



Get knowing

Aetna OfficeLink Updates™ All regions

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Changes to our National Precertification List (NPL)

Note: We encourage you to submit precertification requests at least two weeks before the scheduled services.

Effective **June 1, 2018**, precertification is no longer required for the following home health care services for Medicare Advantage members:

- Home dialysis
- Home health aide or certified nursing assistant
- Home infusion/injectable therapy
- Home nursing care by a registered or licensed nurse
- Home physical/occupational, respiratory and speech therapy

Private duty nursing still requires precertification.

[continued >](#)



Effective **September 1, 2018**, precertification is required for Parsabiv™ (etelcalcetide).

The following new-to-market drugs require precertification effective **March 9, 2018**:

- Luxturna™ (voretigene neparvovec-rzyl) — precertification for both the drug and the site of care is required. This drug is included in the ophthalmic injectables drug class.

- Hemlibra® (emicizumab-kxwh) and Rebinyn®, Coagulation Factor IX (Recombinant), GlycoPEGylated — precertification for the drug and for outpatient infusion of this drug class is required. These drugs are included in the blood-clotting-factor drug class.

The following new-to-market drug requires precertification effective **May 1, 2018**:

- Ilumya™ (tildrakizumab) — this drug is included in the immunologic agent drug class.

You can find more information about precertification under the General Information section of the **NPL**.

New pre-approval requirements for Indiana, Illinois and Tennessee members

Starting **June 1, 2018**, our enhanced clinical review program is expanding with MedSolutions (doing business as eviCore healthcare). This includes **Indiana** members in our Medicare Advantage HMO/PPO Aetna-branded products, and **Illinois** and **Tennessee** members in our commercial and Medicare Advantage HMO/PPO Aetna-branded products.

Services that require pre-approval:

- High-tech outpatient diagnostic imaging procedures, including MRI/MRA, nuclear cardiology, PET scan and CT scan, and CTA
- Nonemergent outpatient stress echocardiography
- Nonemergent outpatient diagnostic left and right heart catheterization
- Insertion, removal and upgrade of elective implantable cardioverter defibrillator, cardiac resynchronization therapy defibrillator and implantable pacemaker
- Polysomnography (attended sleep studies)
- Interventional pain management
- Musculoskeletal large joint (hip and knee) arthroplasty procedures

Precertification won't be required for:

- Emergency departments
- Inpatient radiology services
- Outpatient radiology services other than those listed above

How to precertify



- Review eviCore criteria.
- Call eviCore at **1-888-693-3211**.



- Fax to **1-844-822-3862**.
- Go to **evicore.com**.



Be sure to call eviCore for approval of these services.

We're here to help



If you have questions about these changes, call eviCore at **1-888-693-3211**. Or call us at:

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

Total knee arthroplasty precertification updates

The Centers for Medicare & Medicaid Services (CMS) removed total knee arthroplasty (TKA) from the inpatient-only list on January 1, 2018. TKA is currently reported using the following Current Procedural Terminology® (CPT®) code:

- Code 27447: Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)

What this means

- You don't have to perform all procedures on an outpatient basis.

- We consider the information you share about the member's clinical circumstances, MCG® (Milliman Care Guidelines) and the member's benefits coverage when you request an inpatient precertification admission.
- When precertification is given through a vendor program, that information is shared with us. You don't have to contact us again for the inpatient precertification request.
- There may be cases when we request more clinical information in order to complete your inpatient precertification request.
- Elective inpatient admissions require precertification. See the **National Participating Provider Precertification List** (NPL).

You can also find more information about the precertification process under the General Information section of the **NPL**. If you have questions, call us using the precertification number listed on the member's ID card.

