September 2017

News you can use

Aetna OfficeLink Updates™
All regions

Inside this issue

In order to streamline our publication, OfficeLink Updates will transition to a national publication (all regions) with state news featured at the end. This change will have no impact on how you access the newsletter today. We also hope it will be beneficial to providers who wish to see what is happening in other regions of the country.

Options to reach us
Go to Aetna's **Health Care Professionals** page, then click "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

aetna®

aetna.com

95.22.800.1-SEP (9/17)

Updates to our precertification list

Updates to our Participating Provider Precertification List

These changes will take effect as noted below.

Reminders and updates

We encourage you to submit precertification requests at least two weeks before the scheduled services. Effective January 1, 2018, the following precertification changes will apply:

- We'll require precertification for two new drug classes:
  - Amyotrophic lateral sclerosis (ALS)
  - Chimeric antigen receptor T (CAR-T) cell therapy
- We won't require precertification for artificial lumbar disc surgery or cervicoplasty procedures or for interferon drugs used to treat hepatitis C (Pegasys , Peg-Intron, Intron A and Infergen).
- The following new-to-market drugs require precertification:
  - Bavencio (avelumab) — precertification effective May 26, 2017. This drug is included in the PD1/PDL1 inhibitor drug class.
  - Brineura (cerliponase alfa) — precertification effective July 20, 2017. This drug is included in the enzyme replacement drug class.
  - Imfinzi (durvalumab) — precertification effective July 7, 2017. This drug is included in the PD1/PDL1 inhibitor drug class.
  - Kevzara (sarilumab) — precertification effective July 1, 2017. This drug is included in the immunologic agents drug class.
  - Ocrevus (ocrelizumab) — precertification of the drug and site of care effective May 23, 2017. This drug is included in the multiple sclerosis drug class.
  - Radicava (edaravone) — precertification of the drug and site of care effective July 20, 2017. This drug was added as an independent drug but will move to the ALS drug class on January 1, 2018.
  - Siliq (brodalumab) — precertification effective July 1, 2017. This drug is included in the immunologic agents drug class.
  - Tymlos (abaloparatide) — precertification effective July 1, 2017. This drug is included in the osteoporosis drug class.

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

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
Modifier KL: DMEPOS item delivered via mail*	September 1, 2017	We allow payment of KL only when billed with A4233, A4234, A4235, A4236, A4253, A4256, A4258 or A4259. Modifier KL should be appended only to diabetic supplies that are ordered remotely (by phone, email, Internet or mail) and delivered to a member's residence by common carriers (for example, U.S. Postal Service, Federal Express, United Parcel Service) and not with items obtained by members from local supplier storefronts.
Breast pump supplies	August 1, 2017	We do not cover the following breast pump–related supplies/accessories: bottles that are not specific to breast pump operation, including the associated bottle nipples, caps, lids and locking rings. In addition, covered breast pump replacement supplies are limited to the purchase of one unit per item per rolling 12 months where a covered female would not qualify for the purchase of a new pump. Additional breast pump tubing, adapters and shields or similar equipment purchased or rented for personal convenience or mobility are not covered. For more information, refer to **Clinical Policy Bulletin 0421: Breast Pumps**.
Correct coding of hospital observation, critical care, admission and discharge services*	December 1, 2017	We'll limit coverage for these hospital professional services to one time per day, per patient, across all providers: *Hospital observation services (99234 – 99236) *Critical care services (99291 – 99292) *Hospital admission services (99221 – 99223) *Hospital discharge services (99238 – 99239) This payment policy is in line with CMS guidelines.

