

# Need to know

## Aetna OfficeLink Updates™ Mid-America Region

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### 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



# Updates to our National Precertification List

**These changes to the National Participating Provider Precertification List (NPL) will take effect as noted below.**

## Reminders and updates

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

- The following new-to-market drugs require precertification:
  - Spinraza (nusinersen) and Emflaza (deflazacort), precertification effective March 10, 2017
  - Dupixent (dupilumab), precertification effective April 24, 2017
- Effective June 1, 2017, home health care (HHC) services for Medicare Advantage members require precertification when the home care requests are for more than 60 consecutive days. This applies to all providers rendering HHC services to members enrolled in Aetna and Coventry Medicare Advantage plans.
- We've clarified which prosthetics require precertification. Lower limb prosthetics, such as microprocessor-controlled lower limb prosthetics, require precertification. This is not a new precertification requirement, only a clarification.

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

## Important NPL update

We left off Inflectra (infliximab-dyyb) from the March 2017 issue of *Aetna OfficeLink Updates*. Starting July 1, 2017, we'll review medical necessity of the site of care. This includes the precertification of Remicade (infliximab), Inflectra (infliximab-dyyb), Lemtrada (alemtuzumab) and Tysabri (natalizumab). We'll require precertification for patients receiving outpatient facility infusion services for these drugs. You may need to switch patients to another site of care to keep their benefits coverage.

We're sorry for any confusion this may have caused. View more on precertification **here**.



# 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
Dialysis frequency limits*	September 1, 2017	Effective September 1, 2017, the frequency limit for hemodialysis is 3 times per 7-day period and 14 times per 31-day period. Aetna's Clinical Policy Bulletin 0541 identifies certain medical indications that may warrant additional visits. The frequency limit for peritoneal or other continuous renal replacement therapies is 7 times per 7-day period.
Evaluation and management (E&M) services payment policy*	November 1, 2017	<p>Last June, we notified you of changes to our policy for payment of E&amp;M services for nonphysicians to include behavioral health nonphysician providers. We postponed that change.</p> <p>Effective November 1, 2017, we will not pay for E&amp;M codes (99201 – 99499) for the following behavioral health nonphysician providers:</p> <ul style="list-style-type: none"> <li>• Alcohol and drug counselors</li> <li>• Behavioral analysts</li> <li>• Employee assistance program (EAP) counselors</li> <li>• Licensed professional counselors</li> <li>• Marriage and family social workers</li> <li>• Other mental health counselors</li> <li>• Registered social workers</li> </ul> <p>We will continue to reimburse for:</p> <ul style="list-style-type: none"> <li>• 99408: Alcohol and/or substance (other than tobacco) abuse structured screening (for example, AUDIT, DAST) and brief intervention (SBI) services; 15 – 30 minutes</li> <li>• 99409: Alcohol and/or substance (other than tobacco) abuse structured screening (for example, AUDIT, DAST) and brief intervention (SBI) services; greater than 30 minutes</li> </ul> <p>We are also expanding the policy, effective <b>September 1, 2017</b>, and will not reimburse the following medical nonphysician providers for E&amp;M services:</p> <ul style="list-style-type: none"> <li>• Opticians</li> <li>• Massage therapists</li> <li>• Respiratory therapists</li> </ul>

All professionals listed in this update should review the CPT and Healthcare Common Procedure Coding System (HCPCS) national code sets to select a more accurate code that describes the services they are providing.

