



Up on news

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 **July 13, 2018**, the following new-to-market drug requires precertification:

- Crysvida® (burosumab) — precertification for both the drug and the site of care is required.

Effective **November 1, 2018**, precertification is required for endoscopic nasal balloon dilation.

continued



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Effective **January 1, 2019**, precertification is required for the following:

- Decompression surgery for Chiari malformation
- Laminectomy with rhizotomy
- Shoulder arthroplasty
- Site of Care for Actemra IV® (tocilizumab), Entyvio® (vedolizumab), Orenicia® (abatacept) and Simponi Aria® (golimumab)

Effective **January 1, 2019**, precertification is not required for the following:

- Actimmune® (interferon gamma-1b)
- Gastrointestinal (GI) tract imaging through capsule endoscopy
- Temodar® (temozolomide)
- Xeloda® (capecitabine)
- Zaltrap® (ziv-aflibercept)

Effective **January 1, 2019**, we'll discontinue the pediatric congenital heart surgery steerage program. All inpatient admissions will continue to require precertification.

Again, we encourage you to submit precertification requests at least two weeks before the scheduled services. To save time, request precertification electronically — it's fast, secure and simple! Most precertification requests can be submitted electronically through the provider website or by using your Electronic Medical Record (EMR) system portal.

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

Submit your precertification clinical information online



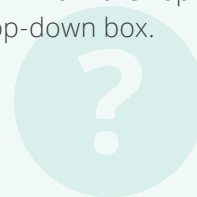
If a precert request is pending for more information, you can send us your supporting information electronically. Use our provider website, NaviNet®, even if you submitted the request on another website or called it in. You can also upload information on open, concurrent review cases.

Getting started

1. **Register for NaviNet.**
2. **Log in to NaviNet.** Find out more about your existing precert request using "Precertification Inquiry" or "Precertification Status Updates." Then upload your information using the "Add Attachment" link.
3. For a new request, use "Precertification Submission." If your new request is pending, you can still upload your clinical information.

Questions?

- Visit NaviNet for step-by-step **Precertification Requests directions.**
- We also offer live **webinars** to teach you how to use this feature.
- You can **email us for help.** Select "Online Precertification" from the Topic of Question/Comment drop-down box.



Coming soon

Later this year, we'll roll out the ability to edit or cancel a precert request online. You'll also be able to include start and end dates on initial requests. Stay tuned!

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
Correct coding of hospital observation, critical care, admission and discharge services*	December 1, 2017	Last September, we said that we would limit coverage for hospital professional services to once per day, per patient across all providers. We updated this policy to exclude hospital admission services (99221-99223) for nonparticipating or participating providers for our Medicare Advantage plans. This policy, including the changes we made, became effective December 1, 2017.
Perfusionist services	December 1, 2018	We do not pay for perfusionist services when billed by an agency or individual. The perfusionist must look to the hospital for reimbursement when they provide services to a patient for inpatient or outpatient services. We pay the hospital for the technicians responsible for assembly and operation of pumps with an oxygenator or heat exchanger.
Expanded claims edits*	December 1, 2018	We told you in December 2017 and June 2018 that we expanded our claims editing capabilities by adding new third-party claims edits. We are adding more edits effective December 1, 2018. To view these edits, check our provider website for information. You'll have access to a new prospective claims editing disclosure tool available on our provider website. After you log in, go to Plan Central > Aetna Claims Policy Information > Policy Information > Expanded Claims to find out if our new claims edits will apply to your claim.
Syringe with unlisted dialysis procedure	December 1, 2018	We will no longer allow payment for Healthcare Common Procedure Coding System (HCPCS) code A4657 when billed with unlisted dialysis procedure code 90999.
Electrodes frequency limit	December 1, 2018	We will allow 48 units/pairs of HCPCS code A4556 per year.

