AETNA BETTER HEALTH® OF MISSOURI

Letter from our CEO

As you are aware, effective June 29, 2015, our health plan changed its name from HealthCare USA to Aetna Better Health®of Missouri. The name change accompanied a substantial change in our operating model, including but not limited to our claims adjudication platform. While we have made significant advances in the volume of claims processed and paid over the past several weeks, Aetna Better Health®of Missouri recognizes that it has been an imperfect process and has presented challenges for many of you as you continue to care for your patients.

As the Chief Executive Officer for this health plan, I take great pride and expect nothing less than excellence. My desire is to share an unencumbered relationship with you so that we can always seek to provide the optimal level of care for our members and your patients. With that in mind, I want to assure you that our staff is working extra hours every day to address the various issues that you have encountered with our new operating platform. In particular, our Provider Relations and Claims Inquiry/Claims Research teams are working together to identify all payment-related issues so that we can remit to you timely, complete and accurate payments for the services you render.

I encourage you to continue to contact the Claims Inquiry/Claims Research and the Provider Relations Departments at **1-800-566-6444** with your concerns. Those teams will continue to exhaust every option to identify, correct and avoid all of the payment-related issues that have become a concern for many of you during our transition. I sincerely apologize for the inconvenience. I value your participation and ask for your patience as we work to return to the high level of service you are most familiar.

Your committed service to our members is always appreciated.

Brian Dobbins

Brian Dobbins, Esq.
CEO

E-NEWSLETTER COMING SOON!

Providers will soon have the ability to sign up for Aetna Better Health® of Missouri's E-Newsletter distribution list. A link will be made available to providers via our public website on or before October 1, 2015.

www.aetnabetterhealth.com/mo

Provider Newsletter

September 2015
Volume 20, No. 3

HOW TO REPORT FRAUD AND/OR ABUSE

If you believe you have information relating to health care fraud, abuse or waste, please contact the Aetna Special Investigation Unit (SIU). The SIU will review the information provided and will maintain the highest level of confidentiality as permitted by law. Providers may also contact Missouri Fraud Control Unit (MFCU).

Please contact:

Aetna SIU	***800-566-6444***
MO MFCU	***800-286-3932***

MEDICAL MANAGEMENT

eviCore, formerly Medsolutions, Inc. (MSI)

Our radiology and pain management benefits administrator recently announced a name change to eviCore. To access their provider resources, visit www.medsolutionsonline.com/, Provider Log In channel. In addition, they have rolled out a new web portal accessible at https://myportal.medsolutions.com. Questions regarding their portal should be directed to online@medsolutions.com, for online, chat or phone assistance. For assistance while navigating their portal, call 1-800-575-4594, option 2 or select the "contact us" link to access an eviCore web support specialist.

Refer to the June 2015 Provider Newsletter in the Provider News section of our public website, **www.aetnabetterhealth.com/mo** for the procedures recently updated with a prior authorization requirement.

Availability of Utilization Management Criteria

Aetna Better Health®of Missouri employees make clinical decisions regarding members' health based on the most appropriate care and service available. Aetna Better Health®of Missouri makes these decisions based on appropriate clinical criteria. The clinical guidelines and criteria used by the Medical Management Department is available to practitioners at any time by contacting your Provider Relations representative to obtain a mailed copy (if you do not have fax, e-mail or Internet access) or as outlined below:

- National Criteria are made available on the website.
- Aetna Clinical Policy Bulletins are available via our secure website: **https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html**
- OB Ultrasound criteria can be accessed on the eviCore secure site via access to: **www.medsolutionsonline.com/portal/server.pt/community/msi_customers/204**

Clinical Practice Guidelines

To help provide our members with consistent, high-quality care that uses services and resources effectively, we have chosen certain clinical guidelines to help our providers. These include treatment protocols for specific conditions, as well as preventive health measures. These guidelines are intended to clarify standards and expectations. They should not:

- Take precedence over your responsibility to provide treatment based on the member's individual needs
- Substitute as orders for treatment of a member
- Guarantee coverage or payment for the type or level of care proposed or provided

Providers can access the Clinical Practice Guidelines via the public website at:
www.aetnabetterhealth.com/missouri/providers/guidelines

Prior Authorization Guidelines

Aetna Better Health®of Missouri requires prior authorization for select, acute outpatient services and planned hospital admissions. Prior authorization is not required for emergency services. Providers can always contact our Pre-Authorization team at (800) 566-6444 to confirm the authorization requirements, or utilize the code specific **prior authorization search tool** available via the Aetna Better Health®of Missouri secure web portal. The search tool is a very efficient way to review all of the authorization requirements by code. The secure web portal can also be utilized to submit an authorization request or check on the status of an authorization.

