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Aetna OfficeLink Updates™

Mid-America Region

Inside this issue

Options to reach us

- Select **Health Care Professionals**
- Select "Medical Professionals Log In"

If you have more questions after viewing the information online, call us:

- **1-800-624-0756** for HMO-based and Medicare Advantage plans
- 1-888-MDAetna (**1-888-632-3862**) for all other benefits plans

Changes to July 1, 2014 National Precert List

The following changes to Aetna's National Precertification List (NPL) will take effect on July 1, 2014, unless otherwise noted:

Additions:

- All protease inhibitors with the exception of Incivek™ (telaprevir) and Victrelis™ (boceprevir) will require precertification
- All nucleotide polymerase inhibitors will require precertification

Reminders

- Effective Dec. 2, 2013, Omontys® (peginesatide) no longer requires precertification. It's been withdrawn from the market.
- Effective Feb. 3, 2014, precertification for Gazyva™ (obinutuzumab) is required.
- Effective March 3, 2014, precertification for Olysio™ (simeprevir) and Sovaldi ™ (sofosbuvir) is required.

View more information about **precertification** on the 2014 Participating Provider Precertification List ("General information").

Questions about Health Insurance Exchanges?

Now that public exchanges/marketplaces are live and members are using their new plans, you may have questions about how these new marketplaces will affect you and your Aetna patients.

We've put together some **Questions & Answers** that address many of the most common questions about reimbursement, eligibility, networks and other issues for members who purchased a plan on a public exchange. They're located on our **Health Reform Connection** website. We recommend that you bookmark this page so you can visit it easily whenever you have questions about exchanges or other aspects of the Affordable Care Act.

You can also learn more about our Aetna plans offered on the exchange on our **Health Insurance Exchange/Marketplace** website.

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 the independent Physician Advisory Board, which provides advice to us on issues of importance to physicians. The chart below outlines coding and policy changes.

Procedure	Implementation date	What's changed
*Oxygen contents – billable times	6/1/2014	E0441–E0444 will not be paid when billed more frequently than once every month.
*DME maintenance, servicing, repair and replacement – modifiers MS, RA, RB and KC	6/1/2014	Aetna allows DME maintenance once every 6 months, beginning 6 months after the rental period ends. Effective 6/1/2014, we will not allow DME maintenance, replacement, or repair for continuously rented DME, frequently serviced DME, or oxygen equipment.
DME continuous rentals moving to capped rental status	6/1/2014	The following codes will be paid up to the purchase price: • E0202 – Phototherapy (bilirubin) light • E0445 – Oximeter device for measuring blood oxygen levels • E0618 – Apnea monitor, without recording feature • E0619 – Apnea monitor, with recording feature • K0455 – Infusion pump used for uninterrupted parenteral administration of medication
*Transcutaneous electrical nerve stimulation (TENS) devices • E0720 – Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation • E0730 – Transcutaneous electrical nerve stimulation (TENS) device, four lead, localized stimulation	6/1/2014	We allow the rental or purchase of one TENS unit per member within a 3-year period.
DME rentals billed after purchase	Reminder	Rental items are paid up to the purchase price (less the plan's cost share when applicable). Claims submitted after the purchase price has been met will be denied.
G0249 – Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria. Includes provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include four tests.	Reminder	G0249 includes materials for four tests and should be billed no more frequently than once every 28 days.
Inappropriate billing or coding	N/A	We make code adjustments for inappropriate billing or coding. Examples of these adjustments include rebundling of services that are considered part of, incidental to, or inclusive to the primary procedure, as well as adjustments for mutually exclusive procedures.

*Washington state providers: This item is subject to regulatory review and separate notification

Clarification

The **September 2013** issue included additional information about Aetna's policy about multiple surgical reductions for mid-level practitioners. This change does not apply to providers in Texas.