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

Enhanced claims editing processes

Our claims system edits complex claim scenarios to make sure coding and modifier usage aligns with industry guidelines. For example, we evaluate appropriate utilization of separate and distinct service modifiers as well as other separately identifiable evaluation and management modifiers. 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

Certain physical medicine services require prior authorization

Starting September 1, 2018, National Imaging Associates, Inc. (NIA) will authorize physical therapy, occupational therapy and chiropractic services in **Pennsylvania, Delaware, West Virginia and New York**. The program affects noncapitated members in our fully insured HMO/PPO commercial plans and Medicare plans.

Services that require preapproval

- Physical therapy services performed by any provider
- Occupational therapy services performed by any provider
- Chiropractic services performed by any provider

For a complete list of procedures requiring an authorization, visit [NIA](#).

The NIA program doesn't apply to services performed in certain places, including therapy provided in an inpatient, home, urgent care or emergent care setting.

What you should know about the process

- Authorizations will include the approved date span and one or more Current Procedural Terminology (CPT®) codes.
- If more services outside of an existing authorization are required or if different codes are needed, you must contact NIA for review and approval before submitting claims.
- If you perform services without approval, we may deny payment. Please don't ask members for payment, as outlined in your agreement with us.
- We have ultimate responsibility for and control over all coverage policies and procedures. We'll continue to pay claims for these procedures based on the terms of your agreement with us.

Have questions or need information?

Visit [NIA](#) or call them at **1-866-842-1542**.

Aetna claims, benefits and eligibility questions

HMO and Medicare Advantage
1-800-624-0756

All other plans
1-888-632-3862

Coventry claims, benefits and eligibility questions

Commercial plans in Eastern PA
1-800-788-8445

Advantra products in Eastern PA
1-800-290-0190

Advantra products in West Virginia
1-888-365-6052

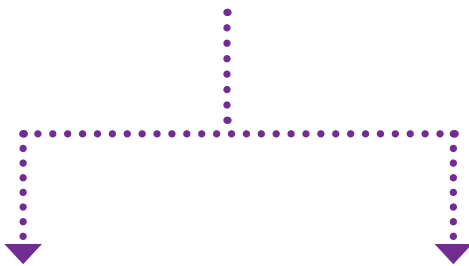
Office news

Coventry to have a new name/logo soon

As you know, Coventry and Aetna have been the same company since 2013.

As part of the rebranding, you or your patients may start seeing the new logos shown below. To avoid confusion, we're informing members about this change.

Old



aetna[®]
COVENTRY[®]

OR

aetna[®]

New

ID cards

We've also redesigned ID cards for more clarity. Refer to the [ID card reference guide](#) we've created for your office staff.

Our relationship with you

Our relationship with you and your patients will remain the same. Also, our contract agreements are not impacted by the name/logo change.

We're here for you

Questions? Just give us a call using the number on the member's ID card.

Aetna[®] Premier Care Network and Aetna[®] Premier Care Network Plus

Aetna Premier Care Network (APCN) is a performance network for businesses with employees in locations across the country. With this network, employers can offer a single benefits design and simplified communications to all employees, regardless of their location.

Aetna Premier Care Network Plus (APCN Plus) includes a combination of performance networks across the country but also includes Accountable Care Organizations (ACOs) and joint ventures (JVs) in certain areas. Members in these networks will have APCN Plus and the name of the ACO/JV on their ID card for identification.

Open enrollment is coming

Many of your existing patients will be participating in open enrollment and selecting a new medical plan. If your patient selects APCN or APCN Plus, it's important to know your network participation status. Many of these networks have fewer providers than our regular networks do based on our quality and efficiency designation process. You should check not only your own status but also the status of providers you refer your patients to.

Check your status

Starting in October, you can check our [online provider referral directory](#) at [aetna.com](#) to see if you're participating in our networks for 2019. If you're added to or terminated from the APCN or APCN Plus network, you'll receive a letter or email from us with your participation status. If you've participated in APCN or APCN Plus before and you do not receive a letter, then your participation status has not changed.

If you have questions, call us at **1-888-632-3862**. Or ask via our [provider website](#).

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:

- 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
- The MR-A (Medical Record Criteria, Element A) list, which is a detailed list of elements we require to be documented in a patient’s medical record — it’s available in the **Office Manual for Health Care Professionals** on our website
- The most up-to-date **Aetna Medicare Preferred Drug Lists**, **Commercial (non-Medicare) Preferred Drug Lists** and **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.

