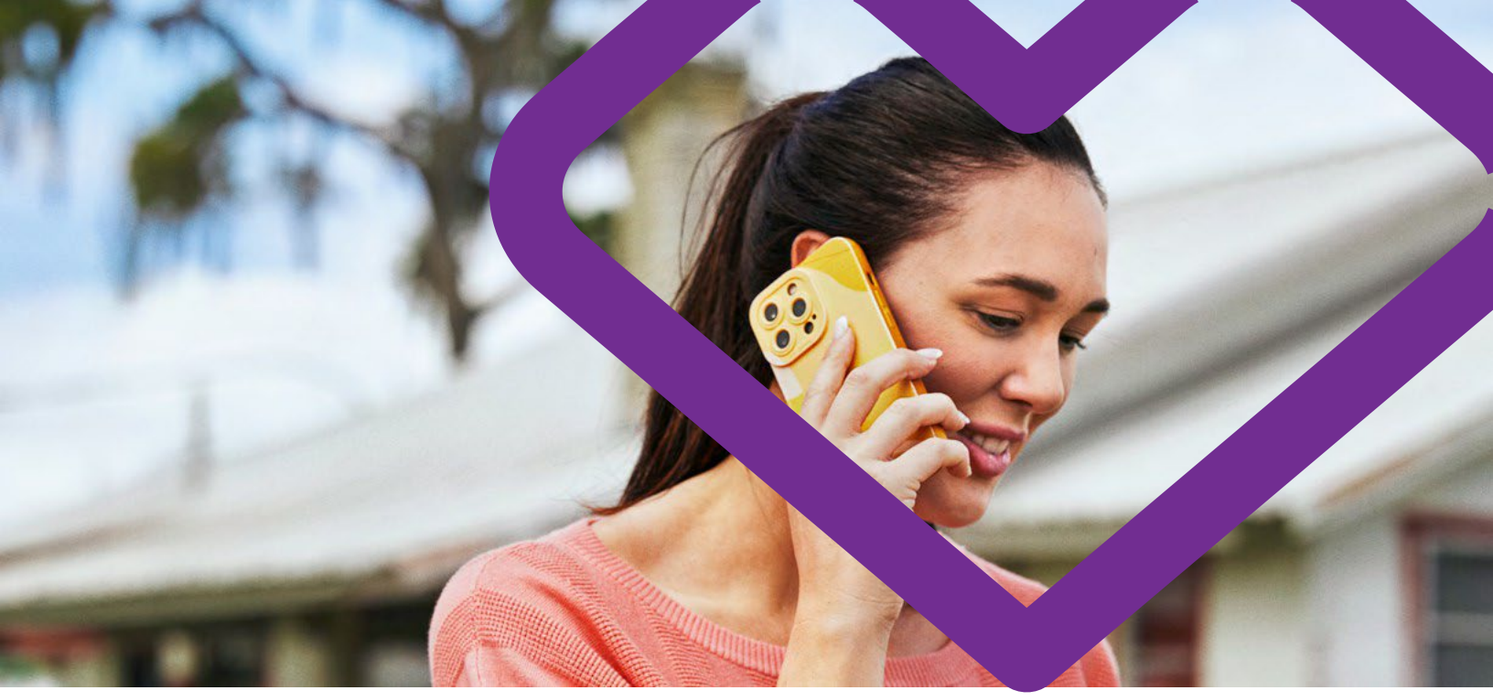


Member Resources

You have the power to fight the flu! Vaccinate!

The CDC has proposed the following strategy: mask up, lather up, and sleeve up. We are encouraging our members to: 1) wear a mask in crowded, indoor spaces; 2) wash their hands with soap and water or an alcohol-based sanitizer; and 3) get their annual flu vaccine. The best time to get vaccinated is during September or October, but vaccination after October can still provide protection during the peak of flu season.

For the 2025 flu season, available formulations of quadrivalent vaccine in the United States include several inactivated influenza vaccines (IIVs), one live attenuated influenza vaccine (LAIV), and one recombinant vaccine. Vaccination is recommended for all adults in the absence of contraindications. The choice of formulation depends upon several factors which include age, comorbidities and risk of adverse reactions.

