Provider Newsletter

Aetna Assure Premier Plus (HMO D-SNP)

Winter 2025

Fast, Secure Clinical Data Exchange Between Hospitals and SNFs

Sharing complete clinical information between the hospital and the skilled nursing facility is essential for safe, coordinated care and to reduce the risk of readmissions. When a skilled nursing facility has details as medications, diagnoses, therapy notes, and discharge instructions, they can continue treatment without delays or errors. The easiest way to send this information is electronically through the Availity® provider portal. It allows providers to upload clinical documents quickly and securely. If you're not registered, you can sign up at www.Availity.com.

Changes to Dental Claims Processing for Medically Linked Services – QNXT Platform

Health plans must allow dental claims to contain medical diagnosis to be accepted and paid by the health plan. **Historically** the health plan has covered dental services with a medical diagnosis attached, and those services were billed to the health plan on a CMS 1500 with appropriate CPT codes.

The CMS **change allows** providers to use the standard dental claim form, 837D, in addition to the CMS 1500. The 837D form can include applicable CDT codes opposed to CPT codes with **medical ICD-10 diagnosis code.**

All dental claims for services inextricably linked to other medically covered services which are submitted to Aetna on a dental claim form must meet the following requirements:

- ICD-10 diagnosis code must be included in the Box 34A of the 837D Dental Claim form.
- Modifier KX must be included at the beginning of the box 30 Description field. Include a pound-sign (#) between the modifier and the service description

Contents

EviCore: Managing Authorizations for Aetna Assure Premier Plus (HMO D-SNP)

Effective November 1, 2025, EviCore healthcare will begin managing prior authorization requests for members enrolled in Aetna Better Health of New Jersey's Assure Premier Plus (HMO D-SNP) plan.

Authorization will be required for the following outpatient services:

- Radiology & Advanced Imaging (CT, MRI, PET)
- Cardiovascular Services (Cardiac Imaging, Stress Testing, Heart Catheterization)
- Musculoskeletal (MSK) & Interventional Pain Management*

Note: Services provided during inpatient stays, emergency room visits, or 23-hour observation do not require prior authorization.

Orientation Sessions Available

To support providers with this transition, EviCore will host online orientation sessions beginning October 2025. These sessions will cover:
The prior authorization process
How to access resources on the EviCore website
A live Q&A session

Each session is free, lasts approximately one hour, and requires advanced registration. All times are listed in Eastern Standard Time (EST).

View the Orientation Schedule & Register Here

How to Request Authorization

Preferred: Online Portal
Phone: 866-668-8295
Fax: 800-540-2406
Urgent Requests: Call 1-855-232-3596 or submit online (mark as urgent)

Reminder: Ordering physicians should request authorization and share approval details with rendering facilities during scheduling. If services change, facilities must update the authorization before submitting claims.

For more resources, visit:
evicore.com/resources/healthplan/aetna-better-health-nj
Questions? Call EviCore Client & Provider Services at 1-800-646-0418 (Option 4)

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 Assure Premier Plus 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/new_ jersey-hmosnp/drug-formulary.html**. 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/new-jersey-hmosnp/drug-formulary.html** for the updated Drug List. For a printed copy of anything on our website, call Member Services toll-free at **1-844-362-0934**.

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 **1-844-362-0934**. 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

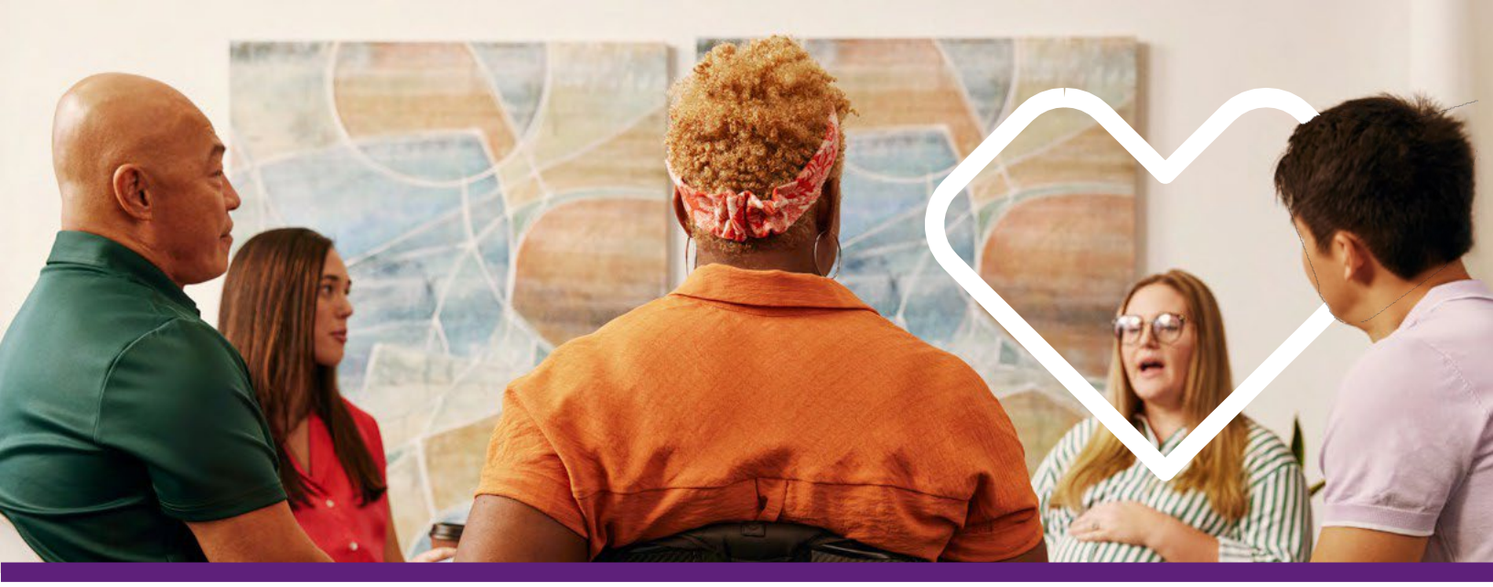
Providers may not bill members for any Medicare or Medicaid covered services. Members are not responsible for Medicare cost sharing under CMS regulations. Medicare cost sharing includes the deductibles, coinsurance and copays included as part of Medicare Advantage benefit plans.