Submit preauthorizations for certain services

Aetna requires preauthorization for certain procedures for patients enrolled in all Aetna network-based medical plans. We do this to verify these procedures are performed in accordance with current evidence-based guidelines. Procedures requiring preauthorization include:

- MRI/MRA
- Nuclear cardiology
- PET scan
- CT scan, including CTA
- Stress echocardiography
- Diagnostic right and left heart catheterization
- Polysomnography
- Insertion, removal and upgrade of elective:
  - Implantable pacemaker
  - Cardiac defibrillator
  - Cardiac resynchronization therapy

Services performed in the inpatient or emergency room setting will not require preauthorization.*

For Northern New Jersey and Metro New York, submit preauthorization requests for these services to CareCore National.

Northern New Jersey

Precert and Customer Service

Phone: **1-888-647-5940**

Fax: **1-800-540-2406** (radiology and cardiology studies)

Fax: **1-888-444-1562** (sleep studies)

Metro New York

Precert and Customer Service

Phone: **1-888-622-7329**

Fax: **1-800-540-2406** (radiology and cardiology studies)

Fax: **1-888-444-1562** (sleep studies)

For all other states, submit preauthorization requests for these services to MedSolutions, which can be reached by:

- Phone: **1-888-693-3211**
- Fax: **1-888-693-3210**
- Online at the **MedSolutions website**.

Note: It's the ordering physician's responsibility to request preauthorization. In addition, providers rendering the above services should verify that the ordering physician obtained the necessary preauthorization before scheduling the patient for services. Failure to do so may result in non-payment of your claim.

Under the terms of the arrangements, Aetna retains ultimate responsibility and control over all coverage policies and procedures. The vendors manage access for these procedures through existing contractual relationships.

*Elective implantable pacemaker, cardiac defibrillator and cardiac resynchronization therapy done in an inpatient setting requires preauthorization.

Effective Jan. 1, 2014, Coventry coverage policies have been retired and Aetna clinical policy bulletins (CPBs) now apply to Coventry members. View **Aetna CPBs**.

HMO members have direct Ob/Gyn access

You've seen HMO-based patients presenting ID cards with "W" ID numbers in 2013. That will continue. The ID number doesn't indicate product type; you'll find that in the upper right corner of the card.

If a member is in an HMO-based plan, follow the HMO processes, regardless of the ID number on the ID card. HMO members have direct access for general Ob/Gyn services. Some of those services are on the automatic studies list. A member who needs other services not included on that list will need a referral.

You'll still find eligibility and benefits information on our **secure provider website**. Just enter the patient's member ID, or first/last name and date of birth.

Enhancements to electronic eligibility and benefits response

You can now get enhanced details for Aetna plans supporting tiers with maximum and standard savings, standard plus savings, and out-of-network benefits.

When you submit your eligibility inquiry using your level-1 individual NPI, service type code, member ID and date-of-service, you'll get a personalized response based on your NPI's relationship to the member's benefits plan. The response also includes out-of-network benefits.

For best results, submit eligibility inquiries using your level-1 individual NPI.

Note these upcoming service code changes

Aetna will be reassigning the individual service codes listed in the chart below within contract service groupings. Changes to an individual provider's compensation will depend on the presence or absence of specific service groupings within their contract. For the purposes of this information, AEG stands for Aetna Enhanced Groupers.

Unless otherwise noted, all changes will become effective as of May 1, 2014.

