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June 2015 • Volume 12, Issue 2

Aetna OfficeLink Updates

Mid-America Region

Inside this issue

Options to reach us

- Select **Health Care Professionals**
- Select "Log In/Register"

If you have 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

Updates to our National Precertification List

Note these changes to Aetna's **National Precertification List** (NPL):

- Precertification for maternity management home care, home uterine activity monitoring and Somatuline Depot (lanreotide acetate extended release) is no longer required effective May 1, 2015.
- Natpara (parathyroid hormone) requires precertification effective May 1, 2015.
- Power morcellation with uterine myomectomy, hysterectomy, or for removal of uterine fibroids requires precertification effective May 15, 2015.
- Zavesca (miglustat) won't require precertification effective July 1, 2015.
- Granulocyte-colony stimulating factor (GCSF) drugs/medical injectables won't require precertification until January 1, 2016. We originally communicated that GCSF would require precertification on July 1, 2015.

Reminders

These new-to-market drugs require precertification (effective date noted):

- Opdivo (nivolumab) and Cosentyx (secukinumab) effective March 6, 2015
- NovoEight (turoctocog alfa) effective April 1, 2015

Also, we updated General information (#1a) on the precertification list to include this reminder:

- We encourage providers to submit precertification requests for scheduled services at least two weeks in advance.

You can find more information about precertification in the "General information" section of the **NPL**.

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 advises us on issues of importance to physicians. The chart below outlines coding and policy changes:

Procedure	Effective date	What's changed
Retracted policy change: **New Jersey observation billed for more than 24 hours**	March 1, 2015	**This applies to New Jersey only.** We communicated in the December 2014 newsletter that we wouldn't reimburse greater than 24 hours of observation. We won't implement this policy. The policy below about observation (effective July 1, 2015) applies.
***Readmissions**	July 1, 2015	Effective July 1, 2015, we're changing our readmissions policy. To match our readmissions policy for Aetna Medicare members, we're also extending the review timeframe for readmissions from 2 days to 30 days for our Aetna commercial members. This policy will apply to agreements that include a diagnosis-related group (DRG) methodology for inpatient stays.
***Unit maximum for CPT 88271**	September 1, 2015	Effective September 1, 2015, Molecular cytogenetics; DNA probe each (88271) will have a limit of 20 units per date of service per provider for facility or non-facility. Modifier 91 won't allow for additional units.
Genetic testing	September 1, 2015	We consider multigene hereditary breast cancer panels that accompany BRCA testing experimental and investigational. This is because there is insufficient published evidence of their clinical validity and utility. See **more information** on page 4.
***Observation stays greater than 24 hours will require precertification**	July 1, 2015 Reminder	We communicated in the March 2015 newsletter that notification is required for observation stays greater than 24 hours. Notification is required by 5 p.m. (local time) on the business day following the stay. The stay over 24 hours in observation is subject to the late notification and/or non-notification penalty for your facility.
***Unusual procedural services** (Modifier 22)	June 1, 2015 Reminder	Payment is calculated at 120%. This will decrease to 115% of either the Reasonable & Customary (R&C) fee allowance (100% of R&C plus an additional 15%) or the contracted fee for the procedure(s) performed. This policy doesn't apply to facility claims.
***Return to operating room for related procedure during post-op period** (Modifier 78)	June 1, 2015 Reminder	Payment is calculated at 75%. This will decrease to 70% of either the R&C fee allowance or the contracted fee for the procedure(s) performed without review for a procedure billed with Modifier 78. This policy doesn't apply to facility claims.

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

Office News

Our response time to appeals is changing

When you send an appeal, we want to spend the time we need for a thorough, complete review of the information you provide. So, we're changing the resolution turnaround time.

Right now, we give you a response within 30 business days (approximately 45 calendar days). On **July 1, 2015**, we're extending this to 60 calendar days. This applies to both commercial and Medicare plans.