Procedure	Effective date	What's changed
Non-physician assistant at surgery reimbursement*	September 1, 2017	We're retracting a communication published in the June issue of OfficeLink Updates. We told you that we'll pay a non-physician assistant at surgery based on the provider type effective September 1, 2017 — that is, we'll pay multiple surgical procedures billed with any assistant surgeon modifier 12 percent for the first procedure with the highest relative value units (RVU), 6 percent for the second procedure with the second-highest RVU and 3 percent for each subsequent procedure. **We are not changing our current payment methodology for non-physician assistant surgery at this time.**
Home sleep studies	June 1, 2017	In March, we told you that we would limit home sleep studies to 1 time per 7 days and 2 times per 365 days. We changed that decision to allow home sleep studies 3 times per 365 days. This change was effective June 1, 2017.
Neuromuscular junction testing with intraoperative neurophysiology monitoring	December 1, 2017	We will no longer allow code 95937 when billed with codes G0453, 95940 or 95941. Modifier 59 will not override this edit.
Assistant surgeon	December 1, 2017	We're retracting a communication published in the March issue of OfficeLink Updates. We told you that we were adding more procedure codes to our assistant surgeon list effective June 1, 2017. **We are not changing our current assistant surgeon list at this time.**
Reminder for readmissions payment policy	Reminder	As a reminder of our readmissions payment policy: We will not recognize and reimburse another DRG payment for any member readmitted to the same facility within 30 calendar days of a prior stay when related to the prior stay's medical condition. This includes evaluation and management of that condition. We consider the subsequent admission included in the original DRG payment for the initial admission. This policy applies to any facility reimbursed at a DRG case rate.
Pass-through billing*	October 1, 2017	In June, we told you that starting September 1, 2017, we'll deny pass-through billing for most lab charges from a facility or a non-facility provider. The effective date will now be October 1, 2017. The provider that performs the tests must bill for these services. We'll pay for pass-through billing during an inpatient hospital admission. We'll also pay facilities for pass-through billing for members receiving outpatient services at the facility when the specimen collection occurs at the facility on the same day as other services. We don't reimburse for specimen collection.

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

Management and Network Services LLC (MNS) contract ends January 1, 2018

Effective January 1, 2018, MNS won't be a contracted provider. It will no longer coordinate the skilled nursing services for credentialing or manage authorizations or claims payments. This change impacts all patients enrolled in Aetna and/or Coventry Medicare, commercial or network access business (First Health®, auto or workers' compensation) lines of business.

Send future claims submissions electronically or by mail

For dates of service on or after January 1, 2018, please submit all patient claims directly to Aetna and/or Coventry. Just check the back of the member's ID card for the correct address or claim-payer ID number.

Properly coding diabetic conditions is critical

It's important to follow the ICD-10 guidelines to ensure you're coding diabetic conditions properly. Here are some important reminders for those inputting codes.

You can no longer assume insulin use determines the type of diabetes the patient has. You must document the condition as E11.9 — type II diabetes mellitus without complications.

Often, providers fail to document other conditions related to diabetes. For example, if you see a diabetic patient for foot ulcers, you need to input two codes for this diagnosis. Depending on the ulcer and location:

• E11.621 (type II diabetes mellitus with foot ulcer)
• L97.512 (non-pressure chronic ulcer of other part of right foot with fat layer exposed)

Other common complications of diabetes include:
• Cardiovascular disease
• Nerve damage (neuropathy)
• Kidney damage (nephropathy)
• Eye damage (retinopathy)
• Foot damage
• Skin conditions
• Hearing impairment
• Alzheimer's disease

Our embedded nurse educator plays an important role by working to ensure that providers accurately document patient conditions. For more information, simply contact your nurse educator. Or call us at **1-855-777-5425**.
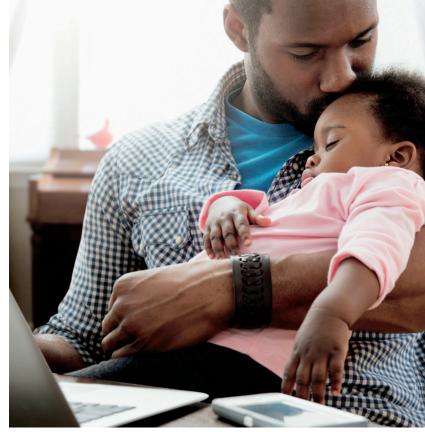
We've sent 2017 HEDIS® results

Every year, we collect Healthcare Effectiveness Data and Information Set (HEDIS)* data from claims, encounters and other administrative records. We also collect data from chart reviews for certain clinical measures. We analyze these results to find opportunities for improvement, and then we design and carry out quality improvement activities.