Procedure	Implementation date	What's changed
95782, 95783	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospital, and Diagnostic Radiology Centers	Will be assigned to SLEEP (Sleep Studies) If a Sleep Studies rate is present in the contract, the Sleep Studies rate will be applied; if contract does not contain a Sleep Studies rate, the All Other Outpatient Default rate will be applied.
G0219, G0252, S8085	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospital, and Diagnostic Radiology Centers	Will be assigned to PET Scan and Radiology Services If a PET Scan rate is present in the contract, the PET Scan rate will be applied; if contract does not contain a PET Scan rate, the Radiology services rate will be applied; if contract contains neither a CAT Scan rate nor a Radiology Services rate, the existing All Other Outpatient rate will continue to apply.
0042T	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospital, and Diagnostic Radiology Centers	Will be assigned to CTSCAN (CAT Scan) and Radiology Services (RADHCPC and RADPRO) • If a CAT Scan rate is present in the contract, the CAT Scan rate will be applied; if contract does not contain a CAT Scan rate, the Radiology services rate will be applied; if contract contains neither a CAT Scan rate nor a Radiology Services rate, the existing All Other Outpatient rate will continue to apply.
72292, 74261, 74262, 74263, 75989, 76376, 76377, 76497, 78071, 78072	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospital, and Diagnostic Radiology Centers	Will be assigned to CTSCAN (CAT Scan) Codes will remain assigned to DIAGRAD, RAD, & RADHCPC (description prints as Radiology Services for all service groupings listed). • If a CAT Scan rate is present in the contract, the CAT Scan rate will be applied; if contract does not contain a CAT Scan rate, the existing Radiology Services rate will continue to apply.
76948	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospital, and Diagnostic Radiology Centers	Will be assigned to MRIMRA and MRIMRAHCPC (description prints as MRI/MRA for both service groupings listed) Codes will remain assigned to DIAGRAD, RAD, & RADHCPC (description prints as Radiology Services for all service groupings listed). • If an MRI/MRA rate is present in the contract, the MRI/MRA rate will be applied; if contract does not contain a MRI/MRA, the existing Radiology Services rate will continue to apply.
S8042	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospital, and Diagnostic Radiology Centers	Will be assigned to MRIMRAHCPC. (description prints as MRI/MRA) and Radiology Services (RADHCPC and RADPRO) • If an MRI/MRA rate is present in the contract, the MRI/MRA rate will be applied; if contract does not contain an MRI/MRA rate, the Radiology services rate will be applied; if contract contains neither an MRI/MRA rate nor a Radiology Services rate, the existing All Other Outpatient rate will continue to apply.
A9580	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospital, and Diagnostic Radiology Centers	Will be assigned to IMAGENHANCE (Imaging Enhancing Substance) and CONTRAST (contrast agents) If an Imaging Enhancing Substance or Contrast Agents rate is present in the contract, the Imaging Enhancing Substance or Contrast Agents rate will be applied; if contract does not contain an Imaging Enhancing Substance or Contrast Agents rate, the All Other Outpatient Default rate will be applied.

Procedure	Implementation date	What's changed
62370	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospital	Will be assigned to AEG2 (Aetna Enhanced Grouper 2) and DEFAULTSUR (All Other Surgery Default) • If contract contains an AEG 2 (Aetna Enhanced Grouper 2) rate it will be applied; if not, then the All Other Surgery Default rate will be applied.
A4650, A9582, A9700	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospital , and Diagnostic Radiology Centers	Will be removed from IMAGENHANCE (Image Enhancing Substance) and CONTRAST (Contrast Agents) Service groupings • The Image Enhancing Substance or Contrast Agent rate will not be applied to this code. The All Other Outpatient Default rate will apply.
Q9555, Q9556	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospital, and Diagnostic Radiology Centers	Will be removed from IMAGENHANCE (Image Enhancing Substance) and CONTRAST (Contrast Agents) Service groupings Code will remain assigned to ALLDRUGSWCS (All Drugs, Agents, Inj. Drug), DRUGSJSQ (All Outpatient drugs including C, J, Q, and S codes, and DRUGS (Drugs). • If an All Drug Agents, Inj. Drugs, All Outpatient drugs including C, J, Q and S codes or Drugs rate is present in the contract, the All Drug Agents, Inj. Drugs, All Outpatient drugs including C, J, Q and S codes or Drugs rate will be applied; if contract does not contain an All Drug Agents, Inj. Drugs, All Outpatient drugs including C, J, Q and S codes or Drugs rate, the All Other Outpatient Default rate will be applied.
Q9957	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospital, and Diagnostic Radiology Centers	Will be removed from IMAGENHANCE (Image Enhancing Substance) and CONTRAST (Contrast Agents) Service groupings Code will remain assigned to ALLDRUGSWCS (All Drugs, Agents, Inj. Drug), and DRUGS (Drugs) • If an All Drug Agents, Inj. Drugs or Drugs rate is present in the contract, the All Drug Agents, Inj. Drugs or Drugs rate will be applied; if contract does not contain an All Drug Agents, Inj. Drugs or Drugs rate, the All Other Outpatient Default rate will be applied.
73706	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospital, and Diagnostic Radiology Centers	Will be removed from CTSCAN (CAT Scan) Codes will remain assigned to RAD, & RADHCPC (description prints as Radiology Services for all service groupings listed) • If a Radiology Services rate is present in the contract, the Radiology Services rate will be applied; if contract does not contain a Radiology Services rate, the All Other Outpatient Default rate will be applied.
S8037	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospital, and Diagnostic Radiology Centers	Will be removed from MRIMRAHCPC (MRI/MRA) Codes will remain assigned to RADHCPC (Radiology Services) • If a Radiology Services rate is present in the contract, the Radiology Services rate will be applied; if contract does not contain a Radiology Services rate, the All Other Outpatient Default rate will be applied.
Recognition of Bill Type 141 for APC pricing *Effective date of change is 8/10/2014	Facilities including Acute Short Term Hospitals and Ambulatory Surgery Centers	Will be assigned to the list of eligible bill types utilized for participating providers who are contracted with the Centers of Medicare and Medicaid (CMS) Ambulatory Payment Classification (APC) payment methodology • When contracted with the APC payment methodology, these claims will begin pricing per this methodology.

