aetna®

March 2017 • Volume 1

Aetna OfficeLink Updates™

Mid-America Region

Inside this issue

Options to reach us

Select **Health Care
Professionals**, then
"Log In/Register."

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

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

80.22.803.1-MAR (3/17)

Updates to our national participating provider precertification list

These changes to **Aetna's national precertification list (NPL)** will take effect
as noted below.

Reminders and updates

The following new-to-market drugs require precertification:

- Stelara IV (ustekinumab) — precertification effective December 1, 2016
- Lartruvo (olaratumab) — precertification effective January 20, 2017

The following will require precertification effective July 1, 2017:

- Electroencephalographic (EEG) video monitoring
- Muscular dystrophy drugs/medical injectables including Exondys 51 (eteplirsen), which
  currently requires precertification
- PD-1/PD-L1 inhibitor drugs/medical injectables including Keytruda (pembrolizumab),
  Opdivo (nivolumab) and Tecentriq (atezolizumab), which already require precertification

In addition to the precertification of Remicade (infliximab), Lemtrada (alemtuzumab) and
Tysabri (natalizumab), we'll review medical necessity of the site of care. Precertification for
patients receiving outpatient facility infusion services for these drugs will be required. You
may be required to switch patients to an alternate site of care for continuation of benefits
coverage.

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

Proposed updates to 2018 Aexcel program

We're making the following changes to the clinical performance measures for our Aexcel program for the 2018 designation cycle:

• The Use of Technology measure is being changed to either:

- An attestation to the **2016 Meaningful Use 2 guidelines** as required by the Centers for Medicare & Medicaid Services (CMS) electronic health record incentive program
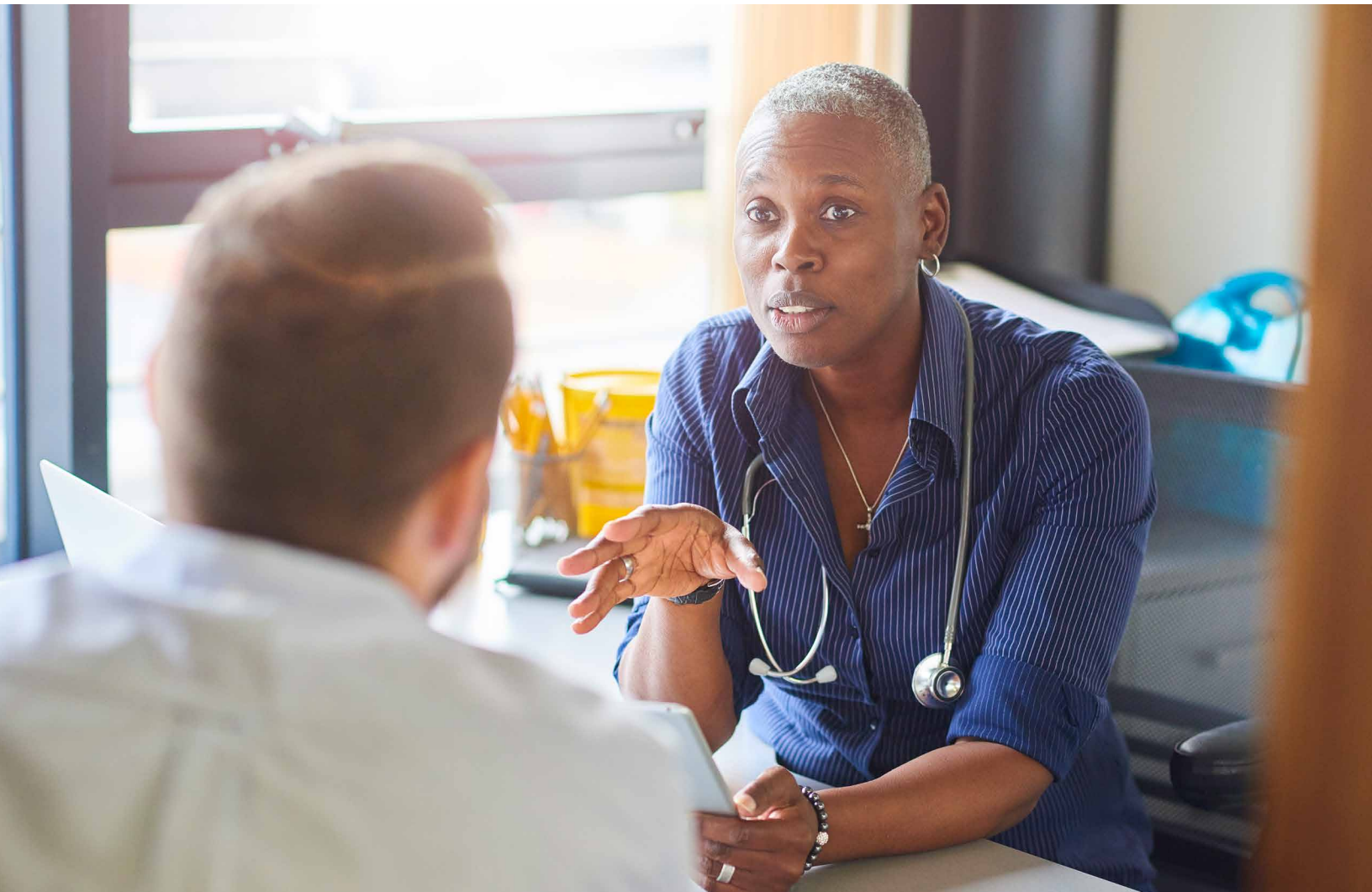- An attestation to participation in the **Physician Quality Reporting System**

