Aetna Medicare FIDE (HMO D-SNP)
PO Box 818051
CLEVELAND OH 44181-8051

Aetna® Medicare FIDE (HMO D-SNP) Provider Notice:
Transition From Sepsis 2 to Sepsis 3 Criteria for Pre-Pay DRG Review
Effective 06-01-2026

Aetna Medicare FIDE (HMO D-SNP) is implementing an update to our clinical review process for inpatient claims involving Sepsis. Beginning on the effective date above, the Clinical Claim Review (CCR) unit will transition from Sepsis-2 criteria to Sepsis-3 clinical criteria for pre-pay Diagnosis-Related Group (DRG) validation.

This change aligns with current evidence-based definitions and will be applied to all applicable inpatient hospital claims.

How the Pre-Pay DRG Review Works
The CCR unit reviews inpatient claims to determine whether the clinical information supports the billed DRG. As part of this transition:

- Clinical documentation will be assessed using **Sepsis-3 criteria**, including the presence of suspected infection with acute organ dysfunction.
- All clinical information gathered during concurrent review and submitted with the claim will be used in the DRG validation process.

What happens next?

- If the billed DRG is supported based on Sepsis 3 clinical criteria, the claim will be processed as submitted.
- If the billed DRG **cannot** be validated using Sepsis 3 criteria:
    - You will receive written notification outlining the diagnosis and/or procedure codes that could not be supported.
    - The claim will be processed using the revised DRG, consistent with Aetna Medicare FIDE (HMO D-SNP) guidelines.

Facility Actions and Appeal Rights
If you disagree with this decision, please refer to your remittance advice, the provider manual or website for plan specific options to disagree with these findings. If you have any questions regarding filing a dispute or appeal, contact Aetna Medicare FIDE (HMO D-SNP) at 1-866-600-2139.

What you need to know
If you are a **contracted provider** and disagree, you may submit your written dispute, including the rationale, through Availty. Or you may mail a copy of the letter. Please review the provider handbook for additional details on how to mail the dispute.

Requesting an appeal
If you are a **non-contracted provider**, you have the right to request a Non-Contracting

Provider Claim Appeal. Non-contracting provider claim appeals must be submitted in writing with a completed Waiver of Liability (WOL) form within **65** calendar days of the remittance advice of the impacted claim:

Fax to:
959-876-7983 *(fastest)*
OR
Mail to:
Aetna Duals Provider Appeals
PO Box 14727
Lexington, KY 40512-4727

Information that may support your appeal includes

- Complete inpatient hospital record (including evaluation and management documentation)
- Clinical laboratory and radiology reports
- Operative reports (when applicable)
- Itemized claim
- Copy of the CCR determination letter
- Any additional relevant clinical documentation
- If photos are part of the record, please submit copies (originals will not be returned)

Additional resources
Review our policies and procedures online at: www.AetnaBetterHealth.com/Illinois/providers/

Sincerely,

Aetna Medicare FIDE (HMO D-SNP)
Provider Experience Team

If you have general questions about this communication, please contact our Provider Services Department:
By Phone: **1-866-600-2139** (TTY: 711)
By Email: COEProviderServices@Aetna.com