Clinical payment and coding policy changes



We regularly adjust our clinical payment and coding policy positions as part of our ongoing policy review processes. Our standard payment policies identify services that may be incidental to other services and, therefore, ineligible for payment. 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
Orthotic braces	September 1, 2018	We apply frequency edits for orthotic braces consistent with language found in our Orthopedic Casts, Braces and Splints Clinical Policy, CPB 0009 .
Genetic testing limits*	September 1, 2018	We will limit genetic testing codes to once per lifetime.
Expanding allergen immunotherapy limits*	September 1, 2018	We are expanding our allergy policy. We currently apply a frequency limit to CPT code 95165, allowing up to 150 units annually in the build-up phase and 90 units in the maintenance phase. We will now apply the same frequency limits for CPT codes 95120 and 95125. Also, we will allow 75 units annually in the build-up phase and 45 units in the maintenance phase for CPT code 95144. The frequency limits apply per code.
Deny venipuncture billed by labs*	September 1, 2018	We will deny venipuncture codes 36415 and 36416 when billed alone by a lab provider.

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

Current Procedural Terminology® (CPT®) codes added to Aetna Enhanced Grouper (AEG) and/or Coventry Enhanced Grouper (CEG) assignments

Individual service codes will be assigned within contract service groupings. Changes to an individual provider's compensation will depend on the presence or absence of specific service groupings within the contract. The changes are outlined below.

All updates will start on **September 1, 2018**, unless otherwise noted.

Codes	Provider types affected	What's changing
27447, 35231, 35236, 35256, 35261, 35266, 35286*	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Ambulatory Surgery — AEG: Category 6 (AEG6). Code will remain assigned to Ambulatory Surgery: Default Rate (DEFAULTSUR). <ul style="list-style-type: none"> • If the contract contains an Ambulatory Surgery — AEG: Category 6 rate, it will be applied; if not, then the Ambulatory Surgery: Default Rate will be applied.
27447*	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be reassigned to CEG: Category 6. <ul style="list-style-type: none"> • If the contract contains an Ambulatory Surgery — CEG: Category 6 rate, it will be applied; if not, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.
43282, 55866*	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Ambulatory Surgery — AEG: Category 5 (AEG5). Code will remain assigned to Laparoscopic Procedures (LAPARO) and Ambulatory Surgery: Default Rate (DEFAULTSUR). <ul style="list-style-type: none"> • If the contract contains a Laparoscopic Procedure rate, there will be no change. • If the contract does not contain a Laparoscopic rate but has an Ambulatory Surgery — AEG: Category 5 rate, then the Ambulatory Surgery — AEG: Category 5 rate will be applied. • If the contract contains neither a Laparoscopic rate nor an Ambulatory Surgery — AEG: Category 5 rate, the Ambulatory Surgery: Default Rate will apply.
57120*	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be assigned to Ambulatory Surgery — AEG: Category 5 (AEG5). Code will remain assigned to Ambulatory Surgery: Default Rate (DEFAULTSUR). <ul style="list-style-type: none"> • If the contract contains an Ambulatory Surgery — AEG: Category 5 rate, it will be applied; if not, then the Ambulatory Surgery: Default Rate will be applied.