Please note that physicians need to meet only one of the clinical performance measures to be considered for Aexcel designation. The additional Aexcel clinical performance criteria are:

• Aetna claims-based measures with minimum member/event volume threshold

• Recognition by the National Committee for Quality Assurance (NCQA) or Bridges to Excellence®

• Attestation to completion of practice improvement module activity in conjunction with maintenance of certification

• Alignment with Aetna's Institutes of Quality® facilities

If your practice meets these criteria and wants to be Aexcel designated, you'll find the **attestation documentation and instructions here**.

We want your feedback

For additional details on the proposed updates, visit **www.aetna.com** and type "performance networks" or "Aexcel" into the search box. Tell us what you think by visiting **www.aetna.com** and selecting "Contact." Next, select "Health Care Professionals" and "Submit Feedback." Then choose "Aexcel."

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. 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
Home health aide/custodial care	June 1, 2017	We will not cover custodial care services if the member did not receive skilled nursing services within the last 30 days of the custodial care services.
Home blood pressure monitors	FYI	McKesson has a dedicated number for members to call to obtain a home blood pressure monitor. The contact number is **1-855-403-6727**. For more information about the clinical criteria, refer to our previous communication in the **December 2016** issue of *Aetna OfficeLink Updates*, and **Clinical Policy Bulletin #0025 — Automated Ambulatory Blood Pressure Monitoring**.
Update to prior notification: ER LOC	May 1, 2017	In September 2016, we said that when CPT code 99285 is billed with a minor diagnosis, we would consider reimbursement consistent with code 99284. We will not implement this policy. Instead, we will implement the following review program in its place: 99285 is used to indicate medical conditions that are of high severity, are potentially life threatening and require the immediate attention of a physician. Services for constipation, earaches and colds, for example, should not be billed using 99285. When a hospital, free-standing emergency center or physician bills a level 5 emergency room service (CPT 99285) with a designated minor diagnosis code, we will request documentation/medical records. Effective date is May 1, 2017, for Texas. Other state effective dates will be determined as they are added to this review process.
Services incidental to intensity-modulated radiation therapy (IMRT)*	June 1, 2017	Services identified by CPT codes 77014, 77280 through 77295, 77305 through 77321, 77331 and 77370 are included in the payment for CPT code 77301 (IMRT planning). These services are incidental to IMRT and should not be reported in addition to CPT code 77301 — on either the same or different date of service.
Lynch/Ashkenazi panel management	June 1, 2017	We will no longer pay specific lab codes when billed within 30 days of Lynch syndrome and Ashkenazi lab testing codes as these procedures differ in technique or approach but lead to the same outcome.
Home sleep studies	June 1, 2017	We will limit procedure codes 95800, 95801, G0398, G0399 or G0400 to 1 time per 7 days and limit these tests to 2 times per 365 days.

*Washington state providers: Starred items were subject to regulatory review and separate notification that will be sent at a future date.

Radiation therapy	June 1, 2017	We're updating our radiation therapy policy with the following billable times changes: • 77280, 77285, 77290 — change to allow 3x per course of treatment (56 days) • 77295 — change to allow 2x per course of treatment • 77306, 77307 — change to allow 2x per course of treatment • 77401, 77422, 77423 — change to allow 1x per date of service
Changes being made to twin delivery edits	June 1, 2017	The following rules for twin deliveries will apply: • A multiple birth diagnosis code will be required to allow payment of more than one delivery. • Only one global delivery code will be allowed per global period. Modifier -59 will not override these edits. • When performing a C-section, only one will be allowed. Modifier -59 will not override these edits. • When performing a failed VBAC (vaginal birth after cesarean), only one will be allowed. Modifier -59 will not override these edits.
Assistant surgeon	June 1, 2017	We are adding additional procedure codes to our assistant surgeon list.
Modifier FX: payment reduction for X-rays taken using film*	<u>Medicare</u> January 1, 2017 <u>Commercial</u> June 1, 2017	Claims billed with modifier FX to indicate X-ray imaging services were provided using film reduces will be subject to a 20% reduction. The reduction applies to the technical component (TC) (including the TC portion of a global service).
Incidental items and services	Reminder	Our standard payment policies do not reimburse services that we consider incidental to the overall episode of care. This includes supplies, materials (for example, sutures or suture substitutes, dressings, syringes, gauze, catheters, guide wires) and equipment (for example, stationary parenteral infusion pumps). We don't pay any additional payment for incidental items or services.