Laboratory, pathology and blood procedures*	September 1, 2017	Effective September 1, 2017, we'll deny pass-through billing for most lab charges from a facility or a non-facility provider. The provider that performs the test must bill for these services. We will pay for pass-through billing during an inpatient hospital admission. We will also pay facilities for pass-through billing for members receiving outpatient services at the facility and for specimen collection that occurs at the facility on the same day as other services.
Laminotomy with arthrodesis*	September 1, 2017	We'll no longer allow modifier -59 to override the incidental denial of codes 63030, 63042, 63047 or 63048 when billed in conjunction with code 22632. We'll add incidental denials of laminotomy/laminectomy codes 63030, 63042, 63047 and 63048 when billed with arthrodesis codes 22633, 22634 or 22612 and restrict modifier -59 from overriding these edits.
Assistant surgeon*	September 1, 2017	Effective September 1, 2017, we're changing how we pay assistant surgeons for multiple surgical procedures for Coventry commercial and participating Medicare claims. This aligns with Aetna's current policy. When modifiers -81 and -AS are eligible for payment, we'll calculate payment for assistant surgeon services as follows: <ul style="list-style-type: none"> <li>• 12 percent for the first procedure with the highest relative value units (RVU)</li> <li>• 6 percent for the second procedure with the second highest RVU</li> <li>• 3 percent for each subsequent procedure</li> </ul>
Maternity*	September 1, 2017	We'll require a multiple birth ICD-10 diagnosis code in order to allow payment of more than one CPT vaginal delivery code. We'll no longer allow modifier -59 to override mutually exclusive edits between global maternity codes (for example, 59400 with 59510), cesarean sections (for example, 59510 with 59514) or failed vaginal birth after cesarean delivery (for example, 59618 with 59620).
Pelvic examination under anesthesia*	September 1, 2017	Code 57410 is included in all major and most minor gynecological procedures and is not separately reportable when billed with CPT ranges 0071T – 0072T, 0404T, 38570 – 38572, 45126, 45990, 49000, 49203 – 49205, 49320 – 49322, 49327, 49406 – 49407, 51597, 52000 – 52400, 52441 – 52442, 59000 – 59350, 59812 – 59871. Modifier -59 will not override these edits.

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Nonphysician  
assistant at  
surgery  
reimbursement\*

September 1, 2017

Effective September 1, 2017, we will pay nonphysician assistant at surgery services based on the provider type. The pay percentage will remain unchanged for nonphysician assistants who currently bill assistant at surgery services with modifier -AS. Nonphysician assistant at surgery services billed with any other assistant surgery modifier will be paid the current nonphysician assistant rate of 12 percent for the first procedure with the highest RVU, 6 percent for the second procedure with the second highest RVU and 3 percent for each subsequent procedure.

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

## New reimbursement codes related to our Aetna Depression in Primary Care Program

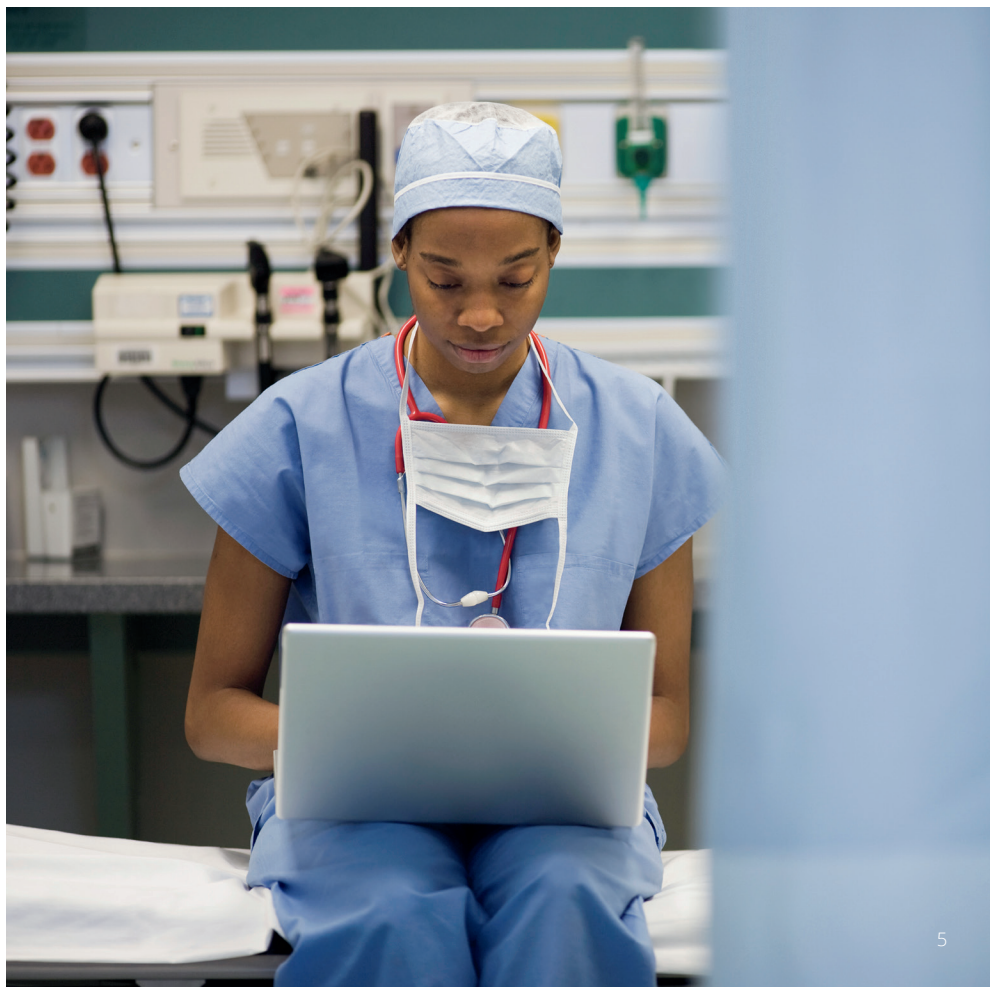
As you may know, some new CPT codes are effective as of January 1, 2017. One change affects the PHQ-9 reimbursement combination codes for our **Aetna Depression in Primary Care Program**.

