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aetna℠

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Aetna OfficeLink Updates™

Mid America Region

Inside This Issue

Options to reach us

- Go to **www.aetna.com**
- Select "Health Care Professionals"
- Select "Medical Professionals Log In"

Or call our Provider Service Center:

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

Aetna accepts electronic claims for Medicare Part A and B

You no longer have to send us your Medicare claims on paper. We now accept both Medicare Part A and B claims electronically.

To save time:

- Don't send us a claim – Medicare pays its share first. In most cases, it then automatically forwards claims information and any remaining balance to us.
- Look for the "MA18" or "N89" codes on your Medicare Explanation of Payment. That means Medicare automatically sent us your claim.
- Check the status with our online Claim Status Inquiry transaction.
- Make a note that Aetna is reviewing your claim.
  - 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.

For more information on Medicare crossover claims, visit our **Coordination of Benefits** (COB) page.

Use Quest Diagnostics for genetic testing

Integrated Genetics/Integrated Oncology (IG/IO) – formerly known as Genzyme Genetics and Esoterix Genetic Laboratories – has been out of network for Aetna members since April 16, 2012.

Quest Diagnostics is a preferred in-network laboratory offering genetic services. Its test menu includes prenatal and postnatal risk assessment, diagnosis, and monitoring testing. Members can get genetic counseling through **InformedDNA** at **1-800-975-4819**.

Saving money

Aetna members who receive care from out-of-network providers typically pay much more for those services. Helping members stay in network can save them money. Consider this when referring your Aetna patients for laboratory services.

Visit **Quest Diagnostics** or call them at **1-866-GENE-INFO (1-866-436-3463)** for specific test information or a consultation.

48.22.808.1-Q2-MA (9/12)

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 accompanying chart outlines coding and policy changes:

Procedure	Implementation date	What's changed
Default par fee schedule - pharmacy services (HCPCS Level II J codes)	1/1/2013	The default values for the Aetna fee schedule for pharmacy services charges under $600 (per line) will pay 50 percent of billed charges.
Pelvic and transvaginal ultrasounds	12/1/2012	76856 will deny as incidental when billed with 76830 on facility claims. Specialist claims are currently subject to this edit.
Modifier 78 - return to the operating room for a related procedure during the post-operative period	12/1/2012	Services billed with modifier 78 will be paid at 75 percent of the negotiated rate or recognized charge.
Evaluation and management codes billed by certain non-physician provider types	12/1/2012	Evaluation and management codes will not be allowed for the following specialists: • Audiologists • Dieticians • Nutritionists • Physical, occupational and speech therapists
Gastric band adjustments	12/1/2012	S2083 will deny as incidental when billed within the 90 day global period of codes 43770, 43771, and 43773.
Breast reconstruction	12/1/2012	S2068 will deny as mutually exclusive to 19364 when billed on the same date of service. Modifier 59 will not override this edit.
Per day limits	12/1/2012	The following per day limits will apply: • 88329 – 4 units per date of service • 85097 – 2 units per date of service • L2810 – 4 units per date of service, 2 times per side • L6682 – 4 units per date of service, 2 times per side • 88346 – 10 units per date of service
Endometrial ablation	12/1/2012	We will require that members having endometrial ablation procedures also have evidence of endometrial sampling performed within one year prior to the endometrial ablation procedure. Endometrial sampling codes are 58100, 58110, 58120 and 58558. Refer to **Clinical Policy Bulletin #0091** – Endometrial Ablation.
Bilateral noninvasive physiologic studies of upper or lower extremity arteries	12/1/2012	Procedure codes 93922 and 93923 will be considered incidental when billed with either G0166 (external counterpulsation) or 92971 (Cardioassist). We first communicated this change in the June 2011 newsletter. We've delayed this policy from September 1, 2011 until December 1, 2012.
Allograft and autograft for spinal surgery only – codes 20930 and 20936	Reminder: effective October 1, 2012 *Effective December 1, 2012 for Ohio, Colorado and Washington	We informed you of this change on June 29, 2012: Codes 20930 and 20936 will be disallowed when billed with another CPT and/or HCPCS procedure code. We do not allow modifier 59 to override these edits.