To register for the portal, complete a registration form found on the public website at:
www.aetnabetterhealth.com/missouri/providers/provider-portal.

PROVIDER RELATIONS

Aetna Better Health® of Missouri Provider Manual

The Aetna Better Health of Missouri Provider Manual is made available to providers via the Aetna Better Health®of Missouri website at **www.aetnabetterhealth.com/mo** and the Secure Web Portal.
This manual is intended to be used as an extension of the Participating Provider Agreement and as a communication tool and reference guide for providers and their office staff. While the provider manual contains basic information about the MO HealthNet (MHD) Managed Care Program and the Centers for Medicare and Medicaid Services (CMS), providers are required to fully understand and apply MHD and CMS requirements when administering covered services. Please refer to Missouri Department of Social Services website **www.dss.mo.gov/** and the CMS website **www.cms.hhs.gov**.

Providers should review the online version of the Provider Manual to access the most current version for reference purposes. Modifications to the Provider Manual may be necessary and will be made to the online version. All modifications will be communicated to participating providers via the quarterly provider newsletters or periodic provider newsflashes. Newsletters and Newsflashes are also saved to the website for reference purposes.

Annual Provider Satisfaction Survey

Aetna Better Health®of Missouri will soon be releasing its annual provider satisfaction survey to network providers. The survey, which will be distributed by a vendor, is intended to measure satisfaction levels with our health plan, various departments, communication and programs. We appreciate your prompt response to the survey.

The objectives of the provider survey are to measure:

- Satisfaction levels from participating health providers regarding:
  - Service levels of Aetna Better Health® of Missouri's departments, including responsiveness and courtesy
  - Aetna Better Health® of Missouri's medical management and quality program
  - Accuracy and timeliness of claims payment
  - Quality of written communication
- Overall satisfaction with Aetna Better Health® of Missouri as compared to other health plans

Demographic or Payment Data Changes

Failure to notify Aetna Better Health®of Missouri of important changes can result in provider access/availability issues, delay of claims processing, and denial of claims. Providers must submit demographic or payment data changes at least 60 days prior to the effective date of change or as soon as possible. These changes include, but are not limited to:

- Practice name
- Address
- Closure of practice location
- Bank Account (EFT)
- Phone/Fax numbers
- Tax ID/NPI
- Addition/Termination of practitioners
- Change in services provided
- Languages spoken

All changes should be submitted in writing or on the Provider Notification Form found on our public website under document library under provider forms.

If you have any questions, please contact your Provider Relations Representative or call **1-800-566-6444.**

QUALITY

Behavioral Health Appointment Waiting Times

Behavioral health providers are required to adhere to standard appointment wait times, regardless of provider type. NCQA has added an additional standard, which is the *Care for non-life threatening emergency appointment, which is within six (6) hours* of the request.

Mental health and Substance Abuse Services	
Appointment Type	Access/Appointment Standard
Emergent	Immediately
Care for non-life threatening emergency	Within 6 hours
Urgent	Within seventy-two (72) hours
Routine Care with or without Symptoms	Two (2) weeks
Aftercare Appointments	Within one (1) week or five (5) business days after hospital discharge

Aetna Better Health®of Missouri randomly verifies appointment availability with network providers.

Please refer to our Provider Manual located at www.aetnabetterhealth.com/mo for additional information on appointment standards, wait times and after hours availability requirements.

New Possibilities in Data Collection for the 2016 HEDIS Season

During HEDIS, Aetna Better Health®of Missouri collects medical record information to assess HEDIS measures, such as Childhood Immunizations.

The health plan previously photocopied excerpts from the medical record and retained paper copies for 7 years. Printing, shipping, and storage of paper are the least secure methods in the HIPAA environment.
Aetna now uses **highly secured iPods**, and all data is transferred from the iPod to an encrypted laptop hard drive before health plan staff leaves your office. This process has moved the health plan from 100% dependence upon paper closer to 35% dependence.