For a full summary of the recommendations from the Advisory Committee on Immunization Practices (ACIP), please refer to the following link: **https://www.cdc.gov/vaccines/acip/recommendations.html**

Preventing Falls with Members

Each year, between 700,000 to a million fall incidents happen within a hospital setting. Up to a 1/3 of these may be preventable. Aetna Better Health Premier Plan MMAI wants to provide several tools and resources to prevent falls for members, both inside your offices or in the patient's home.

Providers can mitigate fall risks by:

- Including fall risk screenings yearly or following a recent fall
- Evaluating patient's footwear, gait, strength and balance
- Review a patient's medication and home hazard risks
- Educate patients on their risk factors and community resources

For more information for offices, please see the CDC's **Stopping Elderly Accidents, Deaths, & Injuries (STEADI) website**. You can find information on medications linked to falls, materials for member distribution, standardized assessments, and staff training and continuing education.
For information specifically catered to facilities, see the Agency for Healthcare Research and Quality's **Hospital Fall Prevention Program** which provides facility-centric training and toolkit to assist facilities mitigate fall risks.

Dental Benefits

The membership has dental benefits included within their plan. Primary care providers should include discussions of dental health during their wellness visits and remind members to utilize their dental benefits by receiving their semi-annual cleanings and visit with a participating dentist. For more information on their dental plan, please review the provider handbooks for further information.

Pharmacy Benefits

Aetna Medicare Medicaid Plans' (Aetna) List of Covered Drugs ("the Drug List" or the formulary) is a comprehensive list of covered prescription drugs, over-the counter drugs, and items at participating network pharmacies. The Drug List a are posted on the plan's website at **https://www.aetnabetterhealth.com/illinois/providers/premier/partd.** The Drug List is updated monthly throughout the year, and the date of last change is noted on the front cover of the Drug List.

Changes to the plan's Drug List is also posted on the plan's website.

Visit **https://www.aetnabetterhealth.com/illinois/providers/premier/partd** for the updated Drug List. For a printed copy of anything on our website, call Member Services toll-free at **1-866-600-2139**.

The Drug List has detailed information about prior authorization, quantity limitation, step therapy, or formulary exceptions under "Necessary actions, restrictions, or limits on use." To request prior authorization or formulary exception reviews, call Member Services toll- free at **1-866-600-2139**. A Member Services representative will work with you to submit a request for prior authorization or formulary exception.

Types of rules or limits:

- Prior approval (or prior authorization)
- Quantity limits
- Step therapy

If a medication is not on the Drug List (called Formulary Exception)

Aetna MMP's formulary covers most drugs identified by Medicare as Part D drugs, and a member's copay may differ depending upon the tier at which the drug resides. The copay tiers for covered prescription medications are listed below. Copay amounts and coinsurance percentages for each tier vary by Aetna MMP plan. Consult your plan's Summary of Benefits or Evidence of Coverage for your applicable copays and coinsurance amounts.

Covered drugs are designated the following coverage tiers.

- Tier 1 drugs are Preferred Generic drugs.
- Tier 2 drugs are Generic drugs.
- Tier 3 drugs are Preferred Brand drugs.
- Tier 4 drugs are Non-Preferred drugs.
- Tier 5 drugs are Specialty drugs.

Balance Billing

Providers may not bill members for any Medicare or Medicaid covered services. Members are not responsible for Medicare cost sharing under CMS regulations. Medicare cost sharing includes the deductibles, coinsurance and copays included as part of Medicare Advantage benefit plans.

Member Rights and Responsibilities

As a practitioner who ensures high quality care for Aetna Medicare Medicaid Plan (Aetna) members, you should be aware of the members' rights and responsibilities For a complete list of member rights and responsibilities visit our **provider handbook**.