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

Codes	Provider types affected	What's changing
57426*	Facilities including acute short-term hospitals and ambulatory surgery centers	<p>Will be assigned to Ambulatory Surgery — AEG: Category 5 (AEG5) as well as Laparoscopic Procedures (LAPARO) Service category.</p> <p>Code will remain assigned to Ambulatory Surgery: Default Rate (DEFAULTSUR).</p> <ul style="list-style-type: none"> • If the contract contains a Laparoscopic Procedure rate, the Laparoscopic Procedure rate will apply. • If the contract does not contain a Laparoscopic rate but has an Ambulatory Surgery — AEG: Category 5 rate, then the Ambulatory Surgery — AEG: Category 5 rate will be applied. • If the contract contains neither a Laparoscopic rate nor an Ambulatory Surgery — AEG: Category 5 rate, the Ambulatory Surgery: Default Rate will apply.
27477, 27485, 35201, 43130*	Facilities including acute short-term hospitals and ambulatory surgery centers	<p>Will be assigned to Ambulatory Surgery — AEG: Category 5 (AEG5).</p> <p>Code will remain assigned to Ambulatory Surgery: Default Rate (DEFAULTSUR).</p> <ul style="list-style-type: none"> • If the contract contains an Ambulatory Surgery — AEG: Category 5 rate, it will be applied; if not, then the Ambulatory Surgery: Default Rate will be applied.
27477, 27485, 43282, 55866*	Facilities including acute short-term hospitals and ambulatory surgery centers	<p>Will be reassigned to CEG: Category 5.</p> <ul style="list-style-type: none"> • If the contract contains an Ambulatory Surgery — CEG: Category 5 rate, it will be applied; if not, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.
31587, 35206, 35226, 36595*	Facilities including acute short-term hospitals and ambulatory surgery centers	<p>Will be assigned to Ambulatory Surgery — AEG: Category 4 (AEG4).</p> <p>Code will remain assigned to Ambulatory Surgery: Default Rate (DEFAULTSUR).</p> <ul style="list-style-type: none"> • If the contract contains an Ambulatory Surgery — AEG: Category 4 rate, it will be applied; if not, then the Ambulatory Surgery: Default Rate will be applied.
31587*	Facilities including acute short-term hospitals and ambulatory surgery centers	<p>Will be reassigned to CEG: Category 4.</p> <ul style="list-style-type: none"> • If the contract contains an Ambulatory Surgery — CEG: Category 4 rate, it will be applied; if not, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.
0312T*	Facilities including acute short-term hospitals and ambulatory surgery centers	<p>Will be assigned to Ambulatory Surgery — AEG: Category 3 (AEG3).</p> <p>Code will remain assigned to Laparoscopic Procedures (LAPARO) and Ambulatory Surgery: Default Rate (DEFAULTSUR).</p> <ul style="list-style-type: none"> • If the contract contains a Laparoscopic Procedure rate, there will be no change. • If the contract does not contain a Laparoscopic rate but has an Ambulatory Surgery — AEG: Category 3 rate, then the Ambulatory Surgery — AEG: Category 3 rate will be applied. <p>If the contract contains neither a Laparoscopic rate nor an Ambulatory Surgery — AEG: Category 3 rate, the Ambulatory Surgery: Default Rate will apply.</p>

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

Codes	Provider types affected	What's changing
0312T*	Facilities including acute short-term hospitals and ambulatory surgery centers	<p>Will be assigned to CEG: Category 3.</p> <ul style="list-style-type: none"> • If the contract contains an Ambulatory Surgery — CEG: Category 3 rate, it will be applied; if not, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.
37761*		<p>Will be assigned to Ambulatory Surgery — AEG: Category 3 (AEG3). Code will remain assigned to Ambulatory Surgery: Default Rate (DEFAULTSUR).</p> <ul style="list-style-type: none"> • If the contract contains an Ambulatory Surgery — AEG: Category 3 rate, it will be applied; if not, then the Ambulatory Surgery: Default Rate will be applied.
20936, 20937, 20938, 22552, 22840, 22842, 22845, 32553, 36596, 63043, 63044, G0104*	Facilities including acute short-term hospitals and ambulatory surgery centers	<p>Will be assigned to Ambulatory Surgery — AEG: Category 1 (AEG1). Code will remain assigned to Ambulatory Surgery: Default Rate (DEFAULTSUR).</p> <ul style="list-style-type: none"> • If the contract contains an Ambulatory Surgery — AEG: Category 1 rate, it will be applied; if not, then the Ambulatory Surgery: Default Rate will be applied.
20936, 20937, 20938, 22552, 22840, 22842, 22845, 63043, 63044*	Facilities including acute short-term hospitals and ambulatory surgery centers	<p>Will be reassigned to CEG: Category 1.</p> <ul style="list-style-type: none"> • If the contract contains an Ambulatory Surgery — CEG: Category 1 rate, it will be applied; if not, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.
46083, 64416, 65435, 68440*	Facilities including acute short-term hospitals and ambulatory surgery centers	<p>Will be assigned to Ambulatory Surgery — AEG: Category 1 (AEG1). Code will remain assigned to Minor Surgery: All Surgery (MINSURDEF); Minor Surgery: Medicare Groupers (MINSURMED); Minor Surgery: Medicare Groupers w/Endo (MINSURMENDO); and Ambulatory Surgery: Default Rate (DEFAULTSUR).</p> <ul style="list-style-type: none"> • If the contract contains any of the following rates: Minor Surgery: All Surgery; Minor Surgery: Medicare Groupers; or Minor Surgery: Medicare Groupers w/Endo, there will be no change. • If contract does not contain any of the above Minor Surgery rates but does contain an Ambulatory Surgery — AEG: Category 1 rate, then the Ambulatory Surgery — AEG: Category 1 rate will be applied. • If the contract contains none of the Minor Surgery rates and no Ambulatory Surgery — AEG: Category 1 rate, the Ambulatory Surgery: Default Rate will apply.
64416*	Facilities including acute short-term hospitals and ambulatory surgery centers	<p>Will be assigned to CEG: Category 1.</p> <ul style="list-style-type: none"> • If the contract contains an Ambulatory Surgery — CEG: Category 1 rate, it will be applied; if not, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.