**Effective January 1, 2017:** Submit claims with the following billing combination: CPT code 96127 in conjunction with diagnosis code Z13.89.

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## 90-day pay and coding service grouping

Individual service codes will be reassigned within contract service groupings. Changes to an individual provider's compensation will depend upon the presence or absence of specific service groupings within their contract. You can see these changes **here**.



# Office news

## Animas Corp. and Aetna team up to improve outcomes for patients with diabetes and reduce costs

Animas Corporation, part of the Johnson & Johnson Diabetes Care Companies, and Aetna have entered into a value-based agreement to improve outcomes and reduce health care costs for diabetes patients using the company's insulin pump therapies. These include the Animas® Vibe® System and the OneTouch Ping® Glucose Management System.

The Animas® Vibe® System is a precise insulin pump with the ability to integrate with continuous glucose monitoring technology to provide real-time, intuitive

blood glucose insights, so patients can manage their blood sugar highs and lows. The OneTouch Ping® Glucose Management System features a meter remote that can control pump functions from up to 10 feet away.

For additional information and/or to place an order for Animas® Vibe® System or the OneTouch Ping® Glucose Management System, please contact them at **1-877-YES- PUMP (1-877-937-7867)**.

## Prepayment diagnosis related group (DRG) clinical review process

As a reminder, we do prepayment clinical reviews for specific DRG claims.

The goal of the program is to improve the accuracy of our DRG payments. We do this by ensuring your claims have the correct information in the patient's medical record.

### More on our review process

- We use clinical criteria to approve admissions and ongoing inpatient hospital stays.
- For DRG facilities, our nurses review the diagnosis codes and procedure codes.
- We'll request records if we find that the DRG billed does not match the diagnosis codes or procedure codes in the clinical notes.
- When we need records, the hospitals will receive an Explanation of Benefits (EOB). They'll also get a detailed letter explaining the discrepancy and requesting more medical records.
- If we don't receive records within the stated time frame, we'll process the claim using the DRG information provided.

### Helpful tips so you can get paid correctly

To make sure we review your claims quickly and correctly, we'll need all the right clinical information up front. After we get your claim, we'll:

- Review DRG facility claims based on case history
- Check to ensure the ICD diagnosis and procedure codes show you billed the correct DRG
- Ask you for medical records (if we need more information)



# Learn about our NaviNet® webinars

As you may know, NaviNet is our secure provider website. **Here**, you have real-time administrative and clinical information available. You're able to access transactions and tools that can help simplify your day-to-day interactions with us.

## Get familiar with NaviNet

You have access to our webinars every month, and you can use the webinars as your personal guide. During these 45-minute sessions, you get to learn more about our transactions and self-service tools.

Here's our 2017 NaviNet webinar schedule. Be sure to register early for these courses.



Webinar topic	Details	Schedule
<i>Working with Aetna on NaviNet</i>	Learning tools and transactions on NaviNet	Fourth Tuesday of each month, 2 p.m. ET
<i>Claims management tools</i>	Understanding claims status, claims reports, EOBs and more	Third Thursday of each month, 2 p.m. ET
<i>Precertification</i>	Managing the precertification process	Second Tuesday of each month, 2 p.m. ET



## How do I get started?

Registering is simple. Just send an email to **[eSolutionsTraining@aetna.com](mailto:eSolutionsTraining@aetna.com)** with the name and date of the webinar in the subject line. You can view more details about our webinars **[here](#)**.