*Washington state providers: Starred items were subject to regulatory review and separate notification that will be sent at a future date.

We're establishing an electronic claim submission standard

We've established electronic claim submission as the standard by which we'll accept your claims.

What does this mean for you? If you don't already submit your claims electronically, we encourage you to start. You'll need an electronic claims vendor. Pick one from our **list** (vendor charges may apply). Or you can choose to send free professional claims through our **secure provider website**.

If you're already submitting some of your claims electronically, we'd like you to send us the remainder that way too, including coordination of benefits (COB). Do you think you need to send us an attachment? Try sending your claim electronically, without the attachment. If we need additional information, we'll tell you what to send us and where to send it.

You might have already received some letters from us about our new standard. We'll be sending more letters this year with tips to help you. Whether you need help getting started or with sending us all of your claims electronically, **contact us**.

Office news

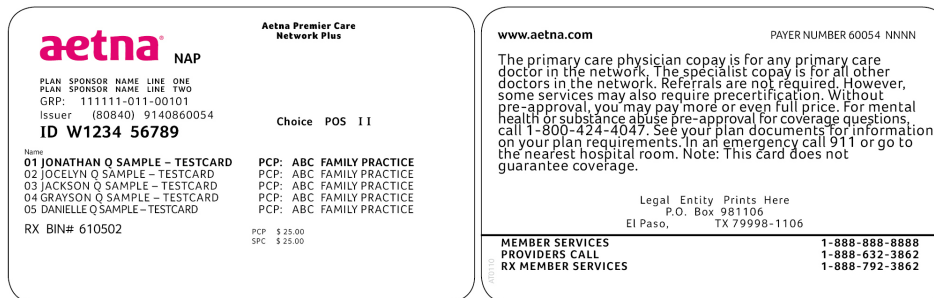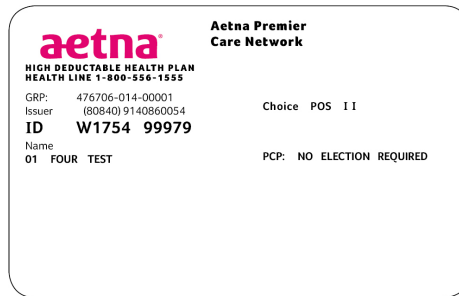## Learn about our performance networks and help patients save

The Aetna Premier Care Network is a network for employers with employees in locations across the country.

With Aetna Premier Care Network, employers can offer a single benefits design to all employees, regardless of their geographic location. Some locations use an accountable care organization (ACO) for the available network in place of another performance network. The version that includes ACOs is called **Aetna Premier Care Network Plus**.

Since you may have patients enrolled in Aetna Premier Care Network or Aetna Premier Care Network Plus, be sure to know your Aetna Premier Care Network participation status. In certain geographic areas, these patients will have a limited provider network for specific types of care, so they should stay in network for their care.

If not, they may pay more. You can identify these patients by the logo on their member ID cards:

- Aetna Premier Care Network
- Aetna Premier Care Network Plus *(If the network offering is an ACO, the ID card is the color gold and includes the ACO partner logo.)*

When you issue referrals or recommend a consult/procedure, refer members to Aetna Premier Care Network providers. Go to our **provider online referral directory**, and enter "Aetna Premier Care Network" or "Aetna Premier Care Network Plus" and your ZIP code in the search boxes. Then, select your plan from the drop-down list to view participating providers.

We're here to help

For Aetna Premier Care Network questions, call our Provider Service Center at **1-888-MDAetna (1-888-632-3862)**. Or users of **NaviNet®, our secure provider website**, can log in there to send us questions.

Aetna Signature Administrators® network and GEHA expand relationship

Starting **January 1, 2017**, Government Employees Health Association (GEHA) members living in **Georgia** and **Pennsylvania** have been able to access the Aetna Signature Administrators PPO program and medical network nationally.