Help Your Patients Get the Most from Their Aetna Better Health Premier Plan MMAI

Aetna Better Health Premier Plan MMAI members with both Medicare and Medicaid benefits have access to valuable supplemental benefits that typically expire on **December 31st.** Please remind your patients to use these benefits before the end of the year, as most unused allowances do not roll over. Members should review their plan documents for details.

Key Benefits Include:

- **Extra Benefits Card & OTC Wallet** – Monthly allowances for healthy foods, utilities, and approved OTC health products like allergy meds and first aid supplies. Funds expire at the end of each month and do not roll over.

  📞 Questions? Call **1-844-428-8147** (TTY: 711) or visit CVS.com/Aetna
- **SilverSneakers®** Membership – Free access to fitness centers, classes, and online resources. Includes one Home or Steps kit per year.

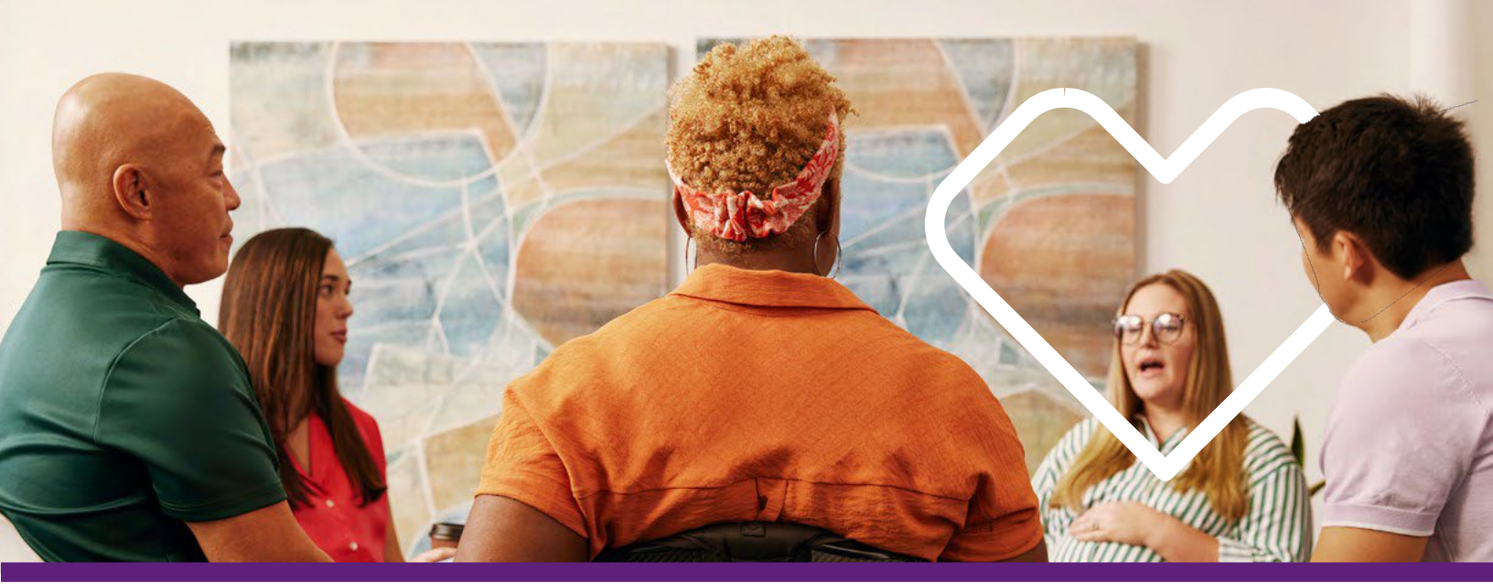
  📞 Learn more at SilverSneakers.com or call **1-855-364-0974** (TTY: 711)
- **Non-Emergency Transportation** – Up to 30 round trips or 60 one-way trips to approved health-related locations.

  📞 Schedule at least **3 days in advance**: **1-855-364-0974 (TTY: 711)**
- **Dental Services** – One exam, cleaning, x-rays, and fluoride treatment every six months.