What to include in your appeal

When you send an appeal, include your contact information, the subject and (if needed):

- Member name and ID
- Date of service
- Supporting documentation
- Medical records
- Denial letter (if applicable)
- Signed member authorization (This is only needed if you're acting on behalf of the member. If you are, the above appeal time frame and process won't apply. You can use the member appeal process.)

How to send an appeal

- Call **1-800-624-0756** for HMO-based and Medicare Advantage plans; **1-888-MDAetna** (**1-888-632-3862**) for all other plans
- Write to: Aetna, PO Box 14020, Lexington, KY, 40512
- For more information, see **Disputes & Appeals** on our website.

Any state laws that require shorter turnaround times supersede this process.

Are you ready for ICD-10?

As you know, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that ICD-10 code sets replace ICD-9 code sets. Along with you, we're required to make this change on **October 1, 2015**.

What you told us

Here are some early results from the readiness survey we sent out in April. If you haven't already taken the **survey**, it's not too late. Complete it by June 3, 2015. So far, we received over 5,000 responses.

- 65 percent have tested with their clearinghouses or plan to do so before October 1, 2015.
- 78 percent said they had some degree of confidence that they'll be ready for ICD-10.

How confident are you? Have you tested with your clearinghouses?

Steps you can take

- Keep working with your billing or software vendors and clearinghouses for conversion information and testing plans.
- Determine the impact of the ICD-10 conversion on clinical, financial, billing and coding processes.
- Read our **Q&A**.
- See related **article on page 9** about ICD-10 testing result webinars.

Note these updates to our overpayment recovery process

Effective April 1, 2015, we updated our process to recover claims overpayments we may have made to your practice or facility.

Specifically, this applies to overpayments that are eligible for us to deduct the amount of the overpayment from a future claim payment. This applies to all Aetna plans.

How the process works

- When we identify an overpayment, we'll send you a communication and ask for a refund. You can either ask us to deduct the overpayment from a future claim payment or send us the refund.
- If you send us the refund, we must receive it within 30 days from the date we requested it. If we don't get it within 30 days from our request date, we'll attempt to deduct the overpayment from a future claim payment. We'll normally send only one letter before deducting.
- If the overpayment isn't eligible to be deducted from a future claim payment or if we can't deduct the eligible overpayment, we'll send you another communication(s). This will ask you to send us the refund.

Any state laws that require longer turnaround times supersede this process.

Aetna Student Health: precertification policy reminder

You should consult Aetna's **National Precertification List** (NPL) and precertification policy before providing services for any Aetna Student Health member.

As a reminder, your contract with us requires you to follow the NPL and comply with Aetna's precertification policy.

What this means for you

If you submit claims to us that are not precertified, we may pay these claims at a reduced rate or not at all.

Questions? Call us at **1-877-480-4161**.

Use our new national network for BRCA testing services

Through our national breast and ovarian cancer genetic testing program, we promote early risk identification and intervention. We cover screening for an inherited mutation in breast cancer genes 1 and 2 (BRCA1 and BRCA2).

Our new, national network of contracted providers offers BRCA services. Quest Diagnostics is our national, preferred provider.
But we also have other providers who offer testing. You can get forms by calling them or visiting their websites. You can also use our **provider online referral directory**.

- Visit **Quest Diagnostics**, Inc. or call **1-866-436-3463**.
- Visit **Ambry Genetics** or call **1-866-262-7943**.
- For Myriad Genetics Laboratories Inc. call **1-800-469-7423**.
- Visit **GeneDx, Genpath, Bio-Reference** or call **1-888-729-1206**.
- Visit **Counsyl**, call **1-888-COUNSYL (1-888-268-6795)** or e-mail **support@counsyl.com**.

Coverage information

We require prior authorization. Go to **Clinical Policy Bulletin #0227** - BRCA Testing.