*Washington state providers: All items under the "Code" column were subject to regulatory review and separate notification sent on or around Jan. 31, 2014.

Office News

Aetna 2014 HEDIS®* data collection is underway

Our staff or our contracted representatives (Verisk or MedSave) will contact your office to collect medical record information on behalf of our members' 2013 visits.

Although we acquired Coventry Health Care, Inc., you will still get separate requests for Aetna and Coventry membership. This will continue until we have one claims processing and data collection system.

Why we need this data

Healthcare Effectiveness Data and Information Set (HEDIS) data collection is a nationwide, joint effort among employers, health plans and physicians. The goal is to monitor and compare health plan performance as the National Committee for Quality Assurance (NCQA) specifies.

We must regularly send member diagnosis data to the Centers for Medicare & Medicaid Services (CMS) for our Aetna and Coventry Medicare Advantage organizations. We collect most of the data from claims and encounters. We also gather diagnosis codes from member medical records.

What we need from you

If you're contacted, we ask that you cooperate with our request. We'll need timely access to our members' medical records by a specific due date. Our representatives will work with you and give you options for sending medical records.

Meeting HIPAA guidelines

Our representatives serve us in a role that Health Insurance Portability and Accountability Act (HIPAA) defines and covers. As HIPAA defines, Aetna is a "Covered Entity" and our representative's role is a "Business Associate" of a "Covered Entity." Giving medical record information to us or our contracted representatives meets HIPAA regulations.

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Consult Clinical Practice Guidelines as you care for patients

The National Committee for Quality Assurance (NCQA) requires health plans to regularly let providers know about the availability of Clinical Practice Guidelines (CPGs). Our CPGs and Preventive Service Guidelines (PSGs) are based on nationally recognized recommendations and peer-reviewed medical literature. They are on our **secure provider website**. Look under "Aetna Support Center" then "Clinical Resources."

Preventive Service Guidelines (PGS)	
• USPSTF* and CDC** biennial source review	Adopted 2/14
• NCI*** recommendation for screening mammogram every 1 to 2 years for women over 40	Adopted 2/14
• USPSTF screening recommendation for gestational diabetes mellitus (GDM) in asymptomatic pregnant women after 24 weeks of gestation	Adopted 2/14
• USPSTF recommendation for prevention of the initiation of tobacco use among school-aged children and adolescents	Adopted 12/13
Behavioral Health	
• Helping Patients Who Drink Too Much	Adopted 2/14
• Treating Patients With Major Depressive Disorder	Adopted 2/14
• ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment of Attention Deficit Hyperactivity Disorder in Children and Adolescents	Adopted 2/14
Diabetes	
• Treating Patients With Diabetes	Adopted 2/14
Heart Disease	
• Treating Patients With Coronary Artery Disease	Adopted 2/14

For a paper copy of PSGs, or a specific CPG, call our Provider Service Center.