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Enhanced claims editing processes

Our claims system edits complex claim scenarios to make sure coding and modifier usage is in line with industry guidelines. For example, we evaluate appropriate utilization of separate and distinct services. When appropriate, we manually evaluate claims against these guidelines.

We use internal coding guidelines as well as:

- The Centers for Medicare & Medicaid Services medical coverage, payment and coding policies
- The American Medical Association Current Procedural Terminology (CPT®) coding standards
- Evidence-based guidelines from nationally recognized professional health care organizations and public health agencies

Office news

Our office manual keeps you informed

Our Office Manual for Health Care Professionals is available on our website. For Innovation Health, once on the website and logged in, select “Physicians & Providers,” then “Practice Resources.”

Visit us online to view a copy of your manual as well as information on the following:

- Our adopted clinical practice guidelines and preventive services guidelines, which address preventive, acute and chronic medical and behavioral health services. Find them on our **provider website**. Once logged in, select “Clinical Resources” from Aetna Support Center.
- Policies and procedures
- Patient management and acute care
- Our complex case management program, including how to refer members
- How to use disease management services and how we work with your patients in the programs
- Special member programs and resources, including the Aetna Women’s HealthSM program, the Aetna Compassionate CareSM program and others
- Member rights and responsibilities
- How we make utilization management decisions, including our policy against financial compensation for denials of coverage

- Medical records criteria — a detailed list of elements we require in a patient’s medical record
- The most up-to-date **Aetna Medicare Preferred Drug Lists**, **Commercial (non-Medicare) Preferred Drug Lists** and the **Consumer Business Preferred Drug List**, also known as our formularies
- How our quality management program can help you and your patients

We integrate quality management and metrics into all that we do. You can find details on the program goals and the progress made toward those goals online.

If you don’t have Internet access, call our Provider Service Center for a paper copy of the manual.

The appeals address for commercial Coventry plans has changed

We’d like to remind office staff that “PO Box 981119, El Paso, TX 79998” is no longer an active address for commercial Coventry plans. The change was effective as of February 2, 2018. Instead, you should send all appeals to the address on the back on the member’s identification card.



Help improve communication between treating providers

Primary care physicians (PCPs) are concerned because they're not getting regular reports about their patients' care from other treating providers. That's according to a recent survey we did assessing our interaction with primary care practices.

This lack of communication can pose a threat to patient care. Coordinating care with various physicians, facilities and behavioral health care professionals can be a challenge. And we appreciate your efforts to improve communication.



Use our tools to share information

To help ensure comprehensive care, it's critical that PCPs and specialists talk openly with each other. Here are some tools, available on [aetna.com](https://www.aetna.com) (Health Care Professionals > Forms > Physician Communications), that may help providers communicate better:

- [Behavioral Health/Medical Provider Communication form](#)
- [Behavioral Health Sample Initial Evaluation form](#)
- [Dilated Retinal Eye examination report form](#)
- [Physician Communication form](#)
- [Physician Communication Post-Fragility Fracture Care form](#)
- [Specialist Consultant report](#)

About the survey

Each year, we survey our primary care practices to get a better understanding of their views on key interactions with us. We use the Center for the Study of Services (CSS), a third-party vendor, to administer the surveys. The center does the surveys at market levels accredited by the National Committee for Quality Assurance.

NaviNet[®], our provider website, provides you with the member information you need

We offer you a wide variety of tools to help you get the information you need. To visit our website, go to [aetna.com/provider](https://www.aetna.com/provider) and log in.