We submitted our data for 2017 according to National Committee for Quality Assurance (NCQA) reporting requirements.

Thanks to all offices and staff that provided medical records in support of our HEDIS efforts.

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

Program can help members with safe transition back home

When members transition to home after leaving an inpatient facility, we want to help make the process both safe and successful. Our Readmission Avoidance Program (RAP) identifies members who are at high risk for readmission, allowing us to work with them to help prevent unnecessary rehospitalization.

How the program works

Case managers work with members for up to 31 days after discharge from a facility.

They will:

· Explain that we want to help with a smooth transition to home
· Review discharge instructions and medications to facilitate case management and consult with our pharmacist for full medication review
· Help with timely follow-up doctor appointments and arrange home health care, if needed
· Educate members about "red flags" or warning signs indicating they should seek medical care
· Work with members to help create a personal health record
· Coordinate extra case management for those with complex needs

If you need to submit a referral for these case management services or get more information, just call us at the number on the member's ID card.

Medtronic value-based agreement

Medtronic and Aetna have entered into a value-based agreement to promote improved outcomes and reduce health care costs for diabetic members using the Medtronic insulin pump. The outcomes-based agreement will measure the health parameters for those eligible Aetna members included in the program and will continue to provide those members access to advanced diabetes technologies, including the new MiniMed® 670G system featuring SmartGuard® technology. (The MiniMed 670G system constantly self-adjusts to keep patients' blood sugar levels in range based on their personalized needs.) Members will also have access to comprehensive Medtronic support services to assist with their insulin pump needs.

For additional information and/or to place an order for a Medtronic insulin pump, please contact Medtronic at **1-800-826-2099**.

We need your help collecting member data

In August, we began working with Episource and ArroHealth to gather risk-adjustment data. Under the Affordable Care Act, we're required to submit this data to the U.S. Department of Health and Human Services and to the Centers for Medicare & Medicaid Services every calendar year. This applies to members of our small group and individual plans, both on and off the exchange. We need your help collecting this information.

The only way to accurately report a clinical diagnosis for risk adjustment is through medical records. Retrieving these records is vital to the program's success. It allows us to accurately support and report our members' acuity level. Once you've documented and coded a patient's conditions, please provide the records to us for validation. (In fact, our contracts require that you comply with medical records requests.)

You don't need a signed consent to submit a patient's medical records. According to privacy rules, you can disclose protected health information (PHI) to health plans without their authorization "when both the provider and health plan had a relationship with the patient, and the information relates to the relationship [45 CFR 164.506(c)(4)]." To learn more about privacy rules, visit **hhs.gov/ocr/privacy**.

Resources for better health

We offer several online tools to help your patients feel better and be more productive.

- **MindCheck℠**: Getting a quick read on emotional health and learning the five signs of suffering is easy. Patients can also download the app at no cost to their Android™ and iPhone® mobile digital devices.
- **It Only Takes a Minute**: Short, inspiring videos show how real people help themselves or others through real-life situations and stay mentally healthy.
- **Assess Wellbeing**: Patients can take short depression and anxiety self-assessments. Quick tips can also help to boost their mood.

Office news

Our office manual keeps you informed

Our Office Manual for Health Care Professionals is available on our website. For Innovation Health, once on the website, select "Health Care Professionals," then "Practice Resources."