This expanded relationship is expected to result in approximately 155,000 total members seeking care with providers nationally. GEHA is the second-largest national health association serving federal employees, federal retirees and their families.

GEHA members in the states listed below are currently accessing Aetna Signature Administrators nationally:

- Arizona
- California
- Connecticut
- Florida
- Kentucky
- Maine
- Massachusetts
- Michigan
- Nevada
- New Hampshire
- New Jersey
- New York
- Oregon
- Vermont
- Washington

How to add providers to the network

If you're looking to add providers from your practice to our network, you can start the process today.

As you know, Coventry and Aetna are now one company. You need to use our process to add providers to an existing group, as well as for providers that are joining our networks for the first time.

For more on this process, visit the **Join the Aetna Network** page on our website.

We're here to help

If you have questions, read our **FAQs**. You can also call us at:

- **1-800-353-1232** for medical and behavioral health
- **1-800-451-7715** for dental (except oral/maxillofacial surgeons)

How to update data about your office

To update your office's demographic information, go to our **secure provider website** and sign in. You should notify us whenever the following information changes:

- Email and mailing addresses
- Phone or fax numbers
- Name, due to marriage or another life event
- If your office is accepting new patients
- Hospital and group affiliations

If you've been calling our Provider Service Center to make these changes, we ask you to 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.

CMS requires Medicare Advantage plans and Qualified Health Plans (QHPs) to maintain accurate directories. Having your up-to-date information allows us to do that.

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 **register** first.

Our office manual keeps you informed

Our **office manual for health care professionals** (manual) is available on our website. For the **Innovation Health** manual, once on the website, select "Health Care Professionals" then "Practice Resources."

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

- Our adopted clinical practice guidelines and preventive service guidelines, which address preventive, acute and chronic medical and behavioral health services. They can be found on our **secure provider website**. Select "Clinical Resources" from Aetna Support Center.
- Policies and procedures.
- Patient management and acute care.
- Our complex case management program. Members can be referred through multiple avenues, and you can learn how to refer members.
- How to use disease management services and how we work with your patients in the programs.
- Special member programs/resources, including women's health programs, the Aetna Compassionate Care℠ program and others.
- Member rights and responsibilities.
- How utilization management (UM) decisions are made based on coverage and appropriateness of care. It includes our policy against financial compensation for denials of coverage.
- Medical record criteria: a detailed list of elements we require to be documented in a patient's medical record. It is available in the **office manual for health care professionals**.
- Our **Aetna Medicare drug lists**, **commercial (non-Medicare) drug lists** and the **Aetna Leap℠ plans drug list**. These drug lists are also known as our formularies.

And visit us online for information on 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 toward those goals online.

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

Adhering to antidepressant medication treatment plans

Depression in adults is the most treatable behavioral health condition when patients follow their medication program. Behavioral health providers can help increase adherence by educating patients at the start of treatment about:

- How antidepressants work
- Benefits of antidepressant treatment
- Expectations about symptom remission
- How long medications should be used
- Coping with medication side effects

Remind your patients to:

- Talk to you about any side effects.
- Tell you about their current medical conditions and the medications they're taking, including over-the-counter drugs, herbs and supplements. This can help identify potential drug interactions.
- Schedule regular follow-up visits to see if the medication is working.
- Expect that they may need to try different medications before finding which one works best.
- Keep taking their medication as prescribed for at least six months after they feel better.

How to monitor adherence

The NCQA has established two measures to monitor patients' adherence to their medications. You should monitor the percentage of patients who stay on their antidepressant medication for at least three months and for at least six months.

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. Our goal is to produce better health outcomes while efficiently managing health care costs.

We may receive referrals for the program from a variety of sources. These include the primary care physician, specialists, UM team members, an Aetna medical director, family members, internal departments or the member's employer. You can submit a referral through the toll-free phone number on the patient's Aetna ID card.

Disease management programs help patients achieve best health

Our disease management programs provide educational materials and, in some cases, individualized care management for members with chronic health conditions. These programs can help your patients:

• Learn how to self-manage their disease
• Understand their condition and doctor-prescribed treatment plan
• Accept lifestyle changes that enable them to achieve their best health

To enroll a member in a disease management program, call us at the number on the back of their ID card.

Coverage determinations and UM

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

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

Our UM staff helps members access services covered by their benefits plans. We don't make employment decisions or reward physicians or individuals who conduct UM reviews for creating barriers to care or for issuing coverage denials. Our decisions are based entirely on appropriateness of care and service and the terms of coverage, using nationally recognized guidelines and resources. We do not pay or reward practitioners, employees or other individuals for denying coverage or care. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.