Eligibility information

Many members have high-deductible plans. These plans have health reimbursement arrangements (HRAs) and health savings accounts (HSAs). Use the Eligibility and Benefits inquiry transaction to get member-specific plan details such as:

- Copay, deductible and coinsurance amounts
- Exclusions and limitations
- Visits used and visits remaining
- Referral and precertification requirements

Checking this information up front will help our members get care when they need it. You can search using the patient's last name, first name and date of birth if you don't have the member ID number.

Find out more about using NaviNet in our [Aetna at a Glance guide](#). Or register for a free webinar.

Webinar: Working with Aetna on NaviNet

This webinar is great for anyone who is just getting started. We discuss most tools and transactions available on our provider website. The webinar is offered on the fourth Tuesday of every month at 2 p.m. ET.

For more information, go to [aetnawebinars.com](https://www.aetnawebinars.com).

Make sure your demographic information is valid

The Centers for Medicare & Medicaid Services (CMS) requires that Medicare Advantage (MA) organizations ensure the validity of provider demographic information.

We need to reach out to providers every quarter to validate their information. Our current vendors — the Council for Affordable Quality Healthcare® (CAQH®) and Availity® — perform this outreach. And you are obligated, as an MA provider, to comply with this validation.

Have you recently moved your office or changed your phone number, email address or any other demographic

information? If so, simply go to our vendors' websites and update your profile within seven days of the change. Don't wait for the quarterly attestation process, and don't call or fax the information to Aetna. We'll get the update from the vendors and process it.

If you're not a Medicare provider or if you have not received vendor communications, you can always go to NaviNet®, our provider website. NaviNet users have access to Aetna's "Update Provider Demographics" function, through which they can submit demographic changes.



We take this compliance obligation seriously. If you don't reply, we will *suppress your information* in our directory. This means that patients and providers won't see you listed as our participating provider. And we may even terminate the participation of providers that don't comply.



Reminder: Banner|Aetna Home Care program

As you may know, Banner|Aetna is owned by Aetna and Banner Health. Banner|Aetna plans are available to employer groups in Arizona.

Members can now benefit from a streamlined health care experience and more coordinated care among providers.

Home care services for Banner|Aetna members

Since March 1, 2018, Banner Home Care (or one of its subcontracted network providers) has provided home care services, including:

- Home health services
- Home infusion services
- Durable medical equipment (DME)
- Orthotics & prosthetic (O&P) devices

Accessing these services

Members, or their referring providers, can call one of the phone numbers listed on **on the following page**.

If a service or item requires precertification, Banner Home Care will get it from Aetna on behalf of the provider.

Services excluded from the program

- Cardiac monitoring devices
- Chemotherapy infusion pumps
- Diabetic pumps and supplies
- Hearing aids
- Speech generating devices
- Eye prosthesis

Banner|Aetna members can get these supplies from any participating provider under their plan.

continued >

Learn more

- Visit the [Banner|Aetna website](#).
- Navigate to our provider website:
 - Go to [NaviNet®](#).
 - Click on the sign-in button at the top left.
 - Enter provider credentials.
 - Select the Banner|Aetna plan view.



Type of service needed	Banner infusion	Banner DME	Banner Home Care
	<i>Last names ending in</i>		
	A – G: 480-657-1155	480-657-1600	480-657-1000
	H – N: 480-657-1156		
O – Z: 480-657-1206			
Weekends	480-657-1155		
After hours	480-657-1000	480-657-1000	480-657-1000
Fax	480-657-1782	480-403-4114	

Help members understand coverage of certain lab tests by consulting our Clinical Policy Bulletins (CPBs)

Not all lab tests are covered by Aetna. Your Aetna patients are financially responsible for medical tests their plan does not cover. So it's important that you let them know if tests you recommend may not be covered by their plan. We want to ensure that our members receive their highest level of benefits when accessing lab services.

H. pylori testing

For example, we consider the H. pylori serology test to be experimental and investigational because of its inadequate performance. But the urea breath and stool antigen test would be covered for members who meet the criteria in our CPB.

Your Aetna member's tests are covered at the network rate when they are done by Quest Diagnostics. Quest's test codes for H. pylori are shown to the right.