Visit us online to view a copy of your provider manual as well as information about:

- Our adopted clinical practice guidelines and preventive services guidelines, which address preventive, acute and chronic medical and behavioral health services. Find them on our **secure provider website**. Select "Clinical Resources" from the Aetna Support Center.
- Policies and procedures
- Patient management and acute care
- Our complex case management program (members referred through multiple avenues; learn how to refer them)
- How to use disease management services and how we work with your patients in the programs
- Special member programs/resources, including the Aetna Women's Health℠ Program, Aetna Compassionate Care℠ and others
- Member rights and responsibilities

- How we make utilization management decisions based on coverage and appropriateness of care. Information includes our policy against financial compensation for denials of coverage.
- Medical records criteria — a detailed list of elements we require to be documented in a patient's medical record is available in the **Office Manual for Health Care Professionals**
- The most up-to-date **Aetna Medicare Preferred Drug Lists, Commercial (non-Medicare) Preferred Drug Lists** and the **Consumer Business Preferred Drug List (also known as our formularies)**.

Also 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. Find details on the program goals and our progress online.

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

Credentialing needed for correct claims payment of RHCs and FQHCs

Does your facility qualify as a Rural Health Clinic (RHC) or a Federally Qualified Health Center (FQHC)?

In order for your claims to be paid correctly, Aetna requires that your facility be credentialed and contracted before participating in our Medicare networks.

Note that credentialing is done by location. Each location must be credentialed separately.

Be sure to allow **at least 18 business days** for credentialing before submitting claims. Credentialing is not retroactive.

For information on credentialing, call our Provider Service Center at **1-800-624-0756**.

Tips for telemedicine providers

Are you a telemedicine provider? Do you diagnose and treat patients through telecommunications technology?

Three things to keep in mind:

1. Telemedicine is not always a covered expense. Many states have adopted coverage mandates for telemedicine. However, laws vary from state to state. And many Aetna members are covered under self-funded medical plans that are exempt from most state-mandated benefits.

2. Know the rules in your states. Find out whether the state in which you practice, or the state in which your patient lives, has other requirements.

3. Remember, you must register before you provide telemedicine services to a member in Alaska. Sign up with Alaska's **telemedicine business registry**.

Care given in doctor's office may impact members' cost share

More and more members may have multiple forms of cost sharing for services given in a provider's office. Members may pay a copay for the office visit, amounts accrued before reaching the deductible, and coinsurance for other specific services.

What this means to you

Beginning January 1, 2018, more plans will include these cost-sharing features. Members may pay two forms of cost sharing for one office visit. For primary care physicians and specialists, certain services in the office may require out-of-pocket payments (due to co-insurance requirements or to not having met the deductible amount) in addition to the copay for the office visit. The office-based services that may be subject to these types of payments could include one or more of the following:

• Lab and X-ray
• Complex imaging
• Infusion
• Surgery

How you can help

Be sure to check member benefits and eligibility at the time of the visit.

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 you have:

• New email or mailing addresses
• New phone or fax numbers
• Name changes due to marriage or another life event
• A new policy regarding accepting new patients
• A new hospital or group affiliation

NaviNet security officers have access to Aetna's "Update Provider Demographics" 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.

If you've been calling our Provider Service Center to make these changes, we ask you to use the secure provider website instead. The site lets you confirm the information you submit. It also prevents unauthorized individuals from submitting incorrect information about your office or facility.

The Centers for Medicare & Medicaid Services (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 the **secure provider website**. These include submitting claims, checking patient benefits and eligibility, and requesting precertifications.

Submitting electronic claims is easy

It's simple to submit your claims electronically. What's the upside? You'll get paid faster because we get your claims more quickly than if you'd dropped them in the mail.

Did you know?

- You can submit claims securely online using one of our approved **vendors** for all **Aetna plans**, including **Aetna Signature Administrators®**. Or you can submit professional electronic claims (claims you'd submit on a CMS-1500 form) on our secure provider website on NaviNet at no cost. You don't even have to be in network to use NaviNet.
  - Register at **connect.navinet.net/enroll**
  - Log in at **connect.navinet.net**

- Submitting your claims electronically saves you time and money. There's no need to write out or print claims and drop them in the mail. **We acknowledge all electronic claims**, so there's no lost mail.