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

CPBs and pharmacy clinical criteria

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

Where to learn more

More information about our UM criteria, CPBs and pharmacy clinical criteria is on our **website**. Call our Provider Service Center if you don't have Internet access and want a paper copy or need a copy of the criteria upon which we base a specific determination.

Help us collect HEDIS®* data

Our staff or our contracted representatives from CIOX or Verscend may soon contact you to collect medical record information for your patients who are Aetna members.

To make the process easier, we're decreasing the number of records we need for Healthcare Effectiveness Data and Information Set (HEDIS) reporting. But we may contact you with a follow-up request if additional records are needed. We appreciate your understanding as we complete this required quality reporting.

Why we do this

HEDIS data collection is a nationwide, joint effort among employers, health plans and physicians. The goal is to monitor and compare health plan performance as specified by the NCQA.

We're required to send health care quality data to CMS for our Aetna and Coventry Medicare Advantage and health exchange members. We collect most of the data from claims and encounters. We also gather data on services provided and member health status from our members' medical records.

What we may need from you

If we contact you, we ask that you provide timely access to our members' medical records. Our contracted representatives will work with you and give you options for sending these records.

Meeting HIPAA guidelines

Our representatives serve us in a role that the Health Insurance Portability and Accountability Act (HIPAA) defines and covers. HIPAA defines Aetna as a "covered entity," and our representative's role is as a "business associate" of a "covered entity." Giving medical record information to us or our contracted representatives meets HIPAA regulations.

*HEDIS is a registered trademark of NCQA.

Medicare

Refer your Medicare patients to network providers

Some of our Medicare Advantage plans offer out-of-network benefits. Members of these plans may opt to use nonparticipating providers. But your agreement with us requires you to refer Aetna members to providers in our network for covered services (for example, laboratory, radiology, therapy).

Using network providers is a critical part of your participation agreement. It allows your patients to access quality providers and get the most from their plan benefits. They may also pay less for the care they receive.

If you must refer your patient to an out-of-network provider, you'll also have to document and retain the member's written consent notice that outlines:

- The hospital, facility or provider isn't a participating provider
- The member's plan may, therefore, provide reduced benefits
- The nonparticipating provider won't be restricted to seeking payment only from Aetna
- The nonparticipating provider may bill the member for amounts other than deductibles, copayments, coinsurance and medical services not covered under the member's plan
- Your affiliation or financial ownership interest in, or with, the nonparticipating provider, if any

Where to find more information

Visit our website to:

- Find a **network provider**
- Access our **referral policies**
- Get more information on **electronic referrals**

CMS conducting Medicare member surveys

From March through May, your Medicare patients may be asked to participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and/or Health Outcomes Survey (HOS).

- The **CAHPS survey** measures patients' experiences with their health plan and providers, as well as vaccine completion.
- The **HOS** asks patients about their physical and mental health and measures their perception of improvement over two years. It also measures if their physician discussed physical activity and fall risk prevention with them.

How you can help

To facilitate a positive patient experience, you should:

- Offer the influenza vaccine during office visits, address any vaccination barriers and, if needed, access our **flu network**
- Use referrals and **prior authorizations** to ensure your patients get needed tests, treatments and specialist appointments
- Coordinate patient care by having patient medical records and care information available during office visits or via a patient portal
- Provide your patients with notes from their office visit and prompt follow-up on test results
- Talk to your patients about improving or maintaining their physical and mental health, perhaps by using the gym membership available at no additional cost with their Aetna Medicare plan
- Discuss how your patients can reduce their risk of falling if they have issues with balance or walking

Use our new form for Medicare member authorization appeals

The **form** will help ensure your patients' appeals and any related medical records reach the right person and are processed in a timely manner. The form identifies the type of appeal being requested:

• Standard appeal: You'll get a written decision within 30 days of the plan receiving the appeal.
• Fast appeal: You'll get a decision within 72 hours of the plan receiving the appeal.

For a fast appeal or to find out more about our Medicare appeals process, call us at **1-800-932-2159**.

Hospitals must follow CMS requirements for written notification

A new CMS rule requires hospitals and critical access hospitals (CAHs) to provide both oral and written notification of status to Medicare beneficiaries receiving outpatient observation services for more than 24 hours.

The new rule doesn't apply to hospital or CAH inpatient stays. Hospitals and CAH organizations must use the Medicare Outpatient Observation Notice (MOON) form CMS-10611 for written notification no later than **March 8, 2017**.

Complete your 2017 Medicare compliance attestation

If you are contracted with us to provide health care services for our Medicare Advantage plans, you are considered a "First Tier Entity." CMS requires you to fulfill specific Medicare compliance program requirements. We describe those requirements in our *First Tier, Downstream, and Related Entities (FDR) Medicare Compliance Program Guide* (**FDR guide**). Review the guide, and make sure you have processes in place to comply with all the requirements. Then complete your 2017 attestation.