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 manual**.

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 11% 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 1-844-362-0934 (TTY: 711). This number is also included on each member's ID card.
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 1-844-362-0934.

Language	Active Members	% of Active Members
ENGLISH	3719	67.66%
No Language	599	10.90%
SPANISH	543	9.88%
UNKNOWN	461	8.39%
GUJARATI	26	0.47%
KOREAN	18	0.33%
ARABIC	15	0.27%
VIETNAMESE	15	0.27%
CHINESE	13	0.24%
POLISH	12	0.22%
HINDI	10	0.18%
MANDARIN	9	0.16%
RUSSIAN	7	0.13%
Haitian - Creole	6	0.11%
BENGALI	5	0.09%
TAGALOG	5	0.09%
UKRAINIAN	4	0.07%
Total	**5497**	**100.00%**

Supporting Culturally Competent Care

Aetna Assure Premier Plus (HMO-DSNP) is committed to advancing health equity and improving the member experience by addressing language and cultural needs. In this edition, we're sharing practical guidance and strategies to help providers deliver care that respects and supports the diverse backgrounds of our members.

Why It Matters:

Culturally competent care helps improve communication, build trust, and reduce health disparities. By understanding and respecting cultural and linguistic differences, providers can create a more inclusive care environment.

Best Practices for Culturally Competent Care:

- Ask About Language Preferences: Confirm the member's preferred language for communication and document it in the medical record.
- Use Qualified Interpreters: Avoid relying on family members for interpretation; use professional interpreters when needed.
- Respect Cultural Beliefs: Be aware of cultural practices that may influence health decisions and treatment adherence.
- Simplify Communication: Use plain language and check for understanding to support health literacy.
- Document Cultural and Linguistic Needs: Ensure these details are captured accurately in the medical record.

Provider Notices

One of the functions available within Availity is updating provider demographics and roster

Updating Rosters and Provider Details

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.

Completing The Special Needs Form

Treating members with special needs

Dual-eligible members of the Aetna Assure Premier Plus (HMO D-SNP) plan are in a special type of Medicare Advantage Plan that provides both Medicare and Medicaid health benefits. If your practice provides Medicare-covered services, you are already able to see our members. The Aetna Assure Premier Plus (HMO D-SNP) members have unique conditions that requires providers to be attentive to their special needs.

The special needs survey

Special Needs Survey is for providers to gauge your current patients’ special needs and your experience in treating them. It also helps to know your practice’s ability to handle new special needs members and your availability and accessibility. Please complete the survey found **here** and return to your provider liaison or to Aetna Assure Premier Plus’s **Provider Mailbox**. If you need assistance in completing the survey or have any questions about our membership or the plan, please feel free to call Aetna Assure Premier Plus’s provider services at 1-844-362-0934 (TTY: 711)

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.

Product Name Change and Plan Term NEW!

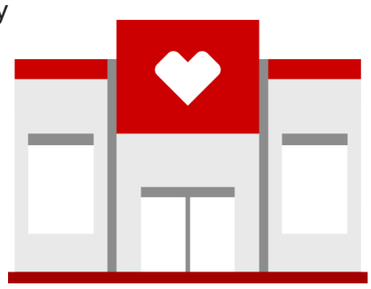
Effective 1/1/2026, The product currently known as '**Aetna® Assure Premier Plus (HMO D-SNP)**' will be renamed as **Aetna Medicare FIDE (HMO D-SNP).** There will be no changes to the plan benefits, provider networks, or member services with this name change. Current Aetna Assure Premier Plus (HMO D-SNP) members will receive communications about this name change with an updated member ID card.
You will receive more details on this change beginning in November 2025.