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. Visit **our website** 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**.

Submitting claims for Aetna Signature Administrators® (ASA) plan

Recognizing an ASA member

An ASA member ID card generally has two logos:

- The payer's logo
- The Aetna Signature Administrators logo:

Aetna Signature Administrators®

Send claims to the correct payer

Send ASA claims to the payer — you'll find the payer ID (for electronic claims) and address (for paper claims) on the back of the member's ID card.

If an ASA member uses a transplant facility in our Institutes of Excellence™ network, the facility will use the Special Case Customer Service Unit for submitting claims.

Additional support

You can direct your questions to the appropriate payer on the ID card. The payer will contact us if needed.

For more information about ASA, see our [ASA flyer](#).

A new way to access our payer partner Continental

Our payer partner Continental has a new way to check eligibility and verify benefits. Simply visit [their new web portal](#). Then go to the Providers tab on the left and click on the "Verify Eligibility" button.

If you need to check claims status or precert authorizations or if you need to view patient accumulators, just request access to the web portal via the "Request Access" button. Once you submit the online form, they'll send authorization documents to you. Please make sure they can verify your email, fax numbers and other general office information online. This will help them reply to your request quickly. They'll provide your user credentials once they process the forms.

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.

New statistics on the national prevalence of ADHD and treatment

A large number of children and teens are diagnosed with attention-deficit/hyperactivity disorder (ADHD) each year. It's important for our providers to monitor and treat this condition according to evidence-based guidelines. We've adopted the **American Academy of Pediatrics (AAP) clinical practice guidelines** for the diagnosis, evaluation and treatment of ADHD in children and teens.

The guidelines recommend that children treated with ADHD medicine have a follow-up visit within 30 days of the first prescription fill and two more follow-up visits within 9 months of the initial visit. These visits should be with a prescribing provider. One of these visits can be a telephone or televideo visit.

Many children with ADHD aren't getting needed care

A 2018 **Journal of Clinical Child & Adolescent Psychology study** found that in the United States, about 6.1 million children from ages 2 to 17 were diagnosed with ADHD in 2016. About 30 percent were not taking their medicine. Almost half had not received any behavioral health treatment. Many also had a co-occurring disorder.

Help kids get the treatment they need

- **Caring for Children with ADHD: A Resource Toolkit for Clinicians**
- **The Centers for Disease Control and Prevention (CDC) ADHD data and statistics page**
- **CDC ADHD resources**



Help your patients reduce the risk of heart disease and stroke

We support the Million Hearts® national initiative co-led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services. The goal of the program is to prevent one million heart attacks and strokes by 2022.

The **Million Hearts website** offers free tools and educational materials you can use to help your patients:

- Manage their high blood pressure and cholesterol
- Control their risk factors for heart disease and stroke
- Lead heart-healthy lives

We offer programs and resources that can help your Aetna® patients reduce their risk of heart disease and stroke:

- Our case management program works with you and your Aetna patients to help them get well and stay healthy.
- Our disease management program can help your Aetna patients learn to manage chronic health conditions and achieve an optimal state of health.
- Our Numbers To Know® initiative promotes the benefits of blood pressure and cholesterol monitoring. Aetna patients diagnosed with high blood pressure are encouraged to work with you to develop a treatment plan that is right for them.

For healthy living information for your Aetna patients, go to the Individuals section on **[aetna.com](https://www.aetna.com)**.



Advise your patients about the Centers for Disease Control and Prevention (CDC) immunization schedules



The CDC's Advisory Committee on Immunization Practices (ACIP) provides immunization schedule recommendations in the United States. Below are links to their immunization schedules. We encourage you to educate your patients about the importance of immunizations and share these schedules with them.