Quality Program

The Quality Management (QM) Program provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service. A multidimensional approach enables the plan to focus on opportunities for improving operational processes as well as health outcomes and satisfaction of members and providers. The QM Program is essential to ensure all medical care and service needs of our members are met and also ensure continuous improvement occurs with the quality of care and services being provided.

The QM Program addresses issues related to quality management and quality performance measures to ensure both state and national compliance. Annually, the health plan evaluates the effectiveness of the QM programs identifying specific opportunities for improvement.



Develop and maintain quality improvement processes, structures and resources in support of the organization-wide commitment to provision of quality healthcare for all members
Development of effective methods to measure outcome of care and services provided to members, as well as interventions to achieve continuous and measurable improvements
Continuous collaboration with appointed entities to develop and implement structures and programs fostering coordination and continuity of care
Compliance with applicable federal, state, regulatory, contractual and accreditation requirements (HEDIS, CAHPS, HOS)
Ensuring adequate accessibility to care and services
Monitor and ensure members receive seamless, continuous and appropriate attention throughout the continuum of care
Ensure members have access to appropriate care management programs, including Case Management and Disease Management
Coordinate, monitor and report QM activities to appropriate committees

Conduct root cause analysis for benchmarks or goals unmet
Implement and monitor programs designed to improve the quality and safety of members through member and provider education

In an effort to meet these general goals, the QM Program implements and tracks a variety of QI activities that address the quality and safety of clinical care and quality of service throughout the year. These activities are described within the program evaluation including results compared to performance goals, trending of measures when appropriate, barrier analysis, opportunities for improvement and interventions.

Ensure effective credentialing and recredentialing processes for providers who comply with state, federal and accreditation requirements

- Ensure the confidentiality of members is maintained at all times
- Analyze member and provider satisfaction survey results and implement effective interventions to address areas of dissatisfaction
- Oversight of all delegated activities to ensure compliance with all state, federal and accrediting organizations
- Promote improved continuity and coordination of care between medical and behavioral healthcare
- Develop and implement programs based on population analysis and incorporate culturally and linguistically appropriate services

Aetna evaluates the overall effectiveness of the QM Program utilizing the aforementioned findings to determine the adequacy of QM Program resources, QM committee structure, practitioner participation and leadership involvement. Where needed, changes to the QM Program for the subsequent year are made.

If you would like more information on our QM Program, please call our Provider Network**.** It is very important to us that all members get access to the highest quality care and services possible. We want providers to know that not only do we listen to their feedback but try to find a way to implement that feedback.

MOOP & Cost-Share Claims

This document is to provide a summary of two regulatory changes that impact Medicare medical providers.

Maximum Out Of Pocket (MOOP)

The MOOP limit for dual members will now be tracked based on the accrual of all Medi- care Part A & B cost sharing in the plan, whether those cost sharing amounts are paid by the member, other secondary insurance, or not paid at all.
As a reminder, once MOOP is met Aetna will pay 100% of Medicare A&B covered services for the remainder of the calendar year.

Prior to 2023, MOOP for dual members was tracked by calculating cost share

amounts paid by the member. CMS projects this change will increase payment to providers serving DSNP and MMP members by $8 billion over 10 years.

Regulatory Citation: 42 CFR § 422.100 and 422.101

Medicaid Enrollment for Cost-Share Claims

State Medicaid programs must accept enrollment of all Medicare-enrolled providers and suppliers if the provider or supplier otherwise meets all Federal Medicaid enrollment requirements. Even if a provider or supplier is of a type not recognized as eligible to enroll in the State Medicaid program or is located out of state.

This change means, the provider does not have to become part of the Medicaid provider network or see Medicaid patients. If the provider or supplier chooses not to enroll with Medicaid, the state is not required to process their cost-share claims. In other words, the payment from Aetna would be payment in full.

Regulatory Citation: 42 CFR § 455.410(d)

Member Language Profile

Understanding Our Members' Communication Needs

Communication and language barriers are associated with inadequate quality of care and poor clinical outcomes, such as higher hospital readmission rates and reduced medication adherence. People with limited English proficiency or those who experience limited vision or hearing may need an interpreter, and those with vision impairment may need materials presented in alternative formats while receiving care in order to ensure equitable care.