- You can even submit **coordination of benefits (COB)**, corrected claims and voided claims electronically.

- Hold on to your notes. Just send us your claims electronically. If we need more information, we'll let you know.

And if you already submit some of your claims electronically, why not send them all electronically? Visit our **website** to learn more about electronic claims.

We're here to help

Questions? Visit the **Contact Aetna** page, then submit your question or comment.

The more codes you add, the better

Did you know that you can include up to 12 DX codes on a claim submission?

That's right. It helps us help you when you include all relevant diagnosis codes — up to 12 per submission. Having more codes helps us with our information gathering to satisfy Healthcare Effectiveness Data and Information Set (HEDIS) requirements. And that means less time we have to spend requesting records from you when we can't verify information.

We're here to help

Questions? Visit **Contact Aetna** page, then submit your question or comment.

Medicare

Expect to see more Aetna Medicare Advantage PPO patients in January

As of January 1, 2018, our Medicare Advantage (MA) PPO plan membership will increase. We're offering a customized group MA PPO plan only available to retirees of the United Auto Workers (UAW) Retiree Medical Benefits Trust ("the Trust"). The Trust is the largest nongovernmental purchaser of health care in the nation. It sponsors health care benefits for more than 700,000 retirees.

We'll be one of their main health plan partners for retiree benefits in 49 states, excluding Michigan. So you'll likely see more Trust retirees as members of our MA PPO plan next year.

If you're part of our Medicare network, these members can find your practice in our DocFind® online provider directory. If you're not part of our Medicare network, **apply today**. Call us at **1-800-624-0756** with any questions.

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

If you provide services to our Medicare and/or Medicare-Medicaid plan (MMP) members, 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 program guide" or "See our office manual" under "Need more information?"

Once you review and ensure 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.

Keep your Medicare Advantage directory information up to date

The Centers for Medicare & Medicaid Services (CMS) requires us to contact you at least quarterly to confirm that your directory information is accurate. This includes:

• Your ability to accept new patients
• Your practice location(s)
• Your practice phone number
• Any other changes that affect your availability to patients

Keeping your directory information up to date makes it easier for our members to find network providers and schedule appointments.

CAQH helps meet this need

The Council for Affordable Quality Healthcare® (CAQH) has a unique solution to ensure the accuracy of your directory information. You simply review, update and confirm the information in your CAQH ProView™ profile. CAQH will do the rest. They'll share your information with the participating health plans you authorize to receive it. This eliminates the need for each to contact you for the same directory information.

Visit **proview.caqh.org/pr** to get started. Be sure to authorize Aetna to access your profile. That way, we can verify and update your information in our directory.

Pharmacy

Changes to commercial drug lists start on January 1, 2018

On **January 1, 2018**, updates will be made to our Pharmacy Management drug lists. Starting on **October 1, 2017**, you can view the list of upcoming changes on our **Formularies & Pharmacy Clinical Policy Bulletins** page.

Reminder: Starting October 1, 2017, safety edits will be added to opioid drugs to help with overprescribing.

Want to select a preferred drug for your patient from your cell phone? Our commercial formulary is available for mobile devices. Just go to Google Play or the App 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 select "Get it on Google Play" or "Download on the App Store" to access this information on your phone.

These changes will affect all 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-AETNARX** (**1-800-238-6279**).

Important pharmacy updates

Medicare

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

For a paper copy of the formularies, 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 we add monthly
- Clinical Policy Bulletins with most current prior authorization requirements for each drug

---

Use these tools to better monitor patients' prescriptions

You can monitor how patients comply with prescribed opioid analgesics and other controlled medications. Tools from Quest Diagnostics, an Aetna-preferred in-network drug testing services laboratory, make it simple.