Correction: arthroscopy codes

In the June 2012 newsletter, the Clinical payment, coding and policy changes grid stated:

• Arthroscopy – effective 9/1/2012 – Modifier 59 will no longer override 29863 and 29863 when billed with 29914, 29915 or 29916.

The correct language is:

• Arthroscopy – effective 9/1/2012 – Modifier 59 will no longer override **29862** and 29863 when billed with 29914, 29915 or 29916.

We're sorry for the error.

Changes to January 1, 2013 National Precertification List (NPL)

The changes below to Aetna's NPL will take effect on January 1, 2013, unless otherwise noted:

Additions

The treating surgeon is required to obtain precertification for cervical, thoracic, or lumbar laminectomy and laminotomy procedures:

- For inpatient procedures effective September 1, 2012
- For outpatient procedures effective December 1, 2012

To precertify for the following additions, call **1-866-503-0857** or fax the related Medication Request Form to **1-888-267-3277**. Forms are available on our secure provider website. Go to our **website** to log in. Then, select "Aetna Support Center" from the Aetna Plan Central home page, then "Forms Library" and "Pharmacy Forms." Newly approved drugs administered by injection or infusion may be subject to precertification review.

Elelyso™ (taliglucerase alfa) – effective August 21, 2012

Infusible/Injectable Immunologic Agents (Aetna members requiring treatment with an infusible agent in this class should be prescribed Remicade® as the formulary preferred infusible. Members requiring treatment with an injectable agent in this class should be prescribed Enbrel®, Humira®, Simponi® or Stelara® as a formulary preferred injectable)

- Actemra® (tocilizumab)
- Amevive® (alefacept)
- Cimzia® (certolizumab pegol)
- Enbrel (etanercept)
- Humira (adalimumab)
- Kineret® (anakinra)
- Orencia® (abatacept)
- Remicade (infliximab)
- Rituxan® (rituximab)
  - Currently requires precertification for rheumatoid arthritis
  - Precertification required for all conditions effective January 1, 2013
- Simponi (golimumab)
- Stelara (ustekinumab)

Omontys® (peginesatide) – effective August 21, 2012

- Precertification for a period of 16 weeks

Wet age-related macular degeneration treatments

- *Eylea® (aflibercept)
- *Macugen® (pegaptanib sodium injection)
- *Lucentis® (ranibizumab injection)

Modifications

Injectable infertility drugs

- Precertification and vial management for injectable infertility medications currently applies to female members enrolled in commercial plans
  - Effective January 1, 2013, the precertification requirement will also apply to male members enrolled in commercial plans

Osteoporosis drugs — injectable and Xgeva®

We will update **Clinical Policy Bulletin #0804** (Denosumab [Prolia and Xgeva]) on January 1, 2013. It will show a preferred product for the following medications currently on the precertification list for osteoporosis indications:

- *Aredia® (pamidronate)
- *Xgeva (denosumab)
  - Expanding precertification requirement for Xgeva (denosumab)
  - Aetna members requiring Xgeva (denosumab) must have a documented trial and failure, contraindication or intolerance of either Aredia (pamidronate) or Zometa® (zoledronic acid)
  - Requirement does not apply to Aetna members receiving treatment on Xgeva (denosumab) prior to the expanded requirements effective January 1, 2013
- *Zometa (zoledronic acid)

Outpatient surgical scopes

- Effective September 1, 2012
  - Notification is no longer required for bronchoscopy, cystoscopy, hysteroscopy, knee arthroscopy, laparoscopic cholecystectomy and shoulder arthroscopy
  - Notification for colonoscopy and upper GI endoscopy remains a requirement

* Precertification approvals are valid for 6 months from the date of issue, unless stated otherwise at the time of precertification. However, approvals for drugs marked with a single asterisk (*) are valid for 12 months from the date of issue.