# Aetna Open Access® HMO plans don't need PCP or referrals

Your patients with Aetna Open Access HMO plans don't need to select a primary care physician (PCP), nor do they need referrals. Unfortunately, "Open Access" or "OA" was left off the 2017 member cards of some of those who enrolled through an exchange (state or federally facilitated) or on their own (not through an employer) in Delaware, Iowa, Nebraska and Virginia.

To confirm your patients have the Aetna Open Access HMO plan, you can verify eligibility and benefits by:

- Calling our Provider Service Center at **1-800-624-0756**
- Going to our secure provider website on **NaviNet**

To access our secure provider site, go to **[aetna.com/provider](https://aetna.com/provider)**, and click "Log In/Register." Then, under "Medical Professionals," choose "Log In to NaviNet" or "Register here."

## Need help?

For registration questions or log-in/password assistance with NaviNet, call **1-888-482-8057**, Monday – Friday, 8 a.m. – 11 p.m. ET, and Saturday, 8 a.m. – 3 p.m. ET.

Although a PCP is not required for these plans, we recommend that the member selects a PCP to provide preventive medical care, treat their illnesses and coordinate specialty services when needed.

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## Your voice is important — patients listen to you about screening for colon cancer

Your word counts in getting patients the screening they need for colorectal cancer. If you can't persuade them to get a colonoscopy, your recommendation for another screening may be a great option. See **[Clinical Policy Bulletin \(CPB\) 0516: Colorectal Cancer Screening](#)**.

Test	Recommended frequency	Notes
Fecal occult blood test (FOBT)	Every year	
Flexible sigmoidoscopy (flex sig)	Every 5 years	
Colonoscopy	Every 10 years	
Stool DNA test (FIT-DNA)	Every 3 years	New Reimbursed for Medicare members only
Computed tomography (CT) colonography	Every 5 years	New Considered medically necessary for certain colon evaluations

See **[CPB 0535: Virtual Gastrointestinal Endoscopy](#)** for more on CT colonography.



# Improving the quality of ADHD care

The American Academy of Pediatrics (AAP) recommends using the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* criteria to diagnose attention deficit hyperactivity disorder (ADHD). The AAP indicates information used to make a diagnosis should come from a range of informants, such as parents, teachers and other adults who care for the child. We've adopted the **AAP clinical practice guideline** for diagnosing, evaluating and treating ADHD in children and adolescents. It states that children treated with medication for ADHD should have at least one follow-up visit with the prescribing provider within 30 days of the initial prescription fill and every quarter thereafter.

## Monitoring adherence

You should use AAP guidelines to help ensure effective, appropriate, quality care. We monitor provider adherence to these guidelines through Healthcare Effectiveness Data and Information Set (HEDIS®\*) data collection and review.

More information about HEDIS measures is available on the **National Committee for Quality Assurance (NCQA) website**.

\*Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the NCQA.

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## Learn about this year's commercial risk adjustment initiatives

The commercial risk adjustment program is for patients with individual or small group plans, either on or off the health insurance exchange. We may ask you to take part in several initiatives if you have members in these plans. Here are this year's initiatives:

### **Prospective — Health assessments (April 2017 – December 31, 2017)**

A health assessment is a comprehensive health exam designed to identify current or suspected acute and chronic conditions. These conditions may require more evaluation and medical management.

Your patients will get information from us about the assessments. They can schedule an assessment with one of our vendors. Or they can call you to schedule one at your office. Assessments performed by a vendor don't replace the care you give your patients.

### **Retrospective — Medical record retrieval (May 2017 – April 2018)**

As a commercial health plan, we're required under the Affordable Care Act (ACA) to submit risk adjustment data on our members to the U.S. Department of Health and Human Services (HHS). When we request medical records from providers, it's to ensure the accurate reporting of current health conditions in our membership's claims data to HHS.

We contract with vendors who retrieve medical records on our behalf. It's important for you to submit medical records upon request. This information helps us identify patients who have documented medical conditions that qualify for risk adjustment and also to validate the information we have.

### **Eliminating the burden of records requests**

We work with vendors who deliver electronic medical records (EMR) to us — and make records retrieval easier on you. Our current vendors are athenahealth, Allscripts, eClinicalWorks and NextGen. We offer all options at no charge to you.