You must fill out the Breast and Ovarian Cancer Screening by Molecular Testing form, which is on our **secure provider website**. Once logged in, select "Support Center → Forms Library → Women's Health Forms." If you have questions, call us at **1-877-794-8720**.

Refer patients to our Complex Case Management program

Patients with complex cases often need extra help understanding their health care choices and benefits. They may also need support navigating the community services and resources available to them.

Our Complex Case Management program is a collaborative process that involves the member, their provider and Aetna. It aims to produce better health outcomes while efficiently managing health care costs.

We have multiple ways to identify members for the program. A provider referral is one of the ways members can gain access. To refer a patient, call the Customer Service phone number on the ID card. Our Case Management staff will call the member, explain the program to them, and request their permission for enrollment.

Reminder: submit complete and accurate Medicare Advantage claims

Your Medicare participation contract requires you to provide encounter data to us in the form and manner that we request. We collect encounter data in many ways, including through claims submissions in a manner consistent with Medicare.

If your Medicare Advantage claims don't include all the required information and are not in the proper format, we'll reject them. If that happens, you should check your claim reject reports to see why we denied your claim. You'll also get the claim back so you can correct and resubmit the information in question.

As of **August 7, 2015**, we'll validate electronic claims against a more complete set of Medicare billing requirements.

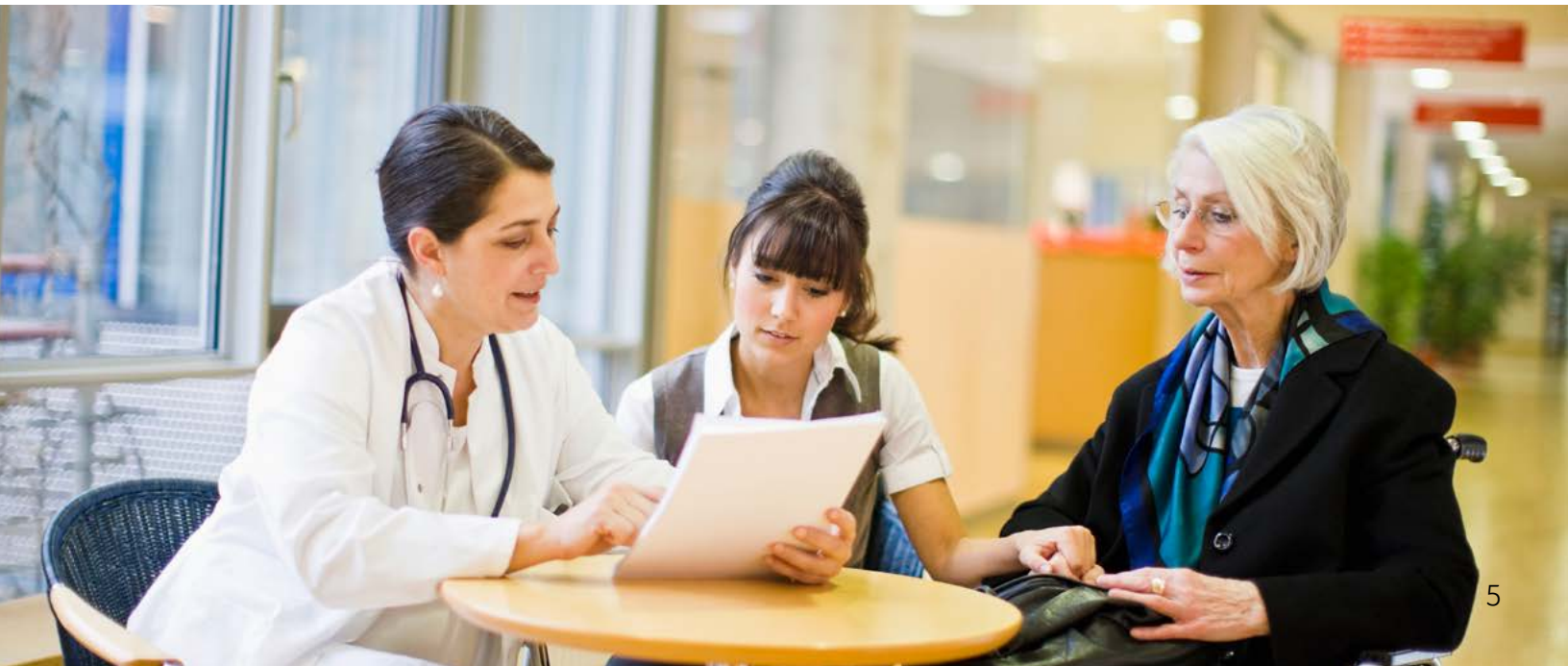
Specifically, we'll review claims to make sure that all required data elements are present and in the correct format. We'll reject your Medicare Advantage claim submissions that don't pass the validation check. This applies to Medicare Advantage claims submitted on the 837I and 837P formats.