Annual requirement

Each year you must confirm you've met the Medicare compliance program requirements by completing an attestation. One attestation meets both Aetna and Coventry compliance obligations. **Not complying could impact your participation status.**

The attestation is available on NaviNet, our secure provider website for Aetna or Aetna and Coventry contracted providers. If you've never used NaviNet, log in or register now:
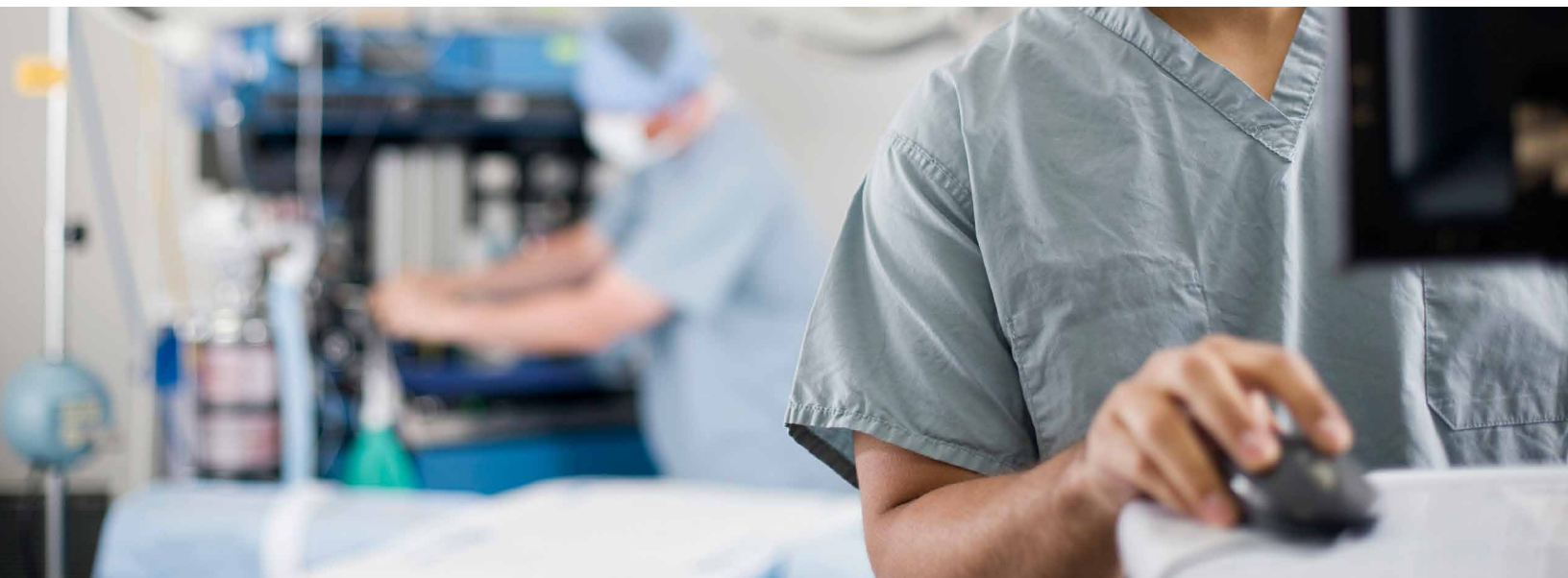
• **New users: Register for NaviNet**.
• **Existing users: Log in to NaviNet**.

Once you log in, go to "Aetna Health Plan." Go to "Compliance Reporting," and then click "Medicare Attestation."

Coventry only and dental contracted providers may take their attestation **online**.

We're here to help

If you need more information, you can find educational content through links within the attestation or call our Provider Service Center at **1-800-624-0756**.

ABNs aren't valid for Medicare Advantage members

Provider organizations should be aware that an Advance Beneficiary Notice of Noncoverage (ABN) is not a valid form of denial notification for a Medicare Advantage member.

ABNs — sometimes referred to as "waivers" — are used in the Original Medicare program. However, you can't use them for patients enrolled in Aetna Medicare Advantage plans because CMS prohibits use of ABNs.

What is and isn't covered

Providers who have elected to participate in the Medicare program are expected to understand which services are covered by Original Medicare and which are not.