While most our members are primarily English- speaking, approximately 5% of our members primarily speak a language other than English. The largest group among these members are those who primarily speak Spanish—about 4% of our member population. To assist with translation services needs for multiple languages (including ASL) on various formats, including in-person, telephonic, and by video (Zoom), you or the member can call our Interpreter Services line at **1-866-600-2139** (TTY: 711). This number is also included on each member's ID card.

2025 Member Language	Grand total	% of total DUALs population
Preferred Language		
Unknown	9592	66.48%
English	4016	27.83%
Spanish	527	3.65%
Polish	56	.39%
Gujarati	19	.13%

Telephonic interpretation can be requested on the same day. All others may need to be requested three business days in advance, and the member will need a cell phone for interpreter service requests via video/Zoom.

For more information, or if you have a request for any other alternative translation assistance needed for one of our members, call Member Services at **1-866-600-2139**.

Provider Notices

Updating Rosters and Provider Details

One of the functions available within Availity is updating provider demographics and roster information. Due to Availity serving multiple payers, providers can update their profiles on the Provider Data Management (PDM) page and have quarterly updates sent to all participating payers. In the page you can update service locations, location ADA compliance, update contact information, modify NPIs for the business, provide hospital affiliations, and correct provider profiles. You can reach the PDM by clicking on "My Providers" on the main page.

needs.

Appointment Availability Standards & Timeframes

Providers are required to schedule appointments for eligible enrollees in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the enrollee's past and current medical history. Our Provider Services Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet

accessibility standards. Providers are contractually required to meet the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of and the need for the services.

Visit our website to review the **appointment wait time standards** for Primary Care Providers (PCPs), Obstetrics and Gynecologist (OB/GYNs), high volume Participating Specialist Providers (PSPs), and Mental Health Clinics and Mental Health/Substance Abuse (MH/ SA) providers.

Level Severity Inpatient (IP) Review and Reimbursement NEW!

The new payment structure for Medicare inpatient claims

Our goal is simple: We want to help you get reimbursed faster for inpatient admissions that are initially denied. You'll receive faster payment and still be allowed to appeal for a higher payment.

Effective November 15, 2025, we'll adopt a new reimbursement approach for hospital stays of 1+ midnight in cases where a member is urgently or emergently admitted to a hospital and the provider has submitted an inpatient order.

- We'll approve the inpatient stay without a medical necessity review and pay the claim at a lower level of severity rate that's comparable to your rate for observation services.*
- If the inpatient stay meets MCG (Aetna Supplemental Guidelines for inpatient admissions), we'll pay the claim at your inpatient rate in accordance with the hospital agreement.

Notes and exceptions

We won't use MCG to determine whether an inpatient stay is medically necessary. Instead, we'll use it to determine the severity of an inpatient admission and whether that severity justifies the inpatient contracted rate.

This policy doesn't apply to stays that are less than 1 midnight. Cases that are less than 1 midnight will still be subject to medical necessity reviews using Centers for Medicare & Medicaid Services (CMS) guidelines.

How this reimbursement change helps you

We're committed to streamlining, simplifying and enhancing how you work with us.

This new structure will pay you faster. Currently, we deny a stay that doesn't meet MCG, requiring you to either resubmit a claim for observation or submit an appeal to receive the inpatient contracted rate. Now, you'll get paid faster without having to re-bill claims for 1+ midnight stays that don't meet MCG. You maintain your right to dispute the inpatient reimbursement rate.

The payment policy will be available on our provider portal on Availity in October.

Provider Satisfaction Surveys

In an effort to better serve our network, Aetna Better Health Premier Plan MMAI will be sending provider satisfaction surveys to selected network providers. Not all providers will receive a survey. If you do receive a survey in the mail, we ask that you please take the time to complete it so that we can continue to improve our services.


aetna

Aetna Assure Premier Plus (HMO D-SNP)
7400 W. Campus Road
New Albany, OH 43054

Dear Provider:

In an effort to provide quality service to the physicians and staff serving our members, Aetna Assure Premier Plus (HMO D-SNP) is providing a Satisfaction Survey for your completion. It is important that we understand how Aetna Assure Premier Plus (HMO D-SNP) impacts your office and practice on a daily basis.

