

# Provider Newsletter

## Summer 2026

### Aetna Medicare FIDE (HMO D-SNP)



#### Contents

Quarterly News .....	1
Keep your information current .....	1
Join Our QM/UM/PAC Committee .....	1
Completing The Special Needs Form.....	2
Treating members with special needs .....	2
The special needs survey .....	2
Member Resources.....	2
Balance Billing .....	2
Krames Online .....	2
Provider Resources.....	2
Appointment Availability Standards & Timeframes .....	2
Operational Resources .....	2
Delivery System Supports.....	3
Availity Portal .....	3
Complex Care Management Referral Options.....	3
Empowering members through coordinated care .....	3
Provider Collaboration with Care Management .....	3
Reminder: Required Prior Authorization Form .....	4
How to request Prior Authorizations.....	4
Affirmative Statement.....	4
Population Health Management (PHM) Strategy .....	5

#### 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 (Non-LTSS)

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.'

**For LTSS providers,** please submit your demographic and provider information updates to: [COEProviderServices@AETNA.com](mailto:COEProviderServices@AETNA.com)

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 1-844-362-0934. Or just [email](#) us to learn more.

##### Join Our QM/UM/PAC Committee

We are seeking providers to participate in our Quality Management / Utilization Management / Provider Advisory Committee (QM/UM/PAC). This forum brings together providers and health plan leadership to collaborate on quality improvement, utilization

strategies, and member outcomes.

**Who:** PCPs, Behavioral Health, MLTSS, and Specialists

**When:** Monthly, virtual (1 hour)

Interested? Contact [Alex Green \(greena1@aetna.com\)](mailto:greena1@aetna.com) or [Dr. Khanna \(khannaa@aetna.com\)](mailto:khannaa@aetna.com) to sign up!

## Completing The Special Needs Form

### Treating members with special needs

Dual-eligible members of the Aetna Medicare FIDE (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 Medicare FIDE (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 Medicare FIDE (HMO D-SNP) [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 provider services at 1-844-362-0934 (TTY: 711)

## 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 the 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.

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 a 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](https://Aetna.Kramesonline.com/Search/3,S,87093)

## Provider Resources

### 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 Use Disorder (MH/ SUD) providers.

## 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 at 1-844-362-0934 or our provider website at [www.aetnabetterhealth.com/new-jersey-hmosnp/providers/index.html](http://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/index.html).

**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.

**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](http://availity.com/provider-portal-registration)

**Complex Care Management Referral Options**

**Empowering members through coordinated care**

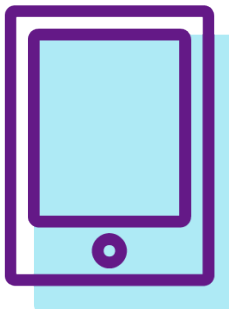
Aetna DSNP offers an evidence-based care management program to help members improve their health and access to the services needed. Care managers—typically nurses or social workers—develop individualized care plans and support members in meeting their health goals. All members are assigned a care manager, 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 1-844-362-0934. A care manager will review and respond within 3–5 business days.

**Provider Collaboration with Care Management**

To support collaborative care management with provider partners and reduce care fragmentation, Aetna and participating providers will share responsibility for delivering coordinated, patient-centered care. Each party will work collaboratively to ensure timely communication, clear accountability, and seamless transitions across care settings in support of patient outcomes and experience. Roles and responsibilities are outlined [here](#) and will be reviewed at least annually or when processes change. This collaborative approach is intended to help reduce patient frustration, improve accountability, and support improved health outcomes.

**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 1-833-322-0034. 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 1-844-362-0934



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 1-844-362-0934.

If response for non-emergency prior authorization is not received within 15 days, please contact us at 1-844-362-0934.

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 1-844-362-0934

- For post stabilization services, hospitals may request prior authorization by calling 1-844-362-0934

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.



**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. 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.

### **Population Health Management (PHM) Strategy**

Population health management programs are available to help support members in their health care journey. We have special programs available for members who are managing conditions or just trying to stay healthy.

Hypertension Management - A care manager is here to help the patient find the care and services they will need. They'll get a call from their care manager soon after they are enrolled. The care manager works with the members and their providers to make sure they understand their hypertension and how to best manage it. Our goal is to build a care plan that will help our members live a healthier life.

Acute Care and ED Utilization (Physical and Behavioral Health) - Many illnesses don't need to be treated at the emergency room. Our Care Management team can provide education and guidance to help all members determine when to contact their physician and when to go to the emergency room. In addition, when a hospitalization is necessary, a care manager will be in contact to help members:

- Schedule follow up appointments
- Obtain prescribed medications
- Understand discharge instructions
- Coordinate any other needed services

### Transition of Care & Life Planning/Advanced

Directives - Before our members leave the hospital, a care manager will help plan them in their next steps. We'll help them move to another care setting or safely return home. If they may be near the end of life in the next year, we'll help them and their family get special care that is kind and respectful.

Diabetes Management - We have a disease management program for members diagnosed with diabetes. Connect with us if your patient has diabetes. We'll work with your patients to learn more about their condition and put together a plan of care

to address any high-risk needs.

Chronic Condition Management - If the member has a long-term health problem, then they will get their own care manager. We'll call them after you join our plan and work with their doctors to make a care plan just for them. A care manager will talk with them by phone or visit you to answer any questions and support your care.

### Preventative Care

Flu Vaccination Program - The flu spreads quickly and can make people very sick. Everyone 6 months and older should get a flu shot every year. We cover flu shots for all our members.

Healthy Adult Wellness Program - Regular check-ups and recommended health screenings can prevent serious illness. We cover preventive care screenings for our members. A care manager can provide a checklist and work with their doctor.

You can learn about these programs online at [www.aetnabetterhealth.com/new-jersey-hmosnp/population-health-programs.html](http://www.aetnabetterhealth.com/new-jersey-hmosnp/population-health-programs.html) or in your provider manual. You can also call 1-844-362-0934.