Aetna proposes the following processes to further modernize data collection with a goal of a full digital platform:

- A **password secured thumb drive.** This data-dump process has the least demand of time on your office staff, is paperless, and is efficient and secure.

- **FTP data transfer** is quite simple and does not require a staff member to come on-site and is paperless. Mention this to your IT support staff.

- **Remote desktop access**. Some provider groups have granted remote desktop access to Aetna staff. This process is quite useful and does not require a surveyor to come on-site to your office.

Do you want to know more about how to streamline the documentation review at your office? We can help! Contact Debbie Murphy in the Eastern Region at 314-444-7290, Dale Pfaff in the Central Region at 573-681-9732 or Rudolph Bremen in the Western Region at 816-410-9751.

Aetna Better Health®of Missouri strives to maintain the highest degree of IT security for our staff and your office, and adherence to HIPAA is one of our top priorities. Our QM Team will strive to create a win-win situation for modern data collection.

New Behavioral Health Performance Improvement Project

Research indicates that less than 23% of behavioral health (BH) patients discharged from the hospital received follow-up care within 7 days of discharge and less than 52% received follow-up care within 30 days. Timely follow-up after hospitalization (FUH) reduces the duration of disability and, for certain conditions, the likelihood of re-hospitalization (http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300139).

Aetna Better Health®of Missouri is working diligently to identify ways to improve the health of our members. One research activity underway is targeted at FUH for BH disorders. This performance improvement project focuses on members ages 6 and older who had an acute inpatient hospitalization for a primary diagnosis of mental illness. In an effort to increase the likelihood that members will get follow-up care with a mental health clinician, the Health Plan is asking providers and practitioners to work in tandem to improve the coordination and continuity of primary care and behavioral health.

More specifically, Aetna Better Health®of Missouri is requesting that BH clinicians assure that appointment slots are timely and available for members who seek post-hospitalization visits. Optimally, the member should be seen within 7 days after a hospital discharge. FUH visits on the day of discharge are acceptable. Visit claims should be complete, accurate, and timely when submitted to Aetna Better Health®of Missouri.

Advance Directives

As part of recredentialing, MO HealthNet requires Aetna Better Health®of Missouri to audit records of Primary Care Providers, Hospitals, Home Health Agencies, Personal Care Providers, and Hospices to determine whether the provider is following policies and procedures related to Advance Directives. Due to this requirement, Aetna Better Health®of Missouri will be requesting advance directive policies and procedures from providers prior to recredentialing.

Aetna Better Health®of Missouri will randomly audit the medical records of adult members to ensure compliance with the policies and procedures. Additional information on Advance Directives is available in our Provider Manual at www.aetnabetterhealth.com/missouri.

Disclosure of Ownership & Controlling Interest Worksheet

The Disclosure of Ownership & Controlling Interest Worksheet is required under federal law to be completed by providers at the time of credentialing, recredentialing and within 35 days of any changes to the information in the form. At credentialing and recredentialing, this form must be completed by every provider. If there have been no changes or updates to the form since the last submission, the provider may send the original form provided there is an updated certification with a signature and date.

A copy of the Disclosure of Ownership & Controlling Interest Worksheet is available to providers at www.aetnabetterhealth.com/missouri.

Re-introducing the Secure Online Portal, with Enhancements for Member Integration

Aetna Better Health®of Missouri is dedicated to providing great service to our providers and our members. That's why our HIPAA-compliant web portal is available 24 hours a day. The portal supports the functions and access to information related to:

- Prior authorization submission and status
- Claim payment status
- Member eligibility status
- eReferrals to other registered providers
- Member and provider education and outreach materials

If you're interested in using this secure online tool, you can register on our "For Providers" page at **www.aetnabetterhealth.com/mo**. You can also contact our Provider Services department to sign up over the phone. To submit your registration via fax, you can download the form from our website or request a copy from Provider Services. Keep in mind that internet access with a valid e-mail is required for registration.

Remember, provider groups must first register a principal user known as the "Provider Representative." Once registered, the "Provider Representative" can add authorized users within each entity or practice.