### **Embedded nurse program (ongoing)**

Our nurses can work side by side with you and your office staff to:

- Educate physicians on coding and medical record documentation
- Assist with retrospective medical record retrieval
- Identify high-risk members who need health assessments and monitoring of chronic conditions

For more information on any of these initiatives, just call us at **1-855-777-5425**.

# Help improve communication among treating providers

Based on the results of a recent survey, PCPs are concerned they don't get regular reports about their patients' ongoing evaluation and care from other treating providers.\*

This breakdown in communication can pose a threat to quality patient care. We know coordinating care with many physicians, facilities and behavioral health care professionals can be a challenge. And we appreciate your efforts to improve communications.

## Use our tools to share information

Comprehensive patient care includes communicating with your patients' other treating health care professionals. To promote collaboration and comprehensive care, it's critical that PCPs and specialists talk openly with each other.

There are tools available to assist. They are posted on [aetna.com](http://aetna.com) on the Health Care Professional Forms page, under the title Physician Communication:

- [Behavioral Health/Medical Provider Communication Form](#)
- [Behavioral Health Sample Initial Evaluation Template](#)
- [Dilated retinal eye examination report form](#)
- [Physician Communication form](#)
- [Physician Communication Post-Fragility Fracture Care form](#)
- [Specialist Consultant Report](#)

\*Each year, we survey primary care practices contracted for all Aetna products. The surveys assess the practices' attitudes and perceptions on key interactions with us. We use the Center for the Studies of Services, a third-party vendor, to administer the surveys. They perform the surveys at market levels accredited by the NCQA.

# Medicare

## New task force helps address overprescribing of opioids

The abuse of — and addiction to — opioids continues to be a serious and challenging public health problem. Our members who are dually eligible for Medicare and Medicaid may be particularly vulnerable to opioid addiction or misuse.

As an organization offering Medicare-Medicaid Plans and Dual Eligible Special Needs Plans, we have a unique opportunity to help prevent, identify and comprehensively treat opioid addiction or misuse among dually eligible enrollees. This includes ensuring you know about:

- Unsafe or inappropriate prescribing associated with opioid misuse
- Evidence-based treatments for substance use disorders for dual eligible beneficiaries

As part of this effort, we created a task force in June 2016 to address the growing problem of opioid overprescribing. Sponsored by Aetna's chief medical officer, the group meets quarterly and is comprised of individuals from across the company. This includes representation from our Behavioral Health, Health and Clinical Services, Medicare, Medicaid and Pharmacy departments.

Participants share and collaborate on activities related to combating the opioid abuse epidemic. Past initiatives include contacting overprescribers and taking part in panel discussions focusing on state strategies for fighting opioid abuse.



## Respond quickly to medical record requests to avoid coverage denials

CMS requires Medicare Advantage organizations to ask network providers to give us clinical documentation to help make coverage decisions for pharmacy or medical services. Under our contract with you, you're obligated to provide this information to us promptly upon request.

Our clinical staff will contact your office by phone and fax when we need documentation. The timelines for making coverage decisions are short and highly regulated. So it is critical that you give us the requested clinical information on a timely basis. If you don't, it adversely impacts your

patients' access to care and results in unnecessary coverage denials. Please make sure your staff knows they must respond quickly to medical record requests.

We have a new process to track responsiveness to these requests. We'll contact your office if, according to our records, you haven't been responding in a timely fashion. Failure to respond may impact your future participation status.

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## Medication reconciliation after discharge from the hospital

Medication reconciliation is a critical piece of care coordination and patient safety for all patients who use prescription medications. The reconciliation must be completed within 30 days of the date of discharge.

- Medication reconciliation can be performed by a prescribing practitioner, clinical pharmacist or registered nurse by comparing the patient's discharge medication list with the list of medications the patient was taking prior to hospitalization.

- Implementing routine medication reconciliation after discharge from an inpatient acute or non-acute facility is an important step to make sure that medication errors are addressed and that patients understand their new medications.

Administrative coding to document completion of this activity includes CPT 99495, CPT 99496 or CPT II 1111F.

# Holding Medicare members harmless

As an Aetna Medicare contracted provider, you're expected to know which services are covered under Aetna's Medicare Advantage plans. If you treat a Medicare Advantage member and the services you perform aren't covered under their plan, you may not be able to hold them financially responsible. CMS won't allow it in most cases.