Aetna Medicare Advantage plans are required to cover everything that Original Medicare covers. In some instances, they may provide coverage that is more generous or otherwise goes beyond what's covered under Original Medicare. We encourage you to call and verify coverage if you're unsure or have questions with regards to what is covered for a Medicare Advantage member.
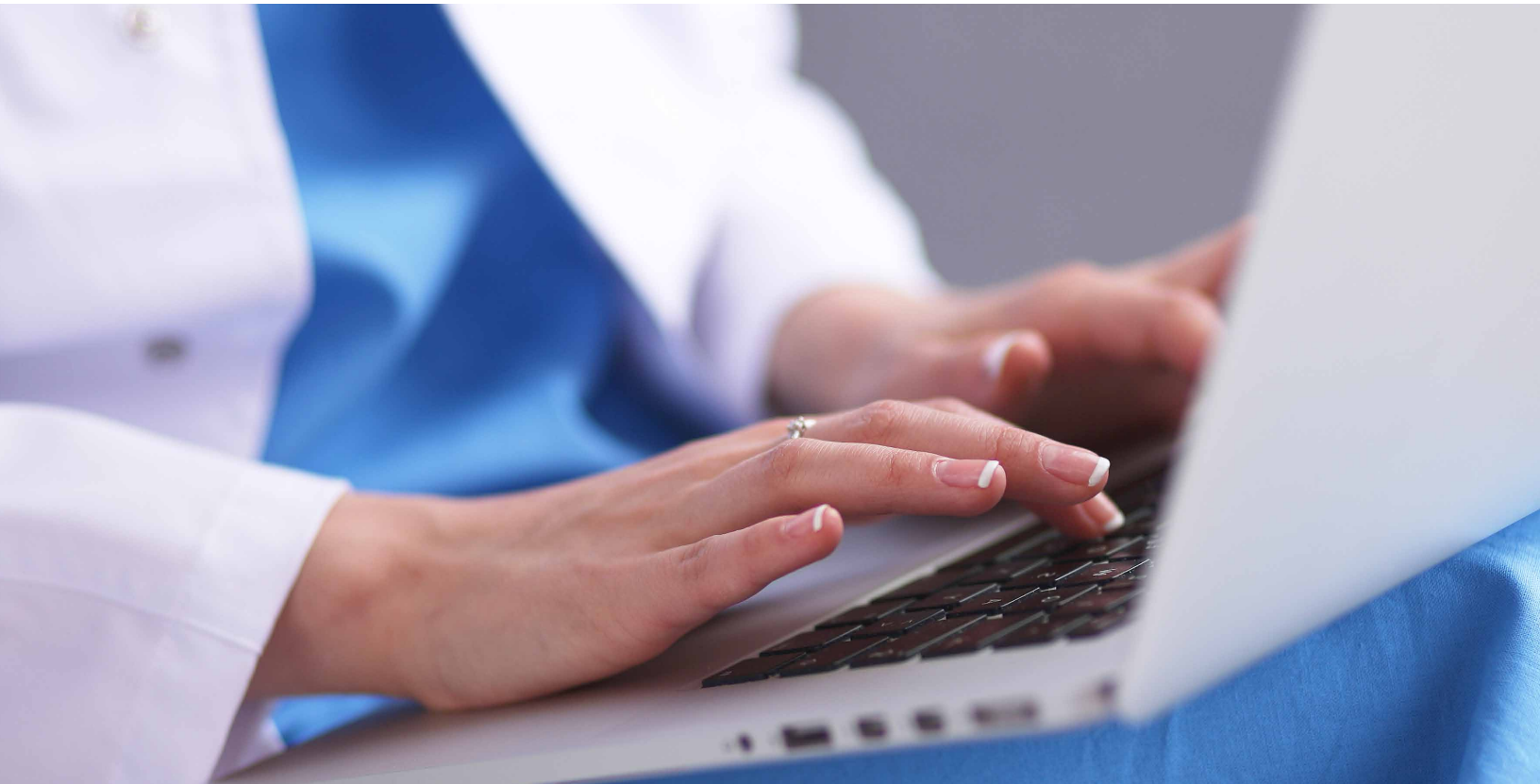
CMS mandates that providers contracted with a Medicare Advantage plan, such as Aetna, can't hold a Medicare Advantage member financially responsible for paying a service not covered under their plan unless that member received a preservice organization determination (OD) notice of denial from Aetna before such services are rendered. If the member doesn't have a preservice OD notice of denial from Aetna, you must hold the member harmless for the noncovered services. This means you can't charge the member any amount beyond the normal cost-sharing amounts (that is, copayments, coinsurance and/or deductibles).

However, where a service is never covered under Original Medicare or is listed as a clear exclusion in the member's Evidence of Coverage (EOC) or other similar plan document, a preservice OD isn't required for you to hold the member financially liable for such noncovered services. Note that services or supplies that are not medically necessary or are otherwise determined to be not covered based on clinical criteria do not constitute "clear exclusions" under the member's plan, as the member isn't likely to know when a service is medically necessary or not.