Deletion**

- Negative Pressure Wound Therapy

** The removal of a service from the precertification list does not mean that the services will be covered. The services are still subject to review upon submission of the claim for services, and may be denied in accordance with the terms of the member's plan.

Reminder:

Beginning September 1, 2012, we will require precertification for outpatient infusion of the following three drug classes that already require precertification:

- Enzyme Replacement drugs
- Immunoglobulin (IVIG) drugs
- Blood Clotting Factor (Hemophilia) drugs

General information

Precertification and notification are the process of collecting information before elective inpatient admissions and/or selected ambulatory procedures and services take place. Therefore, requests for precertification and notification must be received before rendering services. Failure to contact Aetna for precertification or notification will relieve Aetna or employers and members from any financial liability for the applicable service(s), if those services are rendered.

Precertification requirements apply to all Aetna plans, except for Traditional Choice. We will update the precertification list online before January 1, 2013.

Review the **NPL**.

Precertification programs may not be available in all service areas. For example, precertification programs do not apply to fully insured members in Indiana.

California HMO members who are receiving coverage for medications added to the Precertification lists will continue to have those medications covered, for as long as the treating physician continues prescribing them, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition.

In Texas, the term precertification here means the utilization review process to determine whether the requested service, procedure, prescription drug, or medical device meets the company's clinical criteria for coverage. It does not mean precertification as defined by Texas law, as a reliable representation of payment of care or services to fully insured HMO and PPO members. Notifications are not subject to clinical review.

This material is provided for informational purposes only and is not intended to direct treatment decisions.

Office News

Submitting Supplemental Retiree Medical Plan claims

The Aetna Supplemental Retiree Medical Plan is a fully insured, non-network-based commercial retiree group health product.

This plan is only offered to retirees and their eligible dependents enrolled in Original Medicare. The plan offers supplemental benefits and coverage that is similar to true Medicare Supplement (Medigap) plans. However, in most states, this product is not a Medicare Supplement plan.

Members enrolled in the Aetna Supplemental Retiree Medical Plan must seek any Medicare-covered services from licensed health care professionals who are eligible to receive payment under Original Medicare, unless otherwise noted in plan documents.

Original Medicare claims

Note: For members enrolled in the Aetna Supplemental Retiree Medical Plan, you should submit claims for Medicare-covered services to Original Medicare.

Aetna will receive any claim with a balance bill from Original Medicare. The only claims that you should submit directly to Aetna are those relating to non-Medicare-covered services.

Remember to confirm member benefits, as multiple benefits plans are available. Call **1-800-557-5078** (**TTY/TDD: 1-888-200-6124**) with questions.

Home infusion providers

Transition of immune globulin patients

Home infusion providers whose contracts contain "first dose" language for chronic diseases may need to transition Aetna members who need immune globulin.

"First dose" is defined as 56 days for intravenous immune globulin, or 28 days for subcutaneous immune globulin.

The transition should be from the home infusion provider to an Aetna network specialty pharmacy, subject to the provisions of the contract. This applies to patients who are new to immune globulin therapy since January 1, 2012.

New program helps with access to radiology services

We have established the Aetna Smart Choice program to provide cost transparency to members who need radiology services.

As part of the program, MedSolutions, a medical managements services company, will contact members to discuss radiology options and schedule radiology services. If your Aetna patients require radiology services, call MedSolutions at **1-888-693-3211**.

How to update your demographic information

It's now easier than ever to update or correct your office's or facility's phone and fax number(s), mailing addresses and e-mail addresses.

Use our new "**Request Changes to Provider Data**" form. It's located on our DocFind® provider directory.

Updating this information will help ensure that you receive important information we distribute – whether it's by e-mail or on paper. It also will provide patients who use DocFind with the most up-to-date and accurate information about where you're located or how to reach you.

Helping your patients have healthy pregnancies

Through our Beginning Right® Maternity Program, we'll offer your patients education throughout their pregnancy and access to nurse case management, as needed.