The Health Section has helpful articles and information

Check out **The Health Section**, Aetna's external web site that publishes timely news and analysis about innovation, issues and ideas that are shaping health care today and tomorrow.

Recommended reading:

- **Making electronic health records talk to each other**
- **What does health care cost? New website has answers**
- **Precision medicine: right treatment, right person**
- **Changing the direction of mental health**
- **How personalized health care can prevent disease**



Consult CPGs and PSGs 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).

Aetna's CPGs and Preventive Service Guidelines (PSGs) are based on nationally recognized recommendations and peer-reviewed medical literature. You'll find them on our **secure provider website**. On the site, go to "My Health Plans → Aetna Health Plan → Support Center → Clinical Resources." If you need a paper copy, call our Provider Service Center.

Clinical Practice Guidelines	Adopted
Behavioral Health	
• Diagnosis, Evaluation and Treatment of Attention Deficit Hyperactivity Disorder in Children and Adolescents	February 2014
• Helping Patients Who Drink Too Much	February 2014
• Treatment of Patients With Major Depressive Disorder	February 2014
Diabetes	
• Standards of Medical Care in Diabetes	April 2015
Heart Disease	
• Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease	February 2014

Preventive Service Guidelines	Adopted
• Gestational diabetes mellitus (GDM) in asymptomatic pregnant women after 24 weeks of gestation*	February 2014
• Mammogram screening for women over 40**	February 2014
• Prevention of the initiation of tobacco use among school-aged children and adolescents*	December 2013

*U.S. Preventive Services Task Force
**National Cancer Institute

Use our secure site to update demographic data

To update your office's demographic information — new e-mail addresses, mailing address, phone or fax numbers — use our **secure provider website**. Also update your demographic information if your name changes due to marriage or another life event.

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage plans to maintain accurate directories, so having up-to-date information allows us to do that as well.

If you've been calling our Provider Service Center for demographic changes, we ask that you use the secure site instead. The site lets you confirm the information you submit. It prevents unauthorized individuals from submitting wrong information about your office or facility.

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 must first **register**.

You can find answers to your Aexcel® questions online

These four resources can answer your questions about our 2016 Aexcel program:

- **A Physician's Guide to Aexcel** explains both our evaluation process and reconsideration processes.
- **Aexcel Methodology** describes the designation process. This includes a list of all measures we consider, provider attribution, risk adjustments, statistical significance and other technical specifications.
- **Clinical Performance Evaluation Flyer**
- **Efficiency Evaluation Flyer**

This information is available on our **secure provider website**. After logging in, select "Support Center → Doing Business With Us → Aexcel Designation."

Prepare for 2016 designation cycle

Visit our Designation Page for details on the 2016 Aexcel program, including:

- Documentation you need
- Criteria and measures

Let us know if you believe your practice meets the criteria for Aexcel's Use of Technology and/or Performance Improvement Module (PIM) activities. Send supporting documentation to our **AexcelProviderFeedback@aetna.com** mailbox

Our Office Manual keeps you informed

Our **Office Manual for Health Care Professionals** (Manual) is available on our website. For **Innovation Health**, once on the website 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 management 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.