You can complete the survey by visiting **www.sphsurvey.com** or by using your phone's camera to scan the QR code below. On this website, you will be asked for the private username and password below.

Respond now at www.sphsurvey.com
Username: <<Username>>
Password: <<Password>>
or

Results from this survey will be used by Aetna Assure Premier Plus (HMO D-SNP) to help direct administrative and operational changes to our health plan and to point out areas that might need improvement.

If you prefer to submit a hard copy, please complete the survey today and mail it back to Press Ganey in the enclosed postage-paid envelope. Press Ganey is an independent research firm that is helping us conduct the survey.

We greatly appreciate your input. As always, thank you for partnering with us to improve health of individuals, families and communities.

Product Name Change and Plan Term NEW!

There is an important change regarding the **Aetna Better Health Premier Plan MMAI**. As part of a statewide transition, this plan will be **terminating its participation as a Medicare-Medicaid Alignment Initiative (MMAI)** effective 12/31/2025.

However, we remain committed to serving individuals who are dually eligible for Medicare and Medicaid. We are pleased to announce that we will be transitioning from **MMAI** to a **Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)**.

You do not need to take any action to remain active with our products. Current Aetna Better Health Premier Plan MMAI members will receive communications about this plan update with a new member ID card.

Please be on the lookout for updated provider materials featuring our new product name, Aetna Medicare FIDE (HMO D-SNP), beginning January 1, 2026.

You will receive more details on this change beginning in **November 2025.**

Updating Rates for Critical Access Hospital

Aetna Better Health Premier Plan MMAI always strives to provide prompt and accurate payment. Aetna is asking for Critical Access Hospitals to forward any updated rate and fee schedule documentation to Aetna as soon as they receive them.
This will allow Aetna to update claim rates as soon as possible.
Completing rate adjustments in a timely fashion helps avoid claim readjudication or recoupment. Your assistance is greatly appreciated.

Cultural Competency Training

Providers and their office staff are responsible for ensuring all services, both clinical and non- clinical, are provided in a culturally competent manner and are accessible to all patients. This includes those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

Providers should ensure to address and document that patients are effectively receiving understandable, respectful, and timely care compatible with their cultural health beliefs, practices, and preferred languages from all staff members. Providers should also honor members' beliefs, be sensitive to cultural diversity, and foster respect for members' cultural backgrounds.

Aetna conducts initial cultural competency training during Provider orientation meetings. If you have not previously completed Cultural Competency training or annual retraining, please take a moment to watch the video below:

How Effective Healthcare Communication Contributes to Health Equity and visit:
thinkculturalhealth.hhs.gov/

Additionally, Aetna's Quality Interactions© course series is available to Provider who wish to learn more about cultural competency. This course is designed to help you:

- Bridge cultures
- Build stronger patient relationships
- Provide more effective care to ethnic and minority patients
- Work with your patients to help obtain better health outcomes To access the online cultural competency course, please visit: hrsa.gov/culturalcompetence

NEW! Reminder: HFS IMPACT Registration

Providers must complete a revalidation to remain active in the program. If you need a Medicaid ID, please visit the registration site at **https://impact.illinois.gov/** Either registering or obtaining an Active Medicaid ID is sufficient to receive a Medicaid payment for Medicaid primary services.

All providers will be required to re-validate based on their enrollment date. All providers must complete the IMPACT revalidation process to remain enrolled in Medicaid. This includes providers who participate in the Aetna Medicare FIDE (HMO D-SNP).

Your Voice Matters—Join Our Quality & Provider Advisory Committee

We would love to hear from you and be a partner to improve our member health and experience. If you are interested joining our monthly Quality Management/Utilization Management/Provider Advisory Committee, please contact Provider Services at COEProviderServices@AETNA.com to learn more or sign up.