We need your assistance in engaging members to help them get and stay healthy

Aetna Better Health®of Missouri members can now sign up for their own secure member portal accounts. However, we've customized the member portal to better meet their needs. Members will have access to:

- **Health and Wellness Appraisal** – This tool will allow members to self-report and track their healthy behaviors and overall physical and behavioral health. The results will provide a summary of the members overall risk and protective factors. The health assessment can be completed annually and will be accessible in electronic and print formats.
- **Educational resources and programs** – Members are able to access self-management tools for specific topics such as smoking cessation and weight management.
- **Claim status** – Members and their providers can follow a claim from the beginning to the end, including: current stage in the process, amount approved, amount paid, member cost (if applicable) and the date paid.
- **Personalized health plan services information** – Members can now request a member ID card, change PCPs and update their address through the web portal (address update is a feature available for members and providers). Members can also obtain referral and information on authorization requirements. And they can find benefit and financial responsibility information for a specific service.
- **Innovative services information** – Members will be asked to complete a personal health record and complete an enrollment screening to see if they qualify for any disease management or wellness programs.
- **Health information Line** – The Informed Health Line is available 24 hours a day, 7 days a week. Members can call or send a secure message to a registered nurse who can provide medical information and advice. Messages are responded to within 24 hours.
- **Wellness and prevention information** – We encourage healthy living. Our member outreach will continue to include reminders for needed care and missed services, sharing information about evidence-based care guidelines, diagnostic and treatment options, community-based resources and automated outreach efforts with references to web-based self- management tools.

You can help your patients sign up today.

We encourage you to promote the use of the member portal during interactions with your patients.

New Payor ID and Claims Address

Effective June 29, 2015 Aetna Better Health®of Missouri has a new claims EDI payor ID and new claims address. It is very important all providers use the new payor ID and/or claims address for claim submission. If you have not updated your billing systems, please do so as soon as possible to avoid issues with claim submission to Aetna Better Health®of Missouri.

New EDI Payor ID= 128MO
Claims address for paper Claims and resubmissions
Aetna Better Health®of Missouri
P.O. Box 65855
Phoenix, AZ 85082-5855
Behavioral health providers: Please update your billing systems to Aetna Better Health®of Missouri and discontinue sending claims to MHNET.
Medical Providers: Please be advised the HealthCare USA historical claims PO Box in London, KY will be closed by September 30th. Claims submitted after this date will be returned to providers.

Free Claim Submission Portal for Network Providers

We are pleased to advise Aetna Better Health®of Missouri providers of the availability of WebConnect, our free provider claims submission portal via Emdeon Office for professional claims (HCFA). Emdeon Office is the contracted vendor used by Aetna Better Health®of Missouri for electronic claim submission, processing and support. For more information including enrollment and user guides, please visit our public website at **www.aetnabetterhealth.com/missouri/providers/resources/claims**.

Early Elective Deliveries

According to 13 CSR 70-3.250 Payment Policy for Early Elective Delivery effective September 1, 2015, Aetna Better Health®of Missouri will no longer reimburse for early elective deliveries, or deliveries prior to 39 weeks gestational age that are not medically indicated. Those delivery-related services will be denied or recouped.

Non-payment services include those billed by the delivering physicians/provider and the delivering institution.

Early elective delivery is defined as a delivery by induction of labor without medical necessity followed by vaginal or caesarean section delivery before 39 weeks gestation. Vaginal or caesarean delivery following non-induced labor is not considered an early elective delivery regardless of gestational weeks.

SERVICES RELATED TO EARLY ELECTIVE DELIVERY
(I) All services provided during the delivery-related stay at the delivering institution for maternal care related to an early elective delivery shall not be reimbursed by Aetna Better Health®of Missouri. Nonpayment or recoupment includes obstetric and institutional or facility charges; and
(II) Non-routine newborn services provided for newborns during the initial delivery-related stay at the delivering institution for conditions resulting from an early elective delivery and that are identified within seventy-two (72) hours of delivery may be subject to review and recoupment. Non-payment or recoupment includes facility or institutional charges.

NEW REQUIREMENT: GESTATIONAL AGE/DELIVERY INDICATOR
Aetna Better Health®of Missouri to identify early elective delivery services, an additional field will be required on the CMS 1500 claim form and its electronic equivalents including the X12 5010 837P . Claims submitted by the delivering physician will be edited to determine if the service is for an early elective delivery. Field 19 of the CMS 1500 paper claim, Loop 2300, or 2400, NTE, 02 of the 837P format MUST contain a new “gestational age/delivery” indicator. This field will be required for all claims that report a delivery or global prenatal/delivery procedure code. The new field requires one of

the following four (4) digit alphanumeric values. This field will be used to determine the early elective delivery payment policy. If the value entered in the field contains a character that is not indicated below or is not in the format indicated, the value will be considered invalid and the claim will be denied.