Program highlights include:

- Patient educational materials
- A non-nicotine smoking cessation program
- Coordination of home care services arranged during pregnancy
- Authorization for any testing during pregnancy

Encourage enrollment

Some employer groups give a monetary incentive for their employees to participate in the program. We hope you'll encourage your patients to enroll. Either you or your patients can call us at **1-800-272-3531**.

You can learn more about the program in our Health Care Professional Toolkit, available on our **secure provider website**.

Meritain members will have access to new products

We previously told you that we purchased Meritain Health. At that time, Meritain Health was the nation's largest, independent third-party administrator (TPA) of self-funded health care plans.

As an Aetna-owned company, Meritain members can use physicians and hospitals in our network.

ID card facts

- The ID card has the Meritain logo identifying it as an Aetna company.
- The ID card has a logo indicating the network the member is using. If the card:
  - Has an Aetna logo, we pay based on the Aetna fee schedule.
  - Has another network logo, Meritain pays based on the negotiated rate for that network. **Note:** Meritain is contracted with some companies that may use networks other than the Aetna network for their employees.
- Send claims to the Meritain address on the ID card, as Meritain will process claims.

New products coming

Beginning in January 2013, Meritain members will have access to our Aetna Choice® POS II product. The ID card will show the network product being used (Aetna Choice POS II or Aetna PPO designation). We will process claims according to the provider's appropriate contracted rate.

If you have questions, call the number on the ID card.

HMO patients with "W" ID numbers

During 2012, you've seen HMO based patients presenting ID cards with "W" ID numbers, and you will continue to see this activity. The ID number should not be used as an indicator of product type.

You can find the product type in the upper right corner of the ID card. You may also continue to get eligibility and benefits information online by using our **secure provider website**. Just enter the patient's member ID, or first/last name with date of birth.

Identifying Aetna International members

Aetna has many member ID cards. You should accept all patients with cards that have the Aetna name and logo on them. This includes Aetna International members.

Don't be confused by the term "international" – these are Aetna members. You can submit their claims in the same way you do with other Aetna patients. If you use our **secure provider website**, you can review Aetna patient claims and payment status – including most Aetna International members.

If you have questions, call the Provider Service Center.

Electronic Solutions

Batch precert notification offered via Aetna EDI Connect℠

You can submit professional and institutional claims via our **direct connect website**. EDI Connect allows providers, billing companies and vendors to submit their electronic transactions to us free of charge, without using a third party vendor.

Now you also can send us your batch precertification notifications electronically through EDI Connect. While there are several ways you can inform us of admissions electronically, currently only Aetna EDI Connect supports a batch solution.

All you need to do is electronically submit an X216 (278 Health Care Services Review Notification and Acknowledgment) through Aetna EDI Connect. To start:

- Visit the Aetna **direct connect website**.
- Call the Aetna EDI Connect Help Desk at **1-877-309-4255** from 8 a.m. to 5 p.m., ET.

Notify us

To inform us of admissions electronically on an *individual basis*, submit a precertification add X217 (278 Health Care Service Review Request for Review and Response) transaction using our **secure provider website** or through any one of our **contracted EDI vendors**.

Facilities can call the number on the patient's ID card to submit precertification notifications.

Improved search feature on our secure website

Now you can find exactly what you're looking for on our **secure provider website** using our new search feature.

This enhanced capability lets you search content in the Aetna Support Center section. This means you can quickly and easily get to policy information, coverage bulletins and forms, to name a few. The search also includes **aetna.com** content.

Reducing non-emergency use of the ER

We want to stress the importance of reminding your Aetna patients that the use of urgent care (UC) services can often be an appropriate option instead of going to the emergency room.

What you can do

To help your patients' get after-hours care, consider modifying your outgoing phone message to offer options, including "911, urgent care or speaking with the on-call doctor." We also hope that you will talk with your patients about the advantages of using UC centers and walk-in clinics for non-emergent care.