Behavioral health: ICD–10 codes and our PCP support programs

As you may know, ICD-10 codes take effect on October 1, 2015. Some of these changes will affect reimbursement combination codes for our PCP-based behavioral health support programs. You can find out more on our **website**.

ICD-10 codes appear under the billing guidelines in each program description:

- **Alcohol Screening, Brief Intervention and Referral to Treatment**
- **Depression in Primary Care**
- **Integrated Primary Care Behavioral Health Management**
- **Pediatric Behavioral Health Management**

Learning opportunities

Visit **www.aetnaeducation.com**. Log in or registration may be required for some content.

New and updated courses for physicians, nurses and office staff

Courses:

New - 2015 Aetna Medicare Attestation
Updated - Advanced Illness and Compassionate Care

Reference tools:

New - How to use electronic referrals
New - Medicare compliance department policies
New - FDR Newsletter
Updated - Toolbox of resources for FDRs
Updated - Nonparticipating Aetna Medicare – PPO overview
Updated - Aexcel® reference tool
Updated - Aetna Signature Administrators® quick overview
Updated - Membership roster and capitation reports

Note these 2015 CMS compliance requirements

Through your Aetna and/or Coventry provider contract, you must meet Center for Medicare and Medicaid Services (CMS) compliance requirements for First Tier, Downstream or Related Entities (FDRs) on an annual basis. These program compliance requirements include:

- General compliance and fraud, waste and abuse (FWA)* training
- Code of conduct/compliance policies dissemination
- Exclusion list screenings
- Reporting mechanisms for potential FWA and compliance issues
- Offshore protected health information operation reporting
- Downstream entity oversight

Complete your FDR attestation

To avoid changes in participation status, an authorized representative of your organization must complete and submit your 2015 Medicare Attestation. You can submit your attestation within the Aetna Provider Education portal by following these steps:

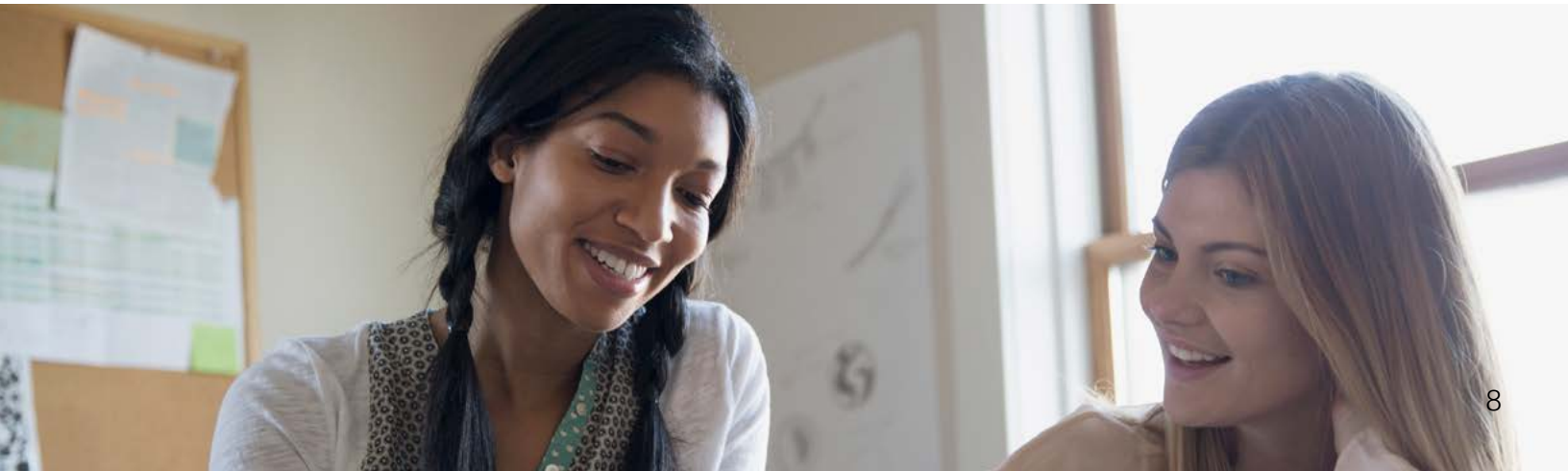
1. Log In or register at **www.aetnaeducation.com**.
2. Type "Attestation" in the search field and click "Go."
3. Select the "2015 Aetna Medicare Attestation" (required log in).