Updating Rates for Critical Access Hospital

Aetna Assure Premier Plus 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

Population Health Management

Aetna Assure Premier Plus 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 Assure Premier Plus 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 **1 844-362-0934**. 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 Assure Premier Plus'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:

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)

Medicare Coverage Database (**link**)

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 **1-844-362-0934** or visit our website at **aetnabetterhealth.com/new-jersey-hmosnp/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 1-844-362-0934, 24 hours a day, 7 days a week. Language translation for members is provided for free by calling 1-844-362 0934. Practitioners may freely communicate with patients about all treatment options, regardless of benefit coverage limitations.

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).*

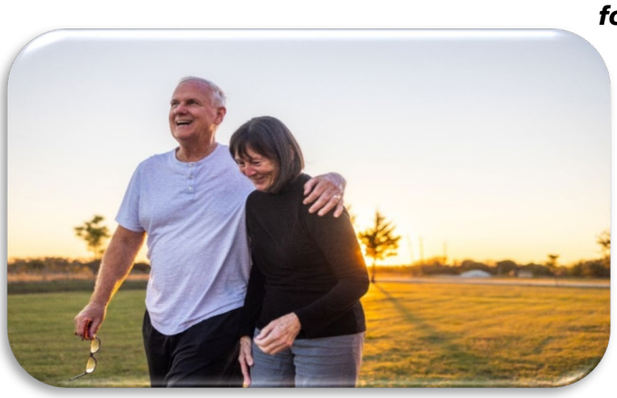
HEDIS® Data Collection to Begin

It's time to collect data for the Healthcare Effectiveness Data and Information Set (HEDIS®). Each year, we review medical records for a sample of members in your care as part of a nationwide effort to measure and improve health plan performance. We'll be contacting you soon to request these records, and your timely response is essential to the success of this project.
We understand confidentiality concerns. Please be assured that all data collection complies with HIPAA regulations. Information is kept confidential, used only in aggregate form, and never shared at the patient level. Members are informed of these quality programs in their handbook, and no signature is required as this activity falls under the HIPAA health care operations exception.

Minimum Documentation Requirements

All records must include:

1) The patient's name on every page of documentation.
2) The patient's date of birth on at least one page of documentation.
3) The information requested for each measure (which will be included with the member list that will be faxed to you at the beginning of the project).



HEDIS® Provider/Facility Frequently Asked Questions

What is HEDIS?

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of health care performance measures in the United States. It is developed and maintained by the National Committee for Quality Assurance (NCQA). The HEDIS methodology provides a systematic and standardized way for health plans to document how well they provide health care services to enrolled members.
Health plans have the option of calculating HEDIS rates by using the administrative data methodology or the hybrid methodology. The administrative data methodology is limited to the use of claim and encounter data submitted to the health plan. The hybrid methodology includes claim and encounter data, but also uses data obtained directly from the member's medical record. This allows the health plan to count services where claim or encounter data were not received.
Use of medical record data requires that we obtain a copy of the member's medical record. Each record should include the member name, gender and date of birth to confirm that the correct record has been obtained. The copy should be limited to required documentation and demographic information.

What is needed from your practice/office/facility?

A response to Aetna's requests for medical record documentation in a timely manner.

When will the Aetna need the records?

HEDIS data collection is a time sensitive project. Medical records should be made available on the date of the onsite review, or by the date requested, in the case of upload/fax/mail. Typically, data collection begins in early February and ends in late April.
It is imperative that you respond to a request for medical records within five (5) business days to ensure we can report complete and accurate rates to state and federal regulatory bodies, as well as NCQA.

Do HIPAA Rules apply?

Yes, all of our nurses will be trained by the health plan on HIPAA, Confidentiality and handling Personal Health Information (PHI) prior to going to provider offices.

Does HIPAA permit me to release records to Aetna for HEDIS Data Collection?

Yes. You are permitted to disclose PHI to Aetna. A signed consent from the member is not required under the HIPAA privacy rule for you to release the requested information to Aetna.

Who will be reviewing medical records?

Aetna contracts with HEDIS reviewers to perform the medical record abstraction for the HEDIS project. The HEDIS reviewers go through a thorough training on HEDIS medical record abstraction and everything it entails including HIPAA and PHI.

Is my participation in HEDIS data collection mandatory?

Yes. Network participants are contractually required to provide medical record information so that we may fulfill our state and federal regulatory and accreditation obligations.

How am I (provider) measured?

HEDIS is NOT a measurement of individual providers, nor how they keep their medical records. It's a measurement of how the health plan is performing to get their members needed services such as immunizations or well child visits. No reports will be given on a specific provider. Aggregated results of the health plan will be shared with CMS and NCQA.

Am I required to provide medical records for a member who was seen by a physician who has

retired, died, or moved?
Yes. HEDIS data collection includes reviewing medical records as far back as 10 years. Archived medical records/data are required to complete data collection.

Will I be reimbursed for copies/materials?
Per the standard contract as a participating provider with Aetna, we do not reimburse for medical record copies requested for HEDIS data collection. If you have additional questions, please consult your participation agreement or talk to your Aetna network representative.

For more information on HEDIS, you can visit **NCQA's website**.

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