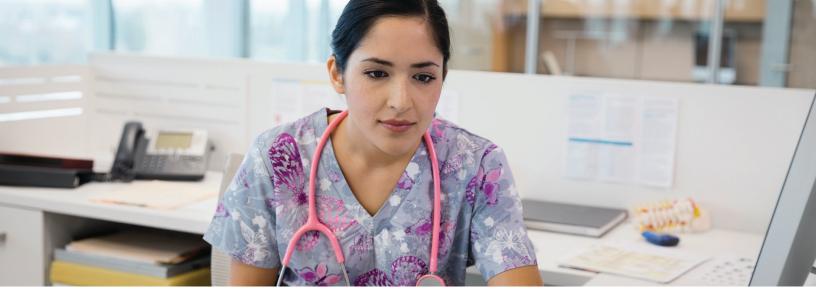Quest offers many prescription drug–monitoring services, including:

- A broad toxicology menu
- Improved medMATCH® results reporting for clear identification of consistent and inconsistent results
- A dedicated toll-free hotline for toxicologist consultation
- On-demand and live learning webinars
- The Quest-sponsored Pain Management Resource Center library of videos, opinion leader interviews, news articles and items on pain management and reducing risks.

To help your patients get the most from their benefits plans, you can refer them to Quest Diagnostics or to other national or local participating labs.

For the most up-to-date list, visit our **Provider Online Referral Directory**. Once there, choose "Labs and Diagnostics Centers" and select "Laboratory (including Quest Diagnostics)."

To request specific test information or a consultation, call a Quest Diagnostics toxicology specialist at **1-877-40 RX TOX (1-877-407-9869)**. Or visit **questdiagnostics.com** for more information.

Using clinical practice guidelines and preventive services guidelines

We adopt evidence-based clinical practice guidelines and preventive services guidelines from nationally recognized sources. You can access them on our secure provider website.

Once you sign in to the site, go to My Health Plans > Aetna Health Plan > Support Center > Clinical Resources.

For assistance in obtaining hard copies from our sources, just call our Provider Service Center.

Also, you can review the following guidelines, which we adopted in 2017:

Clinical practice guidelines
Standards of medical care in diabetes Source: American Diabetes Association
Diagnosis and management of patients with stable ischemic heart disease Source: American Heart Association/American College of Cardiology Foundation
Helping patients who drink too much Source: National Institute on Alcohol Abuse and Alcoholism
Treatment of patients with major depressive disorder Source: American Psychiatric Association
Diagnosis, evaluation and treatment of attention deficit hyperactivity disorder in children and adolescents Source: American Academy of Pediatrics
Prescribing opioids for chronic pain Source: Centers for Disease Control and Prevention

Preventive services guidelines
Grades A & B for healthy people with normal risk Source: U.S. Preventive Services Task Force

State news

Knocking down barriers to home health care for Medicare Advantage members

We understand there's a shortage of home health services in some areas of Southern California, and we're here to help. If it's difficult to find a contracted agency for your patient, go to our **DocFind®** online provider directory. Or call the Provider Service Center at **1-800-624-0756**.

You may be able to reach out to 400 Southern California home health agencies contracted with Aetna's Medicare network. Our goal is to make sure that every member has access to the proper care.

Please note: If the Independent Practice Association (IPA) is responsible for the processing/payment of the home health care claim, the IPA retains responsibility for processing the home health agency's claim.

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 procedure 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 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.

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.

Individual Medicare HMO plans available in WA January 1, 2018

Beginning January 1, 2018, we'll offer individual Medicare HMO plans in King, Pierce and Snohomish counties. We already offer individual Medicare PPO plans in these counties.

You may see new Aetna Medicare members in your office due to this change.

To find our office manuals, go to **aetna.com/health-care-professionals/provider-education-manuals/provider-manuals.html**. If you have questions, call our Provider Service Center at **1-800-624-0756**.

aetna®

aetna.com