*U.S. Preventive Services Task Force **Centers for Disease Control and Prevention ***National Cancer Institute

Our online Office Manual keeps you informed

Our Office Manual (Health Care Professional Toolkit) is available online:

- Aetna: visit our **secure provider website**. Select "Doing Business" from the Aetna Support Center.
- **Innovation Health**: (**www.innovation-health.com**). Select "Physicians & Providers" then "Practice Resources."

The Manual has information to help you serve your patients efficiently and accurately, including:

- Clinical Practice and Preventive Service Guidelines
- Policies and procedures
- Patient management and acute care
- Case and disease management programs
- Special member programs/resources, including the Aetna Women's Health℠ Program, Aetna Compassionate Care℠ and others

If you don't have Internet access, call our Provider Service Center for a paper copy.

Coverage determinations and utilization management

We use evidence-based clinical guidelines from nationally recognized authorities to make utilization management (UM) decisions.

Specifically, we review any request for coverage to determine if members are eligible for benefits, and if the service they request is a covered benefit under their plan. We also determine if the service delivered is consistent with established guidelines. The member, member's representative or a physician acting on his/her behalf may appeal this decision if we deny a coverage request. Members can do this through our complaint and appeal process.

Our UM staff help our members access services that their benefits plans cover.

We don't make employment decisions or reward physicians or individuals (who conduct UM reviews) for creating barriers to care or for issuing coverage denials.

Our medical directors are available 24 hours a day for specific UM issues. Physicians can contact patient management and precertification staff at the telephone number on the member's ID card. When the card only shows a Member Services number, we'll direct you through a phone prompt or a Member Services representative.

CPBs and PCPBs

Clinical Policy Bulletins (CPBs) and Pharmacy Clinical Policy Bulletins (PCPBs) explain and guide our determination of whether certain services, medications or supplies are medically necessary, experimental and investigational or cosmetic. CPBs and PCPBs can help you assess whether patients meet our clinical criteria for coverage. They can also help you plan a course of treatment before calling for precertification, if required.

Where to learn more

You can find information about our UM criteria, CPBs and PCPBs on our **public website**. Call our Provider Service Center if you don't have Internet access and need a paper copy, or need a copy of the criteria upon which we base a specific determination.

Important Quality Management Program information

Here is important program information that can help you and your patients. We integrate quality management and metrics into all that we do.

You can find details on our quality management program, its goals and our progress toward those goals online:

- **Aetna**: (**www.aetna.com**)
- **Innovation Health** (**www.innovation-health.com**)

For both websites, select "Individuals & Families" then search "Quality Improvement Strategy." If you don't have Internet access, call our Provider Service Center for a paper copy.

Review our policies on non-discrimination, accessibility

Our online Office Manual (Health Care Professional Toolkit) is available online:

- Aetna: visit our **secure provider website**. After logging in, select "Doing Business" from the Aetna Support Center.
- **Innovation Health** (**www.innovation-health.com**)

  Select "Physicians & Providers" then "Practice Resources."

It includes important information on all member rights and responsibilities, including those about discrimination. The Manual also has information about accessibility standards.

If you don't have Internet access, call our Provider Service Center for a paper copy.

Non-discrimination policy

All participating physicians should have a documented non-discrimination policy. Federal and state laws prohibit discrimination in the treatment of patients on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information or source of payment.

All participating physicians or health care professionals may also be obligated under the federal Americans with Disabilities Act to give physical access to their offices and reasonable accommodations for patients and employees with disabilities.