- 1st and 2nd digits represent the gestational age, based on the best obstetrical estimate.

- They must be numeric characters and values from 20 through 42.

- 3rd and 4th digits represent the method of delivery. They must be one of following alpha characters:
  - LV – Labor non-induced followed by vaginal delivery
  - LC – Labor non-induced followed by caesarean delivery
  - IV – induced labor followed by vaginal delivery
  - IC – induced labor followed by caesarean delivery
  - CN – caesarean delivery without labor, non-scheduled (i.e. add-ons)
  - CS – caesarean delivery, scheduled

If the gestational age/delivery indicator contains an LV or LC value or contains a gestational age of 39 or greater, the claim will be exempt from this editing and will continue processing through the system.
If the gestational age/delivery indicator contains IV, IC, CN, or CS, and the gestational age is less than 39, the claim will be subject to editing for early elective delivery. If one of the diagnoses on the claim indicates that there is a medical indication for an early delivery, the claim will be exempt from this editing and continue to process. Aetna Better Health®of Missouri will use the American Congress of Obstetricians and Gynecologists (ACOG) list of conditions that may be indications for early induction of labor and delivery to determine diagnosis codes that are appropriate to justify an early delivery.

Claims that have the IV, IC, CN, or CS indicator with a gestational age less than 39 weeks and do not have a qualifying diagnosis for early induction of labor and delivery will be denied.

If an inpatient claim for the participant has been paid for the delivery, the claim will be recouped, unless it contains one of the qualifying diagnosis codes referenced above.

LAST MENSTRUAL PERIOD
In addition to the gestational age/delivery indicator, the last menstrual period (LMP) is still required on all claims for global and/or prenatal/delivery services. There is no change to how this field is completed or used. It will not be used to determine the early elective delivery payment policy. Providers ***must*** enter the date of the last menstrual period (LMP) on the professional claim. The date of service is the delivery date. A delivery diagnosis code must be used.

Please see MO HealthNet's Provider Bulletin Volume 37 Number 07 dated December 3, 2014, at the link http://dss.mo.gov/mhd/providers/pdf/bulletin37-07_2014dec03.pdf for further information.

New Regulatory Billing Requirements for Rural Health Clinic Services Effective July 1, 2015

Services provided by Independent Rural Health Clinics (IRHC) and Provider Based Rural Health Clinics (PBRHC) **must comply with MO HealthNet billing guidelines** for Aetna Better Health®of Missouri members.

The information below highlights the rural health service requirements for dates of service beginning July 1, 2015:

PROVIDER BASED RURAL HEALTH CLINICS

- Claims must be submitted on a UB-04 form.
- Type of bill in field # 4 must be 711.

INDEPENDENT RURAL HEALTH CLINICS

- Claims must be submitted on a UB-04 form.
- Revenue code in field #42 must be 521.
- Type of Bill in field #4 must be 715.
- HCPCS procedure code T1015 is required in field #44.
- EPSDT / HCY EXAM
  - HCPCS procedure code T1015 EP is required in field #44.
  - The five digit EPSDT / HCY screening code is required in field #74.
  - V20.2 is required as the primary diagnosis code in field #67; for dates of service beginning 10/1/15, use crosswalk to the ICD-10 codes.

Please refer to the MO HealthNet Provider manuals for PBRHC and IRHC for any additional billing guidelines at http://dss.mo.gov/mhd/providers

IMPORTANT REMINDER OF BILLING REQUIREMENTS FOR PROPER REPORTING OF ENCOUNTERS

Aetna Better Health®of Missouri is mandated by our contract with MO HealthNet to report all provider encounters. Aetna Better Health®of Missouri requires claims and encounter data to be submitted using a UB or CMS form.

- Facility claims must be submitted on current UB form, with valid revenue codes, CPT, HCPCS codes and the correct type of bill.
- Professional and ancillary claim(s) (non-facility) must be submitted on the current CMS form.

Claim Reconsideration Form

The Aetna Better Health®of Missouri, Claim Reconsideration Form is located on our public website at **www.aetnabetterhealth.com/missouri/providers/resources/claims**. This form is not required but can be utilized as a cover sheet for corrected claims or claim reconsiderations. A copy of your claim form must be submitted with each Claim Reconsideration Form.

For questions about this process, please contact your Provider Relations Representative.

POLICY AND CODING UPDATES

Clinical Payment, Coding and Policy Changes

We regularly adjust our clinical, payment and coding policy positions as part of our ongoing policy review processes. In developing our policies, we may consult with external professional organizations, medical societies and adopt NCCI, CMS, LCD's and Specialty Provider edits and others that may be appropriate. In an effort to keep our providers informed, please see the below chart of upcoming changes and reminders of current edits in place.

Effective for dates of service beginning 9/1/15:

POLICY	WHAT'S CHANGED
Arthrocentesis, aspiration and/or injection, major joint is limited to 1 unit when billed with modifier -50 (Bilateral procedure).	New 2015 CPT code for arthrocentesis, major joint was added to the policy.
Intravenous home infusion services must be billed with the appropriate modifiers for subsequent units, SH (second concurrently administered infusion therapy) or SJ (third concurrently administered infusion therapy, and must be reported on the same date of service as the initial infusion service.	The policy has been updated by expanding the list of intravenous home infusion codes to be fully comprehensive and include all intravenous home infusion therapy services (drug and parenteral nutrition).
An E & M visit is only allowed on the same date as cardiovascular services for programming/interrogation device evaluation, when the visit is a separately identifiable service.	New 2015 CPT codes for Programming/interrogation device evaluation were added to the policy.
An E & M visit is only allowed if it is billed on the same date of service as Electromyography, Nerve Conductive Tests and Reflex Tests, when the visit is a separately identifiable service.	The reference for this policy was updated.
Allergen testing is limited to thirty (30) times per one (1) year.	The quantity limit was revised.
Bone (Mineral) Density Services are limited to once every two (2) years.	New 2015 CPT for Dual-energy X-ray absorptiometry (DXA), bone density study was added to the policy.
Digoxin is only allowed if it is billed with a covered diagnosis.	New 2015 CPT code for digoxin was added to the policy.
Screening mammography is not allowed when the patient's age is less than 35 years old.	New 2015 CPT code for screening mammography was added to the policy.
E0935 (Continuous Passive motion Exercise Device for use on knee only) is limited to 1 unit within the three (3) week period following knee arthroplasty.	The policy has been updated to limit the device to 1 unit within the three (3) week period following knee arthroplasty.

ICD-10 Update

Aetna Better Health®of Missouri will accept ICD-9 coding for dates of service through 9/30/15. Dates of service beginning 10/1/15 and after must be submitted with ICD-10 coding. Outpatient claims for dates of service that span beyond 9/30/15 will need to be submitted as separate claims. Please note only one version of ICD codes can be submitted on a claim. Please refer to the grid below to review how to submit claims which span over the ICD-10 coding effective date:

Service Type & Date	Claims Billing Requirement
Outpatient Claim with services performed on or before 9/30/2015	Submit on one claim using ICD-9 diagnosis codes
Outpatient Claim with services performed on or after 10/1/2015	Submit as a SEPARATE claim using ICD-10 diagnosis codes
Inpatient Claim with date of discharge on or before 9/30/2015	Submit claim using ICD-9 diagnosis codes
Inpatient claim with date of discharge on or after 10/1/2015	Submit claim using ICD-10 diagnosis codes

Our health plan's ICD-10 FAQ is located on our public website at **www.aetnabetterhealth.com/mo**, For Providers, HIPAA, ICD-10. Should you have additional questions that are not answered through this resource, please contact your Provider Relations Representative.

AETNA BETTER HEALTH® Of MISSOURI'S PROVIDER NEWSLETTER is published for the benefit of our participating provider network.

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www.aetnabetterhealth.com/mo

Online version available at:
www.aetnabetterhealth.com/missouri/providers/provider-news

Provider Manual:
Public Website > For Providers > Provider Manual

Provider Portal:
Public Website > For Providers > Provider Portal > Secure provider web portal log in

Prior Authorization:
Public Website > For Providers > Resources > Prior Authorization

Aetna Clinical Policy Bulletins:
Aetna.com > Health Care Professionals > Working with Us > Clinical Policy Bulletins

Aetna Clinical Practice Guidelines:
Public Website > For Providers > Practice Guidelines