Benefits of UC services:

- Members may have the same or a lower copay or coinsurance
- Waiting times are frequently shorter than in the ER
- Often the same or even lower level of care is necessary

Learning Opportunities

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

New and updated courses for physicians, nurses and office staff

Genetics

- New Inherited Breast and Ovarian Cancer: Identifying and Managing CME (see article below)

Medicare Advantage Plans

- New 2012 Aetna Medicare Compliance Program

Reference Tools

- New Products, Programs and Plans: Aetna Supplemental Retiree Medical Plan
- Updated Aetna at a Glance: Mid-America, Northeast, Southeast and West Regions
- Updated Products, Programs and Plans: Aexcel® Reference Tool
- Updated Provider Manuals: Aetna Benefits Products (ABP) Quick Guide

Reminder: Annual Medicare training required

The Centers for Medicare & Medicaid Services (CMS) requires providers and staff who provide services to a Medicare Advantage plan or Medicare prescription drug plan patients to complete Medicare Compliance Program training at the time of contracting and annually after that.

This requirement applies to all provider office staff with access to Medicare patient information.

Aetna's course

Aetna developed a Medicare Compliance Program training course for you. To access it:

- Log in or register to the **Education Site**.
- Type 2012 in the Search field and click "Go"
- Click "Select" for the 2012 Aetna Medicare Compliance Program

You will receive an attestation page to complete after you finish the course.

CMS also requires providers to complete Fraud, Waste and Abuse (FWA) training* annually. CMS offers a web-based training module that satisfies the FWA training requirement. Directions to CMS's web-based training module are provided in the Aetna Medicare Compliance Program training course.

*Providers are considered First Tier, as they have a contractual relationship with Aetna to deliver Part C or Part D Benefits. The sponsor's employees (including temporary workers and volunteers) and governing body members, as well as First Tier, Downstream & Related Entity (FDR) employees who have involvement in the administration or delivery of Parts C and D benefits must, at a minimum, receive FWA training within 90 days of initial hiring (or contracting in the case of FDRs), and annually thereafter.

The only exception is FDRs (who have met the FWA certification requirements through enrollment into Parts A or B of the Medicare program, or through accreditation as a supplier of point of sale durable medical equipment) who are deemed to have met the FWA training and education requirements.

Take our course on managing breast and ovarian cancer

Our new course on the **Education Site** explains the impact of hereditary breast and ovarian cancer to your practice. The course:

- Examines the clinical features of both types of heredity cancers
- Identifies patients who should be referred for further evaluation
- Outlines the distinction between hereditary and sporadic cancers
- Describes management options for patients with BRCA mutations
- Offers patient resources and more

The course is appropriate for family medicine physicians, internal medicine physicians, obstetricians and gynecologists. Physicians can receive a certificate awarding *AMA PRA Category 1 Credit*™.

Get started

- Log in to the **Education Site**
- Type *Inherited cancer* in the Search field and click "Go"
- Click "Select" for the Inherited Breast and Ovarian Cancer: Identifying and Managing course

Accreditation

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of USF Health and Aetna. USF Health is accredited by the ACCME to provide continuing medical education for physicians.

USF Health designates this enduring material for a maximum of 1.5 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Only physicians may receive a certificate awarding *AMA PRA Category 1 Credit*™. Non-physician participants must receive a "Certificate of Completion."

Use proper billing codes for preventive services

The Affordable Care Act (ACA) requires non-grandfathered, non-exempt health plans to cover certain preventive care services without member cost–sharing when provided in network.

Preventive care services include periodic well visits, routine immunizations and routine screenings for symptom-free or disease-free individuals. Based on the ACA's requirement relating to women's preventive health services, additional preventive care services will be included in some plans as they become effective or renew coverage on or after August 1, 2012.

When submitting claims, use the correct preventive care HCPC, CPT and/or ICD-9 billing code(s) as the primary code when the main purpose of the visit was for preventive care. For example, these procedures should be billed as preventive services:

- Bone density scans
- Colonoscopies
- Mammograms
- Any blood tests associated with preventive care

Don't bill these procedures with a non-preventive diagnosis code if you didn't perform them in conjunction with symptoms or a diagnosed condition.