The Medicare Advantage member is only responsible for payment if:

- They went through the preservice organization determination (OD)
- **And** they received a notice of denial before the services were rendered

If your Medicare Advantage patient doesn't have a preservice OD notice of denial, **you can't charge them for services not covered**. The member will still need to pay their usual copayment, coinsurance or deductible. Notices that mimic the Advance Beneficiary Notice of Noncoverage (ABN), including all types of payment waivers, are prohibited by CMS for Medicare Advantage beneficiaries. These notices may only be used for patients with Original Medicare.

ODs can be initiated by members or providers. And they should always be requested prior to rendering the service. To initiate an OD request on behalf of a member, contact us using the information below.

Call: **1-800-245-1206 (TTY: 711)**

Fax: **859-455-8650**

Mail: Aetna Medicare Precertification Unit  
PO Box 14079  
Lexington, KY 40512-4079



# Keep Medicare Advantage directory information up to date

CMS requires all Medicare Advantage organizations to contact you at least quarterly to confirm that the information in our directories is accurate. This includes:

- Ability to accept new patients
- Street address
- Phone number
- Any other changes that affect availability to patients

If you notify us of any changes, we have 30 days to update our online directory. For more information, refer to this [fact sheet](#).

## CAQH solution

Working with Aetna and other health plans, the [Council for Affordable Quality Healthcare® \(CAQH\)](#) developed a solution to help ensure that directory information is accurate. This process uses data from your CAQH ProView® profile. You simply review, update and confirm your information in CAQH ProView. CAQH will share it with all participating health plans that you authorize to receive it.

CAQH will email you a directory validation invitation, which has instructions on how to update your profile. CAQH will call you if you don't reply, so respond promptly.



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## Submit precertification requests for Medicare members with advance notice

When submitting precertification requests for our Medicare members, be sure to allow enough time for us to complete our review of your request within CMS' required time frames:

- Standard requests: as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after we receive the request
- Expedited requests: as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request

Doing so helps reduce:

- Procedure rescheduling
- Member and provider dissatisfaction

# Pharmacy

## Changes to commercial drug lists begin on October 1, 2017

On October 1, 2017, updates will be made to our pharmacy plan drug lists. Starting on **July 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 [formularylookup.com](http://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:

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

## Important pharmacy updates

### Medicare

Visit our [Medicare drug list](#) web page to view the most current Medicare plan formularies (drug lists) and Clinical Policy Bulletins that we update at least annually.

For a paper copy of the formularies and bulletins, call **1-800-414-2386**.

### Commercial

#### Notice of changes to prior authorization requirements

Visit our [Formularies & Pharmacy Clinical Policy Bulletins](#) web 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

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





## New Aetna Specialty Performance Network<sup>SM</sup> plan members need to choose a participating pharmacy

This new specialty pharmacy network will be available to our self-insured members on April 1, 2017. Your patients with this network must choose a participating pharmacy, such as Aetna Specialty Pharmacy<sup>®</sup> medicine and support services, for their specialty drugs. These changes also apply to their covered family members.

Sending a prescription to the correct network pharmacy will make sure members receive full benefits from their drug coverage. They can search for which pharmacy to use from their secure member website. Or they can call the toll-free number on their member ID card.

This change begins with their first refill on or after their plan's effective date. We recommend that they fill their last prescription before that date. This will help to make sure they have the medicine they need during the first month of their plan change.

### How to send in a new prescription

Choose one of four ways to transfer or send in a new prescription:

- Electronically via **e-prescribe**
- By phone: **1-866-782-ASRX (1-866-782-2779)**, option 2
- By fax: **1-866-FAX-ASRX (1-866-329-2779)**
- By mail: Aetna Specialty Pharmacy, 503 Sunport Lane, Orlando, FL 32809

### Need to request precertification?

For specialty drugs on the **National Precertification List** that require precertification, you can submit a request with electronic prior authorization (ePA) services.

- **NaviNet:** If you're a NaviNet user, you can continue to submit your requests there.
- **CoverMyMeds:** If you're not a NaviNet user, you can create a new, free ePA account with CoverMyMeds.

The precertification request forms are also on our **Health Care Professionals Forms** page.

**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).**

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.

