

March 2018

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Aetna OfficeLink Updates™ All regions

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Reminder for Coventry providers

We no longer publish the Coventry provider newsletter. The Aetna OfficeLink Updates™ newsletter will now serve all our providers.

To sign up for electronic communications, including Aetna OfficeLink Updates, log in to our **secure provider website** and select "Aetna Health Plan" from the workflow menu. Choose "Email Options," then "Share Email Address." Enter your email address and review the email acknowledgment.

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Changes to our National Precertification List (NPL)

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

Effective July 1, 2018, the following precertification changes apply:

- We'll require precertification for Calcitonin Gene-Related Peptide (CGRP) receptor inhibitors
- We won't require precertification for the following:
 - Anti-emetic drugs/medical injectables, including Emend IV (fosaprepitant dimeglumine)
 - Observation stays more than 24 hours (for more information, see the **observation policy entry** in the policy chart)
 - Power Morcellator

The following new-to-market drugs require precertification:

- Yescarta (axicabtagene ciloleucel) — precertification effective January 2, 2018. This drug is included in the chimeric antigen receptor T-cell therapy drug class.
- Durolane (hyaluronic acid) — precertification effective February 2, 2018. This drug is included in the viscosupplements drug class.
- Fasentra (benralizumab) — precertification effective February 9, 2018. This drug is included in the respiratory injectables drug class.
- Mepsevii (vestronidase alfa-vjvk) — precertification effective February 9, 2018. This drug is included in the enzyme replacement drug class.



You can find more information about precertification under the General Information section of the [NPL](#).

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).



Request precerts electronically — it's fast, secure and simple



Remember to request precertification electronically.* It's our standard practice. And when you do, you won't have to worry about calling the correct number or waiting on hold. Submitting precertification requests online is faster and easier than calling. And you can submit requests at your convenience.

How to get started

To submit electronic precertification requests, pick a vendor from our [list of approved vendors](#). Or [register](#) for and use [NaviNet®](#), our secure provider website. You don't even have to be participating to register for or to use the site. But if you're participating, you can access administrative tools.

We're here to help

We offer live [webinars](#) to teach you how to submit precert requests electronically. Follow the instructions in the How to Register for Webinars section to register. Or you can [email us for help](#).

*In accordance with Medicare regulations, we'll continue to accept precertification requests initiated by phone for members enrolled in Medicare plans.

Clinical payment and coding policy changes

We regularly adjust our clinical payment and coding policy positions as part of our ongoing policy review processes. Our standard payment policies identify services that may be incidental to other services and, therefore, ineligible for payment. In developing our policies, we may consult with external professional organizations, medical societies and the independent Physician Advisory Board, which advises us on issues of importance to physicians. The chart below outlines coding and policy changes.

Procedure	Effective date	What's changed
Observation policy*	July 1, 2018	<p>Observation services are the use of a bed and periodic monitoring. It consists of short-term treatment by a hospital's nursing or other staff. The use of the observation treatment evaluates a patient's condition to determine the need for possible inpatient admission.</p> <p>Since July 1, 2015, observation stays greater than 24 hours required notification or we applied a late notification penalty.</p> <ul style="list-style-type: none"> • As of February 1, 2018, for all states we no longer apply a late notification penalty to your facility. Working with our provider partners, we're updating our policy to make the steps clearer and easier to follow. <p>Starting July 1, 2018, we are updating our policy as follows:</p> <ul style="list-style-type: none"> • We no longer require notification for observation greater than 24 hours • We no longer cover observation services that extend beyond 48 hours
Eligibility of assistant surgeons and surgical assistants	June 1, 2018	<p>Starting June 1, 2018, we will make changes to some of the procedures we consider eligible for assistant surgeons and surgical assistants for Coventry commercial and participating Medicare claims, in accordance with Aetna's current policy.</p>
Expanded claims edits*	June 1, 2018	<p>We notified you in December that we expanded our claims editing capabilities by adding new third-party claims edits. We are implementing additional edits effective June 1, 2018.</p> <p>To view these edits, check our secure provider website for information. You'll have access to a new prospective claims editing disclosure tool available on our secure provider website. After you log in, go to Plan Central > Aetna Claims Policy Information > Policy Information > Expanded Claims to find out if our new claims edits will apply to your claim.</p>

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

Multiple procedure reductions for therapy services

In December, we issued a reminder about our multiple procedure reductions for therapy. This reminder included an effective date, but it should not have. We are **not** changing our policy. Our intent was to provide a reminder of our current policy.

Reminder: We apply multiple procedure reductions to certain therapy services.

We pay
100%

of the therapy service with the highest practice expense (PE) relative value units (RVUs).

We reduce the PE RVU portion of the total RVU by

↓ 50%

for subsequent therapy services performed on the same day.

Coverage determinations and utilization management (UM)

We use evidence-based clinical guidelines from nationally recognized authorities to make UM decisions. We review requests for coverage to see if members are eligible for certain benefits under their plan. The member, member's representative or a provider acting on the member's behalf may **appeal** this decision if we deny a coverage request.

Our UM staff helps members access services covered by their benefits plans. We don't pay or reward practitioners or individuals for denying coverage or care. We base our decisions entirely on appropriateness of care and service and the existence of coverage. Our review staff focuses on the risks of underutilization and overutilization of services.

Clinical policy bulletins (CPBs) and pharmacy clinical criteria

We determine whether certain services, medications or supplies are medically necessary, experimental, investigational or cosmetic. This helps assess whether patients meet our clinical criteria for coverage. CPB criteria can also help you plan a course of treatment before calling for precertification, if required.

Learn more

Our medical directors are available 24 hours a day for specific UM issues. Contact us by:

- Visiting our **website**
- Calling Provider Services at **1-800-624-0756**
- Calling patient management and precertification staff using the Member Services number on the member's ID card

Share our disease management programs with members

Our disease management programs provide educational materials and, in some cases, one-on-one contact with nurses in the program.

The programs help members self-manage their disease. They help members better understand their condition and their doctor-prescribed treatment plan. The programs also educate members on accepting lifestyle changes that can help them achieve their health goals.

Enroll today

To enroll a member in a disease management program, just call Member Services. The number is on the back of the member's ID card.



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 “Physicians & Providers,” then “Practice Resources.”

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

- Our adopted clinical practice guidelines and preventive services guidelines, which address preventive, acute and chronic medical and behavioral health services. Find them on our **secure provider website**. Select “Clinical Resources” from Aetna Support Center.
- Policies and procedures
- Patient management and acute care
- Our complex case management program, including how to refer members
- How to use disease management services and how we work with your patients in the programs
- Special member programs and resources, including the Aetna Women’s HealthSM program, the Aetna Compassionate CareSM program and others
- Member rights and responsibilities
- How we make utilization management decisions, including our policy against financial compensation for denials of coverage
- Medical records criteria — a detailed list of elements we require in a patient’s medical record
- The most up-to-date **Aetna Medicare Preferred Drug Lists**, **Commercial (non-Medicare) Preferred Drug Lists** and the **Consumer Business Preferred