Accessibility standards

Aetna's Office Manual has accessibility standards for primary care physicians. Accessibility standards for specialists are specific to your state and specialty. Refer to the Manual or your provider contract for details.

Learning Opportunities

Log in or register at **AetnaEducation.com**

Check out our new and improved Education Site

Based on your feedback, we've made **AetnaEducation.com** easier to use and more comprehensive to support your learning and education needs.

We've made the following improvements:

- You no longer need to log in to access most of the content – you can now go directly to the site and immediately start using it. Log-in is needed only for a limited amount of proprietary content.
- A more dynamic "Search" function that gets you to the information you need faster.
- Our "5 Star" rating system, which displays ratings from other users on education they viewed. Plus, you can send us feedback on your experience.
- An "Ask an Expert" function where you can get responses to questions about various learning programs available on the site.
- A new look and feel that makes it easier to navigate and to find what you're looking for.

Of course, the site still contains various reference tools, a calendar of scheduled live webinar events, and complete listing of all available learning courses.

We recommend that you bookmark **AetnaEducation.com** so you can easily visit the site at your convenience.

We have solutions to help fight obesity

We continue to work to address the public health and personal challenges of obesity. A balanced approach that emphasizes a healthy lifestyle, nutrition and physical activity is critical to fighting obesity.

Aetna's Healthy Lifestyle Coaching programs and **CarePass®** consumer website and mobile solution give members support to make changes, including access to helpful health and wellness mobile apps.

New medications available

The FDA has approved two new weight loss drugs: BELVIQ® and Qsymia®. Clinical trials indicate significant potential for effective weight loss ranging between 10-15 percent of body weight. Blood pressure, cholesterol and blood sugar also decreased among participants.

Prescription weight loss drugs are covered only as optional benefits selected by the plan sponsor. Check your patient's benefit plan for details. Precertification may also be required.

Talk to your patients about weight-loss options that are best suited for their needs including lifestyle, prescription support and surgical options.

Submit your Medicare Part A claims electronically

Just follow these tips:

- Don't send us a claim – Medicare pays its share first. Then, in most cases, it automatically forwards us claims information and any remaining balance.
- Look for the "MA18" or "N89" codes on your Medicare Explanation of Payment – That means your claim was automatically forwarded to us.
- Use our online Claim Status Inquiry transaction – Check if we already received your claim from Medicare using our **secure provider website** or your current electronic data interchange (EDI) vendor.
- Make a note that we're reviewing your claim. Then wait 30 days before billing us. Medicare carriers send claims every seven days, and we pay clean claims promptly. Or, create a paper claim if your system can't suppress billing, but don't mail it.
- Follow up with us in 30 days, if needed.

Pharmacy

Changes to our commercial drug lists

We'll make changes to our commercial drug lists on July 1, 2014. These changes may affect our Pharmacy Management Preferred Drug List, Precertification, Quantity Limits and Step-therapy programs.

To precertify a drug:

- Call **1-800-414-2386**
- Or, fax the appropriate medication request form to **1-800-408-2386**

Starting April 1, 2014, you can view the **list of drugs** we're changing:

- Select "Pharmacy Drug (Formulary) List Information"
- Choose "2014 Preferred Drug (Formulary) List Changes"
- Select "2014 Mid-Year Changes" from the drop-down box

Find medication request forms online

You can find forms on our **secure provider website**. Once logged in, select "Aetna Support Center" from the Aetna Plan Central home page, then "Forms Library" and "Pharmacy Forms."

Where to find our Medicare and commercial formularies

At least annually, and from time to time throughout the year, we update the Aetna Medicare and commercial (non-Medicare) Preferred Drug Lists. These drug lists are also known as our formularies.

- Go to our **Medicare Preferred Drug Lists**
- Go to our **Medication Search page** for the commercial Preferred Drug Lists

For a paper copy of these lists, call the Aetna Pharmacy Management Provider Help Line at **1-800-AETNA RX (1-800-238-6279)**.