For additional information about Quest's H. pylori tests, go to Quest's [H. pylori test center page](#).

Test codes

Helicobacter pylori antigen

EIA, Stool
Test code 34838

Helicobacter pylori

Urea Breath Test
Test code 14839

Helicobacter pylori

Urea Breath Test, Pediatric
Test code 92491

Behavioral health



Refer patients to our Complex Case Management program

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

Our Complex Case Management program is a joint process including Aetna, the member, the caregiver and the providers. Our goal is to produce better health outcomes while managing health care costs.

Referral sources

We receive referrals for the program from many sources. These include:

- Primary care physicians
- Specialists
- Family members
- Internal departments
- The member's employer

You can submit a referral by calling us at **1-800-424-4660**.

Antidepressant medicine adherence

When patients follow their medicine program, depression is a very treatable condition. You can help increase adherence by educating your patients as soon as treatment starts.

Talk with your patients about:

- How antidepressants work
- The benefits of antidepressant treatment
- Expectations about symptom remission
- How long antidepressants should be used
- Coping with side effects

Ask your patients to:

- Tell you about their medical conditions and the medicines they're taking. These include over-the-counter drugs, herbs and supplements
- Talk to you about any side effects or about how the medicine makes them feel
- Schedule regular follow-up visits to see if the medicine is working
- Expect that they may need to try different medicines before finding which one works best
- Keep taking their medicine as prescribed for at least six months after they feel better

- Go to scriptyourfuture.com to take the "med pledge," sign up for reminders and learn more about managing their medicine
- Learn more about [depression and resources](#)

How to monitor adherence

The National Committee for Quality Assurance (NCQA) reports that you should monitor the percentage of patients who stay on their antidepressant medicine for at least three months and again at six months.



Depression in Primary Care program

Depression often coexists with other serious medical illnesses, such as:

- Heart disease
- Stroke
- Cancer
- HIV/AIDS
- Diabetes
- Parkinson's disease

Many people don't seek treatment due to the stigma linked with depression. Too often, those treated don't receive appropriate or continued treatment.

About the program

Our Depression in Primary Care program supports the screening and treatment for depression at the primary care level. Our program offers your primary care practice:

- A tool to screen for depression and monitor response to treatment

- A patient health questionnaire (PHQ-9) for use specifically in primary care
- Reimbursement for depression screening (with PHQ-9) and follow-up monitoring

Participation guidelines

- You must be a participating primary care provider or specialty physician, like an OB/GYN physician or internal medicine physician.
- You must use the PHQ-9 tool to screen patients.
- You must submit claims using the following billing codes:
 - CPT code 96127 (brief emotional/behavioral assessment) in conjunction with
 - Diagnosis code Z13.89 (screening for depression)
- Learn more on the [**Depression in Primary Care program website**](#).

Medicare

Don't let your network status change — complete your FDR attestation today

If you are a participating provider in our Medicare plans and/or our Medicare-Medicaid plans (MMPs), you must meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related (FDR) entities. You also have to confirm your compliance with these requirements through an annual attestation.

How to complete your attestation

You'll find the resources you need to ensure your compliance on the [**Medicare Compliance Attestation page**](#) of [**aetna.com**](https://www.aetna.com). Once on the page, click "See Our Medicare Compliance FDR Program Guide" or "See Our Office Manual" under "Need More Information."

Once you review the information and ensure that you've met the requirements, you're ready to complete your attestation. Simply click the link on the Medicare Compliance Attestation page that corresponds to your contracting status. A single annual attestation meets all your Aetna, Coventry and/or MMP compliance obligations.

Where to get more information

If you have compliance-related questions not addressed in our guide, just call us at **1-800-624-0756**. If you're an MMP-only provider, you can email us at [**medicaidmmpfdr@aetna.com**](mailto:medicaidmmpfdr@aetna.com). You'll find more information in our quarterly [**FDR Compliance Newsletter**](#), too.

Help is available if you're having issues with the new Medicare cards

The Centers for Medicare & Medicaid Services (CMS) began mailing new Medicare ID cards with a new Medicare number in April 2018. The mailings will be staggered, with completion expected by April 2019. The new Medicare number will take the place of the HICN on Medicare cards. The new Medicare number won't change Medicare benefits. Once Medicare members get their new card, they should destroy their old card and start using the new card right away.

