



Medicare: CMS Final Rule - Utilization Management and Prior Authorization – Beginning January 1, 2024

Beginning January 1, 2024, the Centers for Medicare & Medicaid Services (“CMS”) will introduce regulations and changes related to Medicare Advantage plans (“MA Plans”) prior authorization, coverage criteria and access to care, as set forth in the 2024 Part C and D Final Rule (the “Final Rule”).¹² Aetna seeks to provide you with some information on how Aetna’s MA Plans will comply with the 2024 Part C and D Final Rule.

CMS’ Final Rule for 2024 requires the following:

Prior Authorization

- Prior authorization policies should confirm the diagnoses or other medical criteria and/or ensure that an item or service is medically necessary based on standards specified in the CMS Final Rule.
- Medicare Advantage (MA) Plans approvals must be valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the individual member’s medical history, and the treating provider’s recommendation.
- MA Plans must provide a minimum 90-day transition period when an enrollee currently undergoing treatment switches to a new MA plan.
- MA Plans must ensure the policies are consistent with Original Medicare’s national and local coverage decisions and guidelines.

Coverage Criteria

- MA Plans must comply with coverage criteria in statute, regulation, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and general coverage and benefit conditions included in Original Medicare as interpreted by CMS.
- When coverage criteria are not fully established in Medicare statute, regulation, NCD, LCD, MA Plans may create publicly accessible internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature.

Access to Services

- Plans must arrange for and cover any medically necessary covered benefit outside of the plan provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet an enrollee’s medical needs.

Proprietary

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Aetna's MA Plans to Follow the Two Midnight Benchmark

- We will follow the Two Midnight Benchmark. Under the Two Midnight Benchmark, surgical procedures, diagnostic tests and other treatments will generally be considered appropriate for inpatient hospital admission and payment under Medicare when the physician expects the patient, based on specific complex medical factors documented in the medical record (such as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of adverse event), to require a hospital stay that crosses at least two midnights and admits the member to the hospital based upon that expectation.
- Our MA Plans are not required to follow the Two Midnight Presumption.

Our Medical Necessity reviews

- We will review the stay to determine whether inpatient admission was appropriate. The entire medical record may be reviewed to support or refute the reasonableness of the physician's expectation, but we will use entries after the point of the admission order to interpret what the physician should have known or should have expected at the time of admission.
- It is important that our providers and facilities supply us with detailed clinical records to support the physician's judgement.

Our MA Plans can use Internal Coverage Criteria to determine Medical Necessity

- We have created publicly accessible internal coverage criteria when coverage criteria are not fully established under the Medicare statute, regulation, national coverage determinations (NCD), or local coverage determinations (LCD).
- Our internal coverage criteria are based on current evidence in widely used treatment guidelines or clinical literature and comply with CMS requirements. You can view these criteria on <https://go.aetna.com/aetnamedicareguidance>.

View more information at [2024 Medicare Advantage and Part D Final Rule \(CMS-4201-F\)](#).

For any questions regarding Medicare individual coverage or benefits, please call Member Services:

- Medicare Advantage plans –
Call us at [1-800-282-5366](tel:1-800-282-5366) (TTY: [711](tel:711)) 7 days a week, 8 AM to 8 PM
- Special Needs plans (SNPs), Dual Eligible Special Needs Plan (D-SNP) –
Call us at [1-866-409-1221](tel:1-866-409-1221) (TTY: [711](tel:711)) 7 days a week, 8 AM to 8 PM
- Aetna Medicare Prescription Drug Plans (PDPs) -
Call us at [1-866-235-5660](tel:1-866-235-5660) (TTY: [711](tel:711)) 7 days a week, 24 hours a day
- Medicare Supplement -
Call us at [1-888-624-6290](tel:1-888-624-6290) (TTY: [711](tel:711)) 7 days a week, 7 AM to 8 PM Central Time
- Employer Group Medicare Advantage -
Call us at [1-888-267-2637](tel:1-888-267-2637) (TTY: [711](tel:711)) Monday to Friday, 8 AM to 9 PM Eastern Time