Measurement Year 2025 HEDIS® Reporting 4th Quarter Push

Annually, we collect Healthcare Effectiveness Data and Information Set (HEDIS®) data from claims, encounters, administrative data and medical records. Our focus during the 4th quarter of 2025 is to work with our providers to close data and care gaps for an enhanced provider and patient experience.
Please use this **HEDIS quick reference guide** for a summary of the HEDIS measures and the commonly used codes. We appreciate your collaboration and attention to closing gaps in care for your patients and our members.

**HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).*

Population Health Management

Aetna Better Health Premier Plan MMAI maintains Population Health Management (PHM) programs and activities selected to meet the needs of the member population and target their individual risks. These programs are designed to support delivery of care. Each PHM program includes measurable goals that are used to determine program effectiveness. Aetna continues to work collaboratively with provider networks to ensure that the recommended screenings and services are completed for the served

membership. Below are some of the programs we offer to members:

Keeping Members Healthy

Programs are targeted to align with low risk populations. With an emphasis on preventive healthcare and closing gaps in care, members are encouraged to get the screenings that are needed to stay healthy. The PHM program for members is a Flu Vaccination Program that includes educational activities to promote annual flu vaccination.

Managing Members with Emerging Risk

Programs are targeted to align with medium risk populations. Engagement with practitioners focuses on supporting Patient Care Medical Home models to centralize care and patient- driven decision-making. The PHM program for members is a Hepatitis C Program that supports members in completing a prescribed treatment regimen.

Patient Safety and Outcomes Across Settings

Programs are targeted to align with members that experience health services across settings. Engagement with practitioners focuses on communication and collaboration with their patients to share information to prevent duplication and potential for harm. The PHM program for members is Appropriate Use of Acute Care Settings that includes early notification through in-patient alerts.

Managing Multiple Chronic Conditions

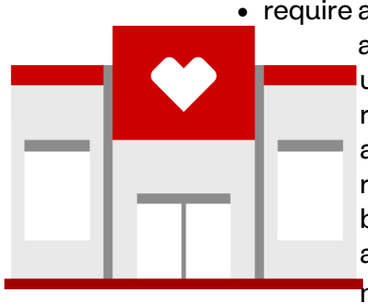
Programs are targeted to align with high and intensive risk populations. Engagement with practitioners focuses on maintaining engagement outside of clinic and office visits. The PHM program for members is Life Planning/Advance Directives/Palliative Care that includes providing life planning/advance directive information to members upon enrollment.

Cognitive Impairment Program

This program is targeted towards members and/or their caregivers who are either formally diagnosed with mild to severe cognitive impairments or are identified with positive findings for cognitive impairment. The focus is on member safety (medication, home safety, driving, financial, wandering), supporting a least restrictive residential setting, and working towards an optimal quality of life for the member and the caregiver. Aetna care managers will work with members and providers to ensure that members receive the right care and services that meet members' needs.

Continuous Glucose Monitoring (CGM)

Aetna Better Health Premier Plan MMAI is working to reduce the long-term sequelae of diabetes. In addition, to working with our diabetic members chronic condition management including to have their hemoglobin A1c checked at least once a year, the plan is encouraging our providers to consider continuous glucose monitoring (CGM) systems for their patients with diabetes that would benefit from this. In general, individuals with diabetes are most appropriate for CGM when they:



- require at least 3 insulin administrations per day or use an insulin pump; and require frequent adjustment of insulin regimen based on their blood glucose levels.

In addition, individuals who suffer from frequent episodes of hypoglycemia may also be appropriate candidates. CGM allows you and your patients to see the fluctuations in blood glucose levels throughout the day, providing a more real-time view of their glycemic control. **CGMs do not require prior authorization.** For additional information, please refer to the following:

https://diabetes.org/tools-support/devices-technology

Complex Care Management Referral Options Empowerment through care management

Aetna Medicare Medicaid Plans offer an evidence-based care management program to help our members improve their health and access the services they need. Care managers typically are nurses or social workers. These professionals create comprehensive care plans that help members meet specific health goals.