Using the right codes helps ensure that we pay your contracted rates. It also protects members from being billed for cost share for the preventive services covered under the ACA.

Where to find codes

We added some new preventive codes for new and renewing plans as of August 1, 2012. You can view all preventive care codes on our **secure provider website**.

Go to "Aetna Plan Central," then "Aetna Support Center," then "Claims," then "Benefit Guidance Statements" and scroll to "016 – Routine Preventive Visits." See our **Health Reform Connection** website for more information.

Preventive prenatal visits covered with no cost share

Effective August 1, 2012, Aetna will provide coverage for the following women's health services at *no cost to the member:*

- Certain manual and standard electric (non-hospital grade) breast pumps for women who recently gave birth
- Lactation consultative services
- Preventive prenatal care visits

Global maternity fee

Billing for prenatal visits is usually combined with delivery charges and post-partum care to form a "global" maternity fee. The preventive prenatal visits represent 40 percent of the global maternity fee. Thus, we will reimburse up to 40 percent of the global maternity fee with no cost share for the member.

These changes are part of the expansion of women's preventive health services under the ACA. They affect non-grandfathered and non-exempt plans upon renewal of coverage or after August 1, 2012. You can find details in Aetna's benefit guidance statement regarding preventive benefits on our **secure provider website**. See the above article on how to access the coding information.

Help improve communication among physicians

To promote comprehensive patient care, it's critical that primary care physicians (PCPs) and specialists talk openly.

Sharing info is easy

Use our online tools to share patient information with other practitioners. You can find them on our **secure provider website**:

- Physician Communication Form and the Specialist Consultation Form
- Behavioral Health/Medical Provider Communication Form
- Specialist Consultation Report

Once logged in, select "Aetna Support Center," "Forms Library" and "Provider Communication Forms."

Try our new solution

iNexx® is a health information (HIE) exchange solution that helps providers securely exchange and share patient information. The **iNexx** platform is free to physicians. We encourage you to learn more about how you and your patients can benefit from this technology.

Pharmacy

Patients can save with generics

As health care costs continue to rise, we encourage our members to use generic medications, whenever appropriate.

Generic drugs can provide quality, safe and effective medication while controlling costs. They include the same medications as the brand-name drug, but at a cost that is far less for your patients.

Here are examples of what patients can save:

Under our Save a Copay® program*, your patients can pay nothing out-of-pocket for six months for certain generic drugs.

All they need to do is switch from their current brand-name drug to the preferred generic alternative.

Brand-name drug	Out-of-pocket cost per fill	Preferred generic alternative drug(s)	Out-of-pocket cost for first six months	Out-of-pocket cost for following six months	Potential savings for the first year
LIPITOR 20 mg	$65	atorvastatin	$0	$15	$690
AMBIEN TAB 10 mg	$40	zolpidem	$0	$15	$390

We encourage you to talk about generic drugs with your patients, as appropriate. You can also refer to our **formulary guide**.

*The Save a Copay program isn't offered to all Aetna members.

2013 changes to Aetna's Preferred Drug Lists

We annually review our Preferred Drug List (formulary). The list shows many of the drugs covered by your Aetna patients' plans.

We update this list regularly, based on the latest medical findings, information from the Food and Drug Administration (FDA) and drug manufacturers, and cost arrangements (which include manufacturer rebates).

View the 2013 formulary changes

While coverage is not limited to medications on the list, you can help your patients lower their out-of-pocket costs by prescribing drugs on the list, when appropriate. Talk to your patients about treatment options, if any of these changes affect their prescriptions.

Learn more

- View **formulary information**
- Call us at **1-800-238-6279**

Providers in Illinois: We are currently waiting for approval from the Illinois Department of Insurance, which must approve Aetna's formulary changes. We will let members and providers in Illinois know about these changes once we receive approval.

Drug utilization program encourages patient safety

Through our new drug utilization program, we identify potential treatment concerns for our members.