If you're having trouble with the new Medicare cards, CMS can help. Their provider ombudsman can assist you if your office is having implementation issues. Contact **Dr. Eugene Freund** to communicate any problems you're having with the new Medicare cards. He'll send you information about the new cards and work inside CMS to settle any implementation problems.

Access your Medicare Administrator Contractor (MAC) provider portal

Do you have access to your MAC provider portal? If not, **sign up** so you can use the provider Medicare Beneficiary Identifier (MBI) look-up tool starting in June 2018. If you're not sure if you have access, check with your billing/administrative staff. They may already have portal access.

Balance billing of Qualified Medicare Beneficiary (QMB) individuals is prohibited

The QMB program is a Medicaid program for Medicare beneficiaries. QMB individuals cannot be charged for Medicare cost sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. But federal law allows states to limit provider reimbursement for Medicare cost sharing under certain circumstances. Dually eligible individuals may qualify for Medicaid programs that pay Medicare Part A and B premiums, deductibles, coinsurance and copays to the extent provided by the state Medicaid plan.

Medicare providers **must** accept the Medicare payment and Medicaid payment (if any) as payment in full for services to a QMB individual. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions.

Clarifications about balance billing

Be aware of these policy clarifications to help ensure compliance with QMB balance billing requirements:

- All Original Medicare and Medicare Advantage providers — not just those that accept Medicaid — must abide by the balance-billing prohibitions.
- QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers can't charge QMB individuals even if their QMB benefit is provided by a state that is different from the one where care is received.

More information

For more information about dual eligible categories and benefits, visit CMS's **[Medicare-Medicaid general information website](#)**. For more on the QMB program and other individuals dually eligible for Medicare and Medicaid benefits, see the Medicare Learning Network® publication **[Dual Eligible Beneficiaries Under Medicare and Medicaid](#)**.



Pharmacy

Important pharmacy updates

Medicare

Visit our [Check Our Medicare Drug List page](#) to view the most current Medicare plan formularies (drug lists), which we update at least annually.

Commercial — notice of changes to prior authorization requirements

Visit our [Formularies & Pharmacy Clinical Policy Bulletins page](#) to view:

- Commercial pharmacy plan drug guides with new-to-market drugs that we add monthly
- Clinical Policy Bulletins with most current prior authorization requirements for each drug



Formulary information at your fingertips

Want to select a preferred drug for your patient from your cell phone? It's fast and easy. You can access our commercial formulary on your mobile devices. Just go to the Google Play™ store and type in "formulary search" — then download the Formulary Search app for free.

You can also search at formularylookup.com. Enter the drug name, state and channel (plan type). Then, under "Payer/PBM," select "Aetna Inc." to view the drug coverage information. At the bottom of the page, you can also select "Download on the App Store" to access this information on your phone.

Changes to commercial drug lists begin on October 1, 2018

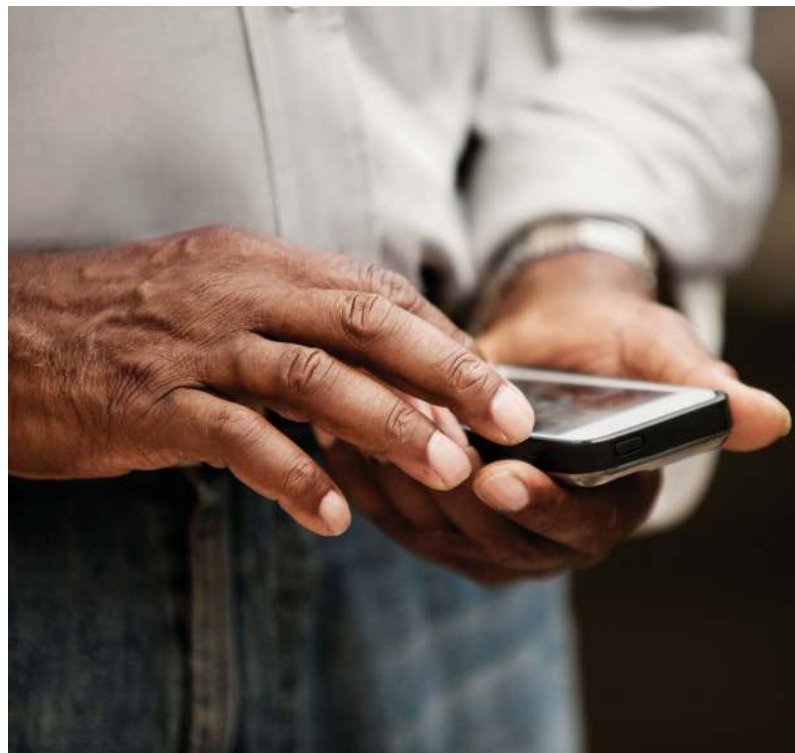
On **October 1, 2018**, updates will be made to our pharmacy plan drug lists. But as early as **July 1, 2018**, you can view the list of upcoming changes on our [Formularies & Pharmacy Clinical Policy Bulletins page](#). Note that the Aetna Standard Plan drug list will be updated on October 1, 2018.