You only need to complete one attestation to meet both Aetna and Coventry compliance obligations.

Questions?

For more details on the FDR program compliance requirements, visit **www.aetnaeducation.com**. Then search "Attestation." Or, you can call our Provider Service Center at **1-800-624-0756**.

*Failure to meet the FDR compliance requirements annually may impact your participation status.



Our ICD-10 testing results are available

We've completed most of our targeted ICD-10 external testing. And we want to share our results with you.

We created four, brief recorded webinars on our **Education Site**. This is a great opportunity for you to hear and learn from our results, and review your own practices.

To hear the results:

- Go to **www.aetnaeducation.com**
- Type "Collaborative" and click "Go"
- Click "ICD-10 collaborative testing results"

Here's what you'll learn

The webinars cover:

- Aetna's approach to ICD-10 collaborative testing
- Aetna's ICD-10 collaborative inpatient testing results overview
- Aetna's ICD-10 collaborative inpatient testing results details
- Aetna's ICD-10 collaborative outpatient/professional testing results overview

We'll keep you informed of our future testing results.

Pharmacy

Save time: submit prior authorization requests online

Coming in 2015, you'll be able to submit electronic prior authorization (ePA) requests for certain specialty drugs on the Aetna's National Precertification List.

The best part? You can submit ePAs for both commercial and Medicare members. In the coming weeks, you'll receive more details on how to register for this new service.

Benefits of ePA

Through this online system, you can:

- Check your patient's benefit eligibility
- Complete a prior authorization and get a determination online without having to call or fax us
- Reduce the amount of time to submit and organize requests
- Get real-time auto-determinations for certain drugs
- Get faster approvals on drugs that meet clinical criteria

Compound medicines made with bulk ingredients aren't covered

We're reinforcing our current clinical policy bulletin (CPB) on **bulk ingredient containing compounds**.

The CPB states that we won't cover compounds made with bulk ingredients. The U.S. Food and Drug Administration hasn't approved bulk ingredients. This is because they're seen as pharmaceutical aids.

If you have patients using a compounded product made with bulk ingredients, we ask that you work with them to find another option.

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. To find them:

- 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**).

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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

Recognizing signs of gum disease can improve patient outcomes

Treating oral inflammation may not only help manage gum diseases, it may help manage other chronic inflammatory conditions as well.

That's why we want you to know about our Dental/Medical Integration (DMI) program. We offer it at no charge to all our members who have medical and dental plans.

This program targets members who haven't gone to the dentist recently and who have diabetes or cardiovascular disease, or who are pregnant. It offers education outreach and enhanced dental benefits. This includes an extra prophylaxis and periodontal services covered at 100 percent.

Fewer inpatient admissions

DMI members who began going to the dentist had improved outcomes. A recent study[1] of more than 200,000 DMI members showed that those receiving dental services had fewer inpatient admissions and emergency room visits.

It's important to refer patients for dental care if you find:

- Red, swollen or receding gums
- Persistent bad breath
- Loose teeth

[1]Ongoing, statistically-valid analysis of Aetna DMI customers. Aetna Informatics, 2014.

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