The purpose of the Aetna Rx Check® Prescribing Cascade program is to:

- Identify situations in which physicians prescribe a drug to treat a side effect caused by another drug
- Tell prescribing physicians about the cascade
- Give physicians information about other treatments
- Encourage physicians to discuss treatment with their patients, as appropriate*

Our goal is to help ensure high-quality, therapeutically sound, cost-effective drug therapy. If you have questions, call us at **1-800-675-9791**.

*All decisions about appropriate patient care are at the sole discretion of treating practitioners. Our formulary and other programs do not dictate or control these decisions.

Where you can find Medicare and Commercial formularies

We update the Aetna Medicare and Commercial Preferred Drug Lists, also known as our formularies, at least annually. To view updated information go to:

- Our **2012 Medicare formulary**
- Our **2013 Medicare individual formularies**
- Our **2013 Medicare group formularies** (available after October 1)
- Our **Commercial Preferred Drug List**

For a paper copy of these guides, call us at **1-800-AETNA RX (1-800-238-6279)**.

Consult Clinical Practice Guidelines as you care for patients

The National Committee for Quality Assurance (NCQA) requires health plans to regularly inform providers 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 located on our **secure provider website** under "Aetna Support Center" then "Clinical Resources."

Preventive Service Guidelines	Adopted 2/12
***USPSTF Cervical Cancer Screening**	Adopted 3/12
Behavioral Health	
• Helping Patients Who Drink Too Much	Adopted 2/12
• Treating Patients With Major Depressive Disorder	Adopted 2/12
Diabetes	
• Treating Patients With Diabetes	Adopted 2/12
Heart Disease	
• Treating Patients With Coronary Artery Disease	Adopted 3/12

*US Preventive Services Task Force

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

See our 2012 HEDIS®* results

We annually collect Healthcare Effectiveness Data and Information Set (HEDIS) data from claims, encounters and other administrative data. Also, we collect data from chart reviews for certain clinical measures. We analyze these results to improve design and implement quality improvement activities.

View our 2012 **HEDIS results**.

We submitted our data for 2012 according to National Committee for Quality Assurance (NCQA) reporting requirements. Thanks for your help with our HEDIS 2012 data collection efforts.

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

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 the member is eligible for benefits and if the service requested is a covered benefit under the member's plan. We also determine if the service delivered is consistent with established guidelines. If a coverage request is denied, members (or a physician acting on their behalf) may appeal this decision through our complaint and appeal process.

Our UM staff help our members access services covered under their benefits plans. We do not reward physicians or individuals (who conduct UM reviews) for creating barriers to care or for issuing coverage denials.

Mid America News

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:

CPE RW3H
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Hartford, CT 06156

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- ○ Primary Care Physicians
- ○ Specialists
- ○ Physician Assistants/Clinical Nurse Specialists
- ○ Nurses

Helping patients with end of life care decisions

Talking to your patients about end of life is difficult. Our **Aetna Compassionate Care℠ Program** (ACCP) offers tools for your patients.

Program benefits

Our ACCP offers members and their families services to help manage complex and emotional issues involved with advanced illnesses. It includes:

- Case management – staffed by trained and experienced nurses who can:
  - Review options and assist with decisions
  - Help implement and support patient choice
  - Provide psychosocial support
  - Help with community resources
  - Facilitate medical services and pain relief
- Advanced care planning information – special tools and assessments that encourage member-centric care planning
- Information and tools – a member website with information about:
  - Living wills
  - Tips for discussing care
  - Treatment options with loved ones

Learn more

This program is open to Aetna medical members with plans that include Aetna Case Management. To learn more, visit us online or have your patients call the number on their ID card and ask for a nurse.

The information and/or programs described in this newsletter may not necessarily apply to all services in this region. Contact your Aetna network representative to find out what is available in your local network. Application of copayments and/or coinsurance may vary by plan design. This newsletter is provided solely for your information and is not intended as legal advice. If you have any questions concerning the application or interpretation of any law mentioned in this newsletter, please contact your attorney.

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