- [Infants and children \(birth through 6 years\)](#)
- [Preteens and teens \(7 through 18 years\)](#)
- [Adults ages 19 and older](#)

New/updated recommendations and clarifications

Changes in the 2018 immunization schedules for children and adolescents ages 18 and younger include new or revised ACIP recommendations for the following:

Polio vaccine

- Clarification of catch-up recommendations for children ages 4 and older

Measles, mumps and rubella vaccines

- Updated to include guidance regarding the use of a third dose of mumps-containing vaccine during a mumps outbreak

The ACIP also made these clarifications:

- The meningococcal vaccine footnote has been edited to create separate footnotes for MenACWY and MenB vaccines.
- The maximum ages for the first and last doses of the rotavirus series have been added to the rotavirus vaccine row of the catch-up schedule.

The comprehensive summary of the ACIP recommended changes to the schedule can be found in the February 6 [**Morbidity and Mortality Weekly Report**](#).

2018 HEDIS® results have been submitted

Every year we collect Healthcare Effectiveness Data and Information Set (HEDIS®)* data from claims, encounters and other administrative functions. We also collect data from chart reviews for certain clinical measures. Then we analyze the results to find ways to improve quality and design.

We submitted our data for 2018 according to the National Committee for Quality Assurance (NCQA) reporting requirements.

We want to thank the offices and staff that provided medical records in support of our HEDIS efforts.

Our provider manual gets a new look

Early in 2019 we'll release an updated provider manual. It will provide more clarity on our policies and procedures. It will also be reorganized and streamlined to be more user friendly.

It's important to review our provider resources for information on our policies and procedures. Our [**current provider manual**](#) is available on our website.

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

Fulfill your laboratory needs faster and easier than before



Introducing **Quantum™ for Healthcare Professionals (HCP)** from **Quest Diagnostics**, Aetna's preferred national laboratory provider. Quantum is a new, easy-to-use platform for all your laboratory needs.

Make lab-related tasks easier

Review orders, results and critical action items all in one place, as soon as you log in — from any device. Know what's in stock, what's arriving soon and where your specimens are without picking up the phone. And you can access results in seconds at no extra cost, saving your practice time to focus on patient care.

Gain more insight and price transparency

You can find clinically relevant information at the point of care and also share transparent pricing with your patients to improve their satisfaction.

Take a virtual tour of the site.

With Quantum, you can help minimize errors and save time. So you can focus on what matters most — your patients.

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**. Once on the page, click "See Our Medicare Compliance FDR Program Guide" or "See Our Office Manual" under "Need More Information."

Get started today

Visit

QuestDiagnostics.com/QuantumHCP

Log in

Use your existing Care360® credentials or visit **GetCare360.com** to set up an account.

Technical support questions?

1-844-346-9580



Your patients will enjoy a digital experience when visiting our Patient Service Centers, too:

- Easy online appointment scheduling
- Quicker service with eCheck-In
- Test results through MyQuest™

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**. You'll find more information in our quarterly **FDR Compliance Newsletter**, too.

Centers for Medicare & Medicaid Services (CMS) inpatient only list

Reminder: We follow the CMS guidelines by considering the procedures on the **CMS Inpatient Only (IPO) list** at the inpatient setting for Medicare Advantage membership. See 2018 NFRM Addendum E.10.18.17.xlsx. This applies to all hospitals.

According to **CMS.gov**, the IPO list includes procedures that are typically provided in the inpatient setting and are not paid under the Outpatient Prospective Payment System. Yearly, CMS uses established criteria to review the IPO list to determine removal of any procedures from the list.

When CMS makes changes to the IPO list, we adjust our internal handling based on these updates. Since CMS publically announces these changes, we do not send notices for those updates. Surgical procedures not on the IPO list do not need to be performed on an outpatient basis to receive reimbursement. We may cover those procedures as outpatient or inpatient, depending on many factors.

Providers cannot collect these payments from Qualified Medicare Beneficiary (QMB) program enrollees

Federal regulations prohibit providers from collecting certain payments from their QMB program patients. The QMB program is a state Medicaid benefit. It assists low-income Medicare beneficiaries with Medicare Part A and Part B cost sharing.

The regulations prohibit providers from collecting the following:

- Medicare Part A and Part B coinsurance
- Copayments
- Deductibles

Please consider your patient's QMB status before collecting cost share.