Use in-network laboratories

Refer your Aetna members to in-network laboratories for lab services.

Referring your patients to out-of-network labs will cause them to pay more out of pocket. Quest Diagnostics is our national preferred lab and your patients may save the most money when using them.

You can get more information on cost savings or a list of **in-network and out-of-network labs**. You can also find a full list of in-network providers on our **DocFind®** online provider directory.

Aetna's Readmission Risk Reduction Program

We want to help make an Aetna member's transition to home successful after leaving your facility. Our Readmission Risk Reduction Program identifies members at high risk for readmission, and can help prevent avoidable readmissions.

How the program works

An Aetna case manager works with a member in the hospital and for up to 30 days after discharge from your facility. Our case manager will:

- Inform the member in the hospital that we want to help with a smooth transition home or to a lower level of care.
- Consult with the member's post-discharge treating physician about follow-up appointments and treatment plan.
- Review discharge instructions to help facilitate case management.
- Review medication treatment to support case management.
- Encourage follow-up provider appointments when appropriate, and help schedule visits from a home health care provider. (Note: We require preauthorization of home health care services for Aetna Medicare Advantage plan members only.)
- Continue case management for members with complex needs.

Mid-America News

Results of our 2013 Medical Record Audit

Every two years we conduct an audit to assess how health care professionals are complying with our medical record documentation criteria. We evaluated 23 documentation criteria categories in the Mid-America Region.

Three areas fell below the 85 percent compliance goal and are targeted for improvement:

- Documentation of a patient's personal data: gender, date of birth, emergency contact, address, home/work phone numbers, marital status.
- Advance directives in a prominent part of a patient's record.
- Documentation of advance directives for patients over 18 years of age.

You can find our documentation criteria in our online Office Manual (Health Care Professional Toolkit) on our **secure provider website**. There are also tools and forms to help improve medical record documentation such as:

- Adult Health Maintenance form
- Medical History form
- Pediatric Health and Immunization Summary forms

Advance directives

Aetna Participating Practitioner Medical Record Criteria require that an advance directive, whether it's executed or not, is in a prominent place in a patient's record. The exception is for patients under age 18.

The Centers for Medicare & Medicaid Services requires this documentation for Medicare patients. We must also monitor the compliance of participating physicians.

Advance directive forms for specific states are on the **Aetna Compassionate Care℠ Program** website. If your state is not listed, go to the **U.S. Living Will Registry®** website for an applicable advance directive form or for more information. If you don't have Internet access, you can request a paper copy of the Toolkit by calling our Provider Service Center.

Ohio

Notice of Material Amendment to Contract

For important information that may affect your payment, compensation or administrative procedures, see the following articles in this newsletter:

- Changes to July 1, 2014 National Precert List – page 1
- Clinical payment, coding and policy changes –page 2
- Note these service code changes – pages 4-5
- Changes to our commercial drug list – page 9
- Where to find our Medicare and commercial formularies – page 9

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Contact us at: OfficeLinkUpdates@aetna.com

Route this publication to:

- ○ Office Manager
- ○ Referral and Precertification Staff
- ○ Business Staff
- ○ Front Desk Staff
- ○ Medical Records/Medical Assistants
- ○ Primary Care Physicians
- ○ Specialists
- ○ Physician Assistants/Clinical Nurse Specialists
- ○ Nurses

Use secure site to update demographic data

If you need to update your office's demographic information – new e-mail addresses, mailing address, phone or fax numbers – use our **secure provider website**. You also should update your demographic information if your name changes due to marriage or another life event.

By using the secure site, you can confirm the information you submit. It prevents unauthorized individuals from submitting wrong information about your office or facility.

Reminder: electronic transactions

You also can do most electronic transactions through this website. This includes submitting claims, checking patient benefits and eligibility, and requesting precertifications.

NaviNet Security Officers have access to Aetna's "Update Provider Profiles" function, through which they can submit demographic changes. They also can authorize other users' access to this feature as appropriate. To use the secure website you first need to **register**.

www.aetna.com

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