Ways to request a drug prior authorization:

- Submit your completed request form through our [provider website](#).
- Fax your completed [prior authorization request form](#) to **1-877-269-9916**.
- Call the Aetna Pharmacy Precertification Unit at **1-855-240-0535**.

These changes will affect all Pharmacy Management drug lists, precertification, quantity limits and step-therapy programs.

For more information, call the Aetna Pharmacy Management Provider Help Line at **1-800-238-6279 (1-800-AETNA-RX)**.



State-specific articles

California



How to access your fee schedule

In accordance with the regulations issued pursuant to the Claims Settlement Practices and Dispute Mechanism Act of 2000 (CA AB1455 for HMO) and to the expansion of the Health Care Providers Bill of Rights (under CA SB 634 for indemnity and PPO products), we're providing you with information about how to access your fee schedule.

- If you're affiliated with an Independent Practice Association (IPA), contact your IPA for a copy of your fee schedule.
- If you're directly contracted with Aetna, you can call our Provider Service Center for help with up to ten Current Procedural Terminology® (CPT®) codes. For requests of eleven or more codes, you can enter the codes on an Excel spreadsheet (include tax ID, contact telephone number, CPT codes and modifier) and email them to us at feeschedule@aetna.com.
- If your hospital is reimbursed through Medicare Groupers, visit the [Medicare website](#) for your fee schedule information.

Colorado



Notice of material change to contract

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

- Clinical payment and coding policy changes — [page 3](#)
- Note these upcoming service code changes — [pages 4 - 5](#)

Connecticut



Adding handicap accessibility details to provider directories

We must now indicate in our provider directories if a medical office or facility is handicapped accessible. When you submit a request to add or change a service location, you must also tell us if it is handicap accessible.

There are two ways to submit these requests:

- Through NaviNet, our provider website
- By calling our Provider Service Center:
 - HMO-based Medicare Advantage — **1-800-624-0756**
 - All other plans — **1-888-632-3862**

New Jersey



Where to find our appeal process forms

We have updated the information about internal and external [provider appeal processes](#) on our public website.

If you use the [NJ Health Care Provider Application to Appeal a Claims Determination form](#) when submitting certain claims appeals, you should make sure your claim is eligible. You can find this form and the correct procedures on our public website.

North Carolina

Aetna Whole HealthSM is growing in North Carolina

We're expanding

The Aetna Whole HealthSM Duke Health & WakeMed product continues to grow.

Starting June 1, 2018, we're expanding the network into Caswell, Guilford, Randolph and Rockingham counties.



Welcome THN-Cone Health providers

We're adding the THN-Cone Health providers to the network. These include the Moses H. Cone Memorial Hospital, Wesley Long Hospital, Women's Hospital, Annie Penn Hospital and Behavioral Health Hospital. Plus, the affiliated Triad HealthCare Network providers are part of the network.

A new name

The name is changing to Duke Health, WakeMed & THN-Cone Health.

Quick reference guide

The **reference guide** includes important information about:

- How benefits plans are structured
- Sample member ID cards
- How to identify Tier 1 (designated) providers in the plan network

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