Helpful tips

If you feel an inpatient setting is the appropriate care:

- Our standard **precertification policy** for an inpatient admission applies.
- We consider the information you share about the surgery, the patient's clinical circumstances, Milliman Care Guidelines® and the member's benefits coverage.
- We may ask for more clinical information to complete the request.



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 the 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.

*Google Play and the Google Play logo are trademarks of Google Inc. App Store is a service mark of Apple Inc. registered in the U.S. and other countries.

Changes to commercial drug lists begin on January 1, 2019

On **January 1, 2019**, updates will be made to our pharmacy plan drug lists. But as early as **October 1, 2018**, you can view the list of upcoming changes on our [Formularies & Pharmacy Clinical Policy Bulletins](#) page. Changes to the Aetna Standard plan may be viewed beginning November 1, 2018.

Ways to request a drug prior authorization:

- 1 Submit your completed request form through our [provider website](#).
- 2 Fax your completed [prior authorization request form](#) to **1-877-269-9916**.
- 3 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.

Updates for granulocyte colony-stimulating factor (G-CSF) products

- As of January 1, 2019, **Fulphila™** (pegfilgrastim-jmdb) will be considered the least costly long-acting G-CSF product.

- All **G-CSFs** will remain on the National Precertification List and require precertification.
- Coverage for **Neulasta®** will require a trial of **Fulphila™**. They will also need to meet the clinical precertification criteria. **Zarxio®** will remain our least costly short-acting G-CSF product.

Updates for epoetin alfa products

- As of January 1, 2019, **Retacrit™** (epoetin alfa-epbx) will be considered the least costly epoetin alfa product.
- All **epoetin alfa** products will remain on the National Precertification List and require precertification.
- Coverage for **Procrit®** and **Epogen®** will require a trial of **Retacrit™**. They will also need to meet the clinical precertification criteria. **Aranesp®** will not be affected by this change.

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

Confirm your system has the right NPI for Aetna Rx Home Delivery® to avoid prescription delivery delays

The correct National Provider Identifier (NPI) for Aetna Rx Home Delivery mail-order prescription drug service is Plantation: 1427096809. Our Aetna Rx Home Delivery occasionally receives prescriptions that were sent to old or incorrect provider IDs. This can result in prescription fulfillment delays for the member.

You can ensure that your patients will not experience these delays by electronically prescribing to the Aetna Rx Home Delivery NPI — Plantation: 1427096809.



State-specific articles

INDIANA, ILLINOIS, KENTUCKY, OHIO, MICHIGAN

New payer partner Indiana University (IU) Health Plan



Aetna Signature Administrators® network has partnered with Indiana University Health Plan to be the network solution for care outside of the IU Health network for their employee plan starting July 1, 2018, and for their self-funded commercial offering on January 1, 2019.

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.

continued

New plan in Northern California: Sutter Health | Aetna

Sutter Health and Aetna have created **Sutter Health | Aetna**, a jointly owned health care company. Effective January 1, 2019, we'll offer a network of providers in the greater Sacramento, Central Valley and Bay Area communities.

Please verify your participation and member eligibility before you see members with the ID cards below.

Simply call the toll-free number on the member ID card. We'll help you and redirect the member if needed. You can also call the Provider Service Center at **1-888-632-3862**.



Gallo members can use the Aetna Signature Administrators® (ASA) program and network

Starting January 1, 2018, Gallo members can use the ASA preferred provider organization program and medical network nationally.

To check eligibility or verify benefits for Gallo, call WebTPA at **1-866-547-4207**. You'll also find the number on the member's ID card. Or **log in** and select "Provider Log In."

They handle all claims processing and claims questions. Send claims electronically to WebTPA's payer ID #75261. You'll also find this number on the member's ID card.

Or send paper claims to:



WebTPA
PO Box 99906
Grapevine, TX 76099-9706



Please note: Neither Aetna nor ASA will be able to verify eligibility or process claims.