ODs can be initiated either by you or by the member to determine if the requested/ordered service is covered prior to a member receiving or prior to scheduling a service, such as a lab test, diagnostic test or procedure.

Holding members responsible

Unless a service or supply is never covered under Original Medicare, you'll only be able to hold an Aetna Medicare member financially responsible for a noncovered service if the member received a preservice OD denial from Aetna and decides to proceed with the service knowing they will be financially liable.

Pharmacy

Using Avastin® for macular degeneration

We consider intravitreal Avastin as an efficacious and cost-effective medication for certain ocular conditions.

We reviewed evidence-based, peer-reviewed literature that supports our findings. And we consider intravitreal Avastin, as well as Lucentis®, Eylea® and Macugen® to be medically necessary for treating certain indications such as:

• Diabetic macular edema
• Glaucoma surgery, control of wound healing
• Macular edema following retinal vein occlusion
• Neovascular glaucoma

For more information, view **Clinical Policy Bulletin #0701 — Vascular Endothelial Growth Factor Inhibitors for Ocular Indications**.

Some of the benefits of using Avastin are that it:

• Provides comparable treatment at a lower cost
• Saves patients money if they have high out-of-pocket costs due to copays and coinsurance
• Doesn't need prior authorization (PA) — Eylea, Lucentis and Macugen are specialty products that need PA beginning on January 1, 2017
• Is available from compounding pharmacies, which allows you to add a steroid to the injection

These findings and benefits are for consideration only. As your patients' provider, the most appropriate treatment and medication is your decision.

Changes to commercial drug lists begin on July 1, 2017

On **July 1, 2017**, updates will be made to our pharmacy plan drug lists. Starting on **April 1, 2017**, you can view the list of upcoming changes on our **Formularies & Pharmacy Clinical Policy Bulletins** page.

Want to select a preferred drug for your patient from your cell phone? Our commercial formulary is available for mobile devices. Just go to your phone's app store and type in "Formulary Search" — then download the app for free.

You can also search at **www.formularylookup.com**. After "Sort by," choose "Name," then select "Aetna Inc." to view plan information. At the bottom of the page, you can select one of the icons to get the app and access this information on your phone.

The changes may affect all 2017 pharmacy management drug lists, precertification, quantity limits and step-therapy programs.

Ways to request a drug prior authorization:

1. Call the Aetna Pharmacy Precertification Unit at **1-855-240-0535**.
2. Fax your completed **prior authorization request form** to **1-877-269-9916**.
3. Submit your completed request form through our **secure provider website**.

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

Note these important pharmacy updates

Visit our **Medicare drug list** web page for the most current Medicare plan formularies (drug lists) and CPBs that we update at least annually. For paper copies of the formularies and bulletins, call **1-800-414-2386**.

Notice of changes to prior authorization requirements — commercial

Visit our **Formularies & Pharmacy Clinical Policy Bulletins** web page to view:

• Pharmacy plan drug lists with new-to-market drugs that we add monthly
• Pharmacy plan drug lists that we update quarterly
• CPBs with most current prior authorization requirements for each drug

Mid-America news

Iowa/Nebraska

Quick tips: 2017 Aetna Leap^{SM} plans

Since January 2017, you may have seen patients with Aetna Leap plans. Here's a reminder of what you need to know:

Digital member ID card is the key to care

You can see digital member ID cards via our **secure provider website** or **Availity**. Your website security officer must enable this feature for you to see the cards.

Pharmacy network

These members have a smaller network of pharmacies.

Check eligibility and benefits using one of these options

• Member name/date of birth
• Member ID number/date of birth (using the patient's 12-digit ID)
• Member ID number/member name (using the patient's 12-digit ID)

Use the correct member ID format to ensure timely claims processing

• Member IDs are 12 digits and begin with "10," plus 2 more digits
• Example: subscriber: 100000134500; dependent #1 = 100000134501 (don't add a hyphen)

Electronic claims submission

Submit claims for these plans using payer ID 60054. Claims for these individual plans are separate from your other Aetna claims.

How to see if you're in network

Use our **provider online referral directory** to find out which networks you're in. You may accept Aetna, but you may not be in network for all plans. You could be out of network for a specific plan. Under "Search for," enter the provider name or specialty and enter location (ZIP, city or state). Click "Search," then choose a 2017 Aetna Leap plan from the "Select a Plan" drop-down box.

How to reach us

Call us at **1-888-MDAetna (1-888-632-3862)**. When using our self-service phone system, enter the correct member ID, so we can send your call to the right area.

Resources

• Check out our **Quick reference guides** (scroll to the bottom of the page).

• Use this **reference guide** to learn how to check your network status.

aetna®