¹ *Reviewing Short Stay Hospital Claims for Patient Status: Admissions on or After January 1, 2016*

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Reviewing-Short-Stay-Hospital-Claims-for-Patient-Status.pdf>

¹ 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013
([avhttps://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medical-review/downloads/gasforwebsiteposting_110413-v2-clean.pdf](https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medical-review/downloads/gasforwebsiteposting_110413-v2-clean.pdf)).

How to access Aetna® eviCore Supplemental Guidelines

By following these instructions, you will be able to view the guidelines from your web browser.

Access for members

Aetna Medicare Advantage members can visit their secure member website at [AetnaMedicare.com](https://www.aetna.com) and “Log in.” from there:

- Scroll down to the bottom right
- Go to the section labeled Member Resources
- Select www.eviCore.com
- Follow the prompts below

Access for all

The links below will give anyone who is not a member access to the Aetna Supplemental Guidelines portal.

- www.eviCore.com

Once you are in the criteria guidelines, follow these prompts:

Step 1: Select Provider Hub, then scroll down to the icon listed Clinical Guidelines.

Step 2: Choose what type of category best fits your interest in the guidelines

Step 3: You must read, and “Accept Terms and Conditions” go to the next page.

Step 4: Once you accept the terms and conditions, you will need to enter the following:

Plan Name: Aetna

Then click on the search glass.

These guidelines are proprietary to eviCore. Aetna is not able to distribute them without the permission of eviCore.

How to access Aetna® American Specialty Health (ASH) Supplemental Guidelines

By following these instructions, you will be able to view the guidelines from your web browser.

Access

The link below will give provide access to the Aetna Supplemental Guidelines

- [CPG 264 - S \(ashlink.com\)](#) Acupuncture Services Medical Policy/Guideline
- [CPG 278 - S \(ashlink.com\)](#) Chiropractic Services Medical Policy/Guideline

These guidelines are proprietary to ASH.

How to access Aetna® supplemental guidelines

By following these instructions, you will be able to view the guidelines from your web browser.

Access for members

Aetna Medicare Advantage members can visit their secure member website at [AetnaMedicare.com](https://www.aetna.com/medicare) and “Log in.” from there:

- Scroll down to the bottom right
- Go to the section labeled Member Resources
- Select Aetna Supplemental Criteria Guidelines
- Follow the prompts below

Access for providers

Aetna providers can log in to Availity® at

<https://apps.availity.com/availity/web/public.elegant.login> from the landing page

Then:

- Select the Payer Spaces on the navigation bar
- Choose the Aetna payer space tile to bring you to our payer space
- Select Resources
- Choose Aetna Supplemental Criteria Guidelines
- Follow the prompts below

Access for all others

Lastly, the link below will give anyone who is not a member access to the Aetna Supplemental Guidelines portal.

- [Aetna Supplemental Criteria Guidelines](#)

Once you are in the criteria guidelines, follow these prompts:

Step 1: On the landing page, you must read, and “Accept Terms and Conditions” go to the next page.

Step 2: Once you accept the terms and conditions, you will need to enter the following information before selecting next:

- a. First Name
- b. Last Name
- c. What type of category best fits your interest in the guidelines

Step 3: MCG will ask for your preferred way of receiving a verification code (text, email, or telephone).

Step 4: Once you receive your verification code, enter it into the MCG site.

- You will be shown a list of MCG Guidelines selected for Aetna Medicare content.
- You can choose the guidelines you want to review in your web browser.
- You will not be able to print the guidelines.

These guidelines are proprietary to MCG. Aetna is not able to distribute them without the permission of MCG. MCG has provided a Cite Transparency tool that allows accounts and regulators to view multiple guidelines at one time through a web browser.