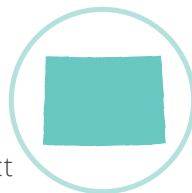
For more information about ASA, see our [ASA flyer](#).

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:

- Updates to our National Precertification List — [page 1](#)
- Clinical payment and coding policy changes — [page 3](#)



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.



NORTHERN VIRGINIA

Innovation Health (IH) Medicare Advantage Plan for Northern Virginia



Starting January 1, 2019, you may start seeing patients with Medicare Advantage plans from IH. IH is the result of a partnership between Inova® and Aetna.

The Annual Enrollment Period (AEP) starts on October 1 and runs through December 7. During this time, patients may enroll in 2019 plans. You'll find more information on the [IH website](#).

Details about 2019 plans:

- Medicare plans offer preferred and standard cost sharing on select medical services, helping members save money.
- Member ID numbers start with **10**.
- The payer ID code is **40025**.
- **Members don't need a referral** to see a specialist (including for HMO plans).

If you have any questions, please call the Provider Service Center at **1-855-249-1282**, from 8 a.m. to 8 p.m., Monday through Friday.

Plan grid and sample ID cards

We want you to have the information you need to serve our members. Be sure to review the ID card samples below and the grid on the next page for more plan and service area details.



Medicare Advantage plan name	Product type	Member ID card	Out-of-network benefits?	Service area*
Innovation Health Medicare Connection Plan (HMO)	Open Access HMO	Members can access and print their digital member ID card online. Their ID card lists: <ul style="list-style-type: none"> • A PCP (required) • Preferred/standard copays 	No	Includes 12 cities and counties in Northern Virginia: <ul style="list-style-type: none"> • Alexandria City • Arlington County • Fairfax County • Fairfax City • Falls Church City • Loudon County • Fredericksburg City • Manassas City • Manassas Park City • Prince William County • Spotsylvania County • Stafford County
Innovation Health Medicare Voyager Plan (PPO)	PPO	Members can access and print their digital member ID card online. Their ID card lists: <ul style="list-style-type: none"> • A PCP (if selected) • Preferred/standard copays 	Yes	

*With Innovation Health, the provider network covers members beyond their neighborhood for routine care. Members can travel and receive care at in-network rates in Arizona, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia and the District of Columbia. Standard network rates apply.

UTAH

Use our network/ID card reference guide to refer your Aetna® patients to in-network specialists



We've created a **quick reference guide for Aetna® networks and ID cards**. We encourage you to download the guide and post it in your office. The guide includes:

- A list of the major health care systems and facilities that participate in our Utah networks. The Utah networks are Standard, Peak Preference and Utah Connected.
- Real ID card examples, with tips for what to look for when identifying a patient's network.

You can use this guide to refer your Aetna patients to in-network providers when they need specialty care. This can protect your patients from unnecessary charges and help them see the financial savings of their plan.

For additional information about our Utah networks, please see our **Utah network FAQ**.

WASHINGTON

Changes to how Sound Health & Wellness Trust (SHWT) will pay provider claims for participants



For dates of service starting on **October 1, 2018**, SHWT's third-party administrator, Zenith American Solutions, will now issue payment (instead of Aetna) on provider claims for SHWT participants. We'll still be processing and pricing the claims. But Zenith American Solutions will be handling the payment for all provider claims through its payment vendor, Zelis® Payments.

Where do you submit your claims?

How you submit claims is not changing. You'll still send claims for SHWT participants to Aetna the same way you do today.

What does this change mean?

Payment for your SHWT participants' services will come from Zenith American Solutions' payment vendor, Zelis® Payments. Payment will no longer come from Aetna.

We're working with Zenith to ensure seamless electronic payments. You may already be contracted with Zelis, in which case you need to do nothing. To enroll for ePayments, please **visit Zelis**, email **membership@zelispayments.com** or call Zelis at **1-877-828-8834**.

If you haven't contracted with Zelis before October 1, 2018, you'll get your SHWT claims payments by check via USPS. You'll get electronic payments after contracting with Zelis.

Questions?

We know you may have questions about this change. Just call us at **1-888-632-3862 (TTY: 711)**.

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.