All members are assigned their own care manager. The amount of care management a member receives is based upon an individual member's needs. Some of the reasons you may want to ask the health plan to have a care manager contact the member are:

- Does the member frequently use the emergency room instead of visiting your office for ongoing issues?
- Has the member recently had multiple hospitalizations?
- Is the member having difficulty obtaining medical benefits ordered by providers?

- Has the member been diagnosed with Congestive Heart Failure (CHF) diabetes, asthma, or Chronic Obstructive Pulmonary Disorder (COPD), hypertension, or End Stage Renal Disease (ESRD), yet does not comply with the recommended treatment regimen and would benefit from telemonitoring of these conditions?
- Does the member need help to apply for a state-based long-term care program?
- Does the member live with HIV?
- Is the member pregnant with high-risk conditions?
- Is the member pregnant and over 35 years of age?
- Has the member received a referral to a specialist, but is unsure of the next steps?
- Does the member need information on available community services and resources (e.g. energy assistance, housing assistance)?

What happens to your referral?

After you make a referral, the member's care manager contacts the member. The care manager might also contact the member's caregivers or others as needed.

What will a care manager do?

To help the member learn how to manage their illness and meet their health and other needs, a care manager contacts the member to schedule a time to complete an assessment. The care manager asks the member questions about his or her health and the resources currently being used. Answers to these questions help the care manager determine what kind of assistance the member needs most.

What will a care manager do?

Next, the member and the care manager work together to develop a care plan. The care manager also educates the member on how to obtain what they need. The care manager also may work with the member's health care providers to coordinate these needs. The amount of care management and frequency of contact with the member and others will vary based upon the individual needs of the member.

To make referrals for care management consideration, please call Provider Services at **1-866-600-2139**. A care manager will review and respond to your request within 3-5 business days.

Clinical Criteria for Utilization Management Decisions

How to request criteria

Aetna Better Health Premier Plan MMAI's medical necessity decisions for requested medical and behavioral services are based upon CMS National Coverage and Local Coverage Determinations, and nationally recognized evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Aetna uses the following medical review criteria for physical and behavioral health medical necessity decisions which are consulted in the following order:

1) National Coverage Determination (NCD) or other Medicare guidance (e.g., Medicare Policy Benefit Manual, Medicare Managed Care Manual, Medicare Claims Processing Manual, Medicare Learning Network (MLN) Matters Articles)
2) Medicare Coverage Database (**link**)
3) Local Coverage Determination (LCD) and Local Policy Articles (A/B MAC & DME MAC) (**link**)
4) Aetna Clinical Policy Bulletins (CPB) available on Aetna.com (**link**)
5) Medical Coverage Guidelines (MCG): For inpatient stays, Aetna Medicare uses MCGs as a resource for determining medical necessity for inpatient hospital and long-term acute care hospital (LTACH) stays in conjunction with Medicare Benefit Policy Manual Chapter 1
   - Inpatient Hospital Services Covered Under Part A. Medicare guidelines are very general so MCGs provide condition specific guidance (**link**)
6) Pharmacy clinical guidelines
7) Aetna Medicaid Pharmacy Guidelines

To request criteria, call Provider Experience at **1-866-600-2139** or visit our website at

www.aetnabetterhealth.com/illinois/providers/

Affirmative Statement

Making sure members get the right care

Our Utilization Management (UM) program ensures members receive the right care in the right setting when they need it. UM staff can help you and our members make decisions about their health care. When we make decisions, it is important to remember the following:

We make UM decisions by looking at members' benefits and choosing the most appropriate care and service. Members also must have active coverage.

We don't reward providers or other people for denying coverage or care. Our employees do not get any incentives to reduce the services members receive.

You can get more information about UM by calling us at **1-866-600-2139**, 24 hours a day, 7 days a week. Language translation for members is provided for free by calling **1-866-600-2139.** Practitioners may freely communicate with patients about all treatment options, regardless of benefit coverage limitations.