Provider Newsletter

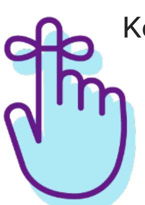
Summer 2026

Aetna Medicare FIDE (HMO D-SNP)

Contents

Quarterly News

Keep your information current



Keeping your details up to date in our directories helps members find the right information about you and your practice. This also helps ensure that you receive timely payment, communications, reminders and more.

Updating your provider data info

You can update your provider information, including:

- New service locations for an existing contracted TIN
- Change of name, address, phone number, fax and office hours
- Specialty, hospital affiliations, board certifications and other details

Submitting through Availity

Need to update information? The best way to do so is to follow these:

1. Log in to Availity: Access the Availity portal
2. Access Payer Spaces: Select 'Payer Spaces' in the top navigation, then select the Aetna logo.
3. Use Provider Data Management (PDM):
    a. Select 'Provider Data Management' from the menu to manage your provider roster.
    b. Select your business profile
    c. Choose Manage Type 1 Providers to add a new provider or update existing NPI information.
4. Submit changes: Follow the prompts to add the new provider's NPI, address, and specialization, then click 'Save.'

After you send us your materials and information, we'll process the change or contact you for more details. Need to update your participation in our network? Call us at 1-855-463-0933. Or just email us to learn more.

Member Resources

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 deductibles, coinsurance and copays included as part of Medicare Advantage benefit plans

Krames Online

We believe our patients' well-being comes first—always. We understand that during clinical encounters, not every question can be addressed in the moment. To support you and your patients beyond the visit, Krames Online provides 24/7 access to trusted health education resources.

With more than 4,000 topics covering health conditions and medications, Krames Online empowers you to confidently guide patients and their families to reliable answers for both common and complex questions. Providers can easily encourage patients to use the search function to continue learning at their own pace; while continuing to support patients with Limited English Proficiency (LEP), patient education materials are available in Spanish (alternative languages if exist). These resources help ensure patients fully understand their care, treatment options, and self-management instructions. Providers are encouraged to offer these translated materials as part of routine care to promote equitable access, informed decision-making, and improved health outcomes.

This resource reflects our commitment to supporting your care delivery—ensuring patients receive the information they need, the answers they deserve, and the tools that reinforce informed, high-quality care.

September is Fall Prevention Awareness Month

Each year, between 700,000 to a million fall incidents happen within a hospital setting. Up to 1/3 of these may be preventable. Aetna Medicare FIDE 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

Discuss how to prevent falls at home with patients. You may advise your patients to review the health sheet (also available in Spanish): Aetna.Kramesonline.com/Search/3,S,87093

Provider Resources

Appointment Availability Standards & Timeframes

Providers are required to schedule appointments for eligible members 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 Use Disorder (MH/ SUD) providers.

Availity Portal

The Availity Portal offers secure online access to and the ability to manage business transactions through a single, easy to use site. Availity features include buy are not limited to:

- Claim Submission and Status
- Eligibility and Benefits Search
- Authorization Request
- Case Management Link
- Grievance Submission
- Panel Roster

If your organization isn't registered with Availity, get started today at availity.com/provider-portal-registration

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.

Operational Resources

We want to support our health care providers as we work together to reach health care goals. We offer a variety of webinars and training opportunities throughout the year to help you, and your staff stay up to date on essential responsibilities. This section includes just some of the resources. Additional tools and resources can be found in your provider manual.

For more information, contact our provider service department

Delivery System Supports

Aetna Medicare FIDE wants to support our health care providers as we work together to reach health care goals. We offer a variety of webinars and training opportunities throughout the year to help you, and your staff stay up to date on essential responsibilities. Additional tools and resources can be found in your provider manual.

Complex Care Management Referral Options

Empowering members through coordinated care

Aetna Medicare Medicaid Plans offer an evidence-based care management program to help members improve their health and access needed services. Care managers—typically nurses or social workers—develop individualized care plans and support members in meeting their health goals. All members are assigned a care manager, with support levels based on clinical and social needs. Some of the reasons you may want to ask the health plan to have a case manager contact the member are:

- Does the member frequently use the emergency room instead of visiting their providers office for ongoing issues?
- Has the member recently had multiple hospitalizations?
- Is the member having difficulty obtaining authorizations for medical benefits ordered by providers?
- Has the member been diagnosed with Congestive Heart Failure (CHF) diabetes, asthma, or Chronic Obstructive Pulmonary Disorder (COPD), yet does not comply with the recommended treatment regimen?
- Does the member need help applying for a state-based long-term care program?
- Does the member have 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 not covered by Medicaid (e.g. energy assistance, SNAP, housing assistance)?

A care manager will contact the member—and caregivers when appropriate—to complete an assessment. This helps determine the level of support needed.

The care manager will then work with the member to develop a care plan, provide education, and coordinate services with the member's healthcare providers.

Frequency of outreach varies based on the member's individual needs.

How to refer

To request care management support, call Provider Services at 1-855-463-0933. A care manager will review and respond within 3–5 business days.

Members can be referred to the complex case management program from a variety of sources, including our medical management programs, discharge planners, members, caregivers, and providers.

To referral a member into case management, call 1-1-855-463-0933 (TTY: 711) or visit our website.

Reminder: Required Prior Authorization Form

To help us process requests efficiently and ensure members receive timely access to care, please remember to use the Prior Authorization Form available on our website when submitting requests. The form must be fully completed, including the urgency designation (Standard or Expedited). Providing complete and accurate information allows our team to correctly prioritize incoming requests and avoid delays in review. Thank you for your partnership and commitment to supporting high quality, timely care for our shared members.

How to request Prior Authorizations

A prior authorization request may be submitted by:

- Submitting the request through Availity
- Fax the Prior Authorization Request Form to 1-833-280-5224. Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing
- Through our toll-free number at 1-855-463-0933.

To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the Availity, or call us at 1-855-463-0933.

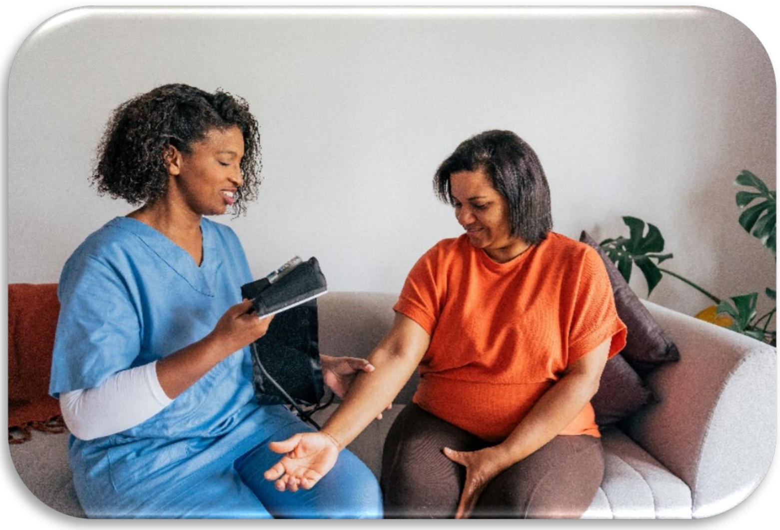
If response for non-emergency prior authorization is not received within 15 days, please contact us at 1-855-463-0933.

When requesting prior authorization, please provide the following:

- Member's identification number
- Demographic information
- Requesting provider contact information
- Clinical notes/explanation of medical necessity
- Other treatments that have been tried
- Diagnosis and procedure codes
- DOS

Important Note:

- Emergency services do not require prior authorization; however, notification is required the same day.
- All out of network services must be authorized.
- Unauthorized services will not be reimbursed, and authorizations are not a guarantee of payment.
- If providers do not receive outreach or response to non-emergency authorizations, please reach out to provider services at 1-855-463-0933
- For post stabilization services, hospitals may request prior authorization by calling 1-855-463-0933



Decision and Notification Requirements

Decision	Decision/notification timeframe
Urgent pre-service approval/denial	Within seventy-two (72) hours of receipt of request
Non-urgent pre-service approval/denial	Within five (5) calendar days of receipt of request
Post-service approval/denial	Within thirty (30) calendar days of receipt of request

Due to the federal and state guidelines, the turnaround time (TAT) for non-urgent pre-service decisions (5 days). It is critical that you submit complete and accurate information upfront to support your authorization request. This includes the designated point of contact, all required medical documentation, and relevant medical history. Missing or incomplete details can delay the review process and impact timely access to care for enrollees. Ensuring thorough submissions helps us meet regulatory requirements and deliver prompt decisions within the timeframe.

We use the MCG criteria to ensure consistency in hospital-based utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The MCGs are updated regularly as each new version is published. UM Criteria is electronically available to practitioners and copies of individual guidelines are available for review upon request.

You can request a copy of the Medical Necessity Criteria. Call us at 1-855-463-0933 or visit our website.

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 1-844-463-0933. Language translation for members is provided for free by calling 1-844-463-0933. Practitioners may freely communicate with patients about all treatment options, regardless of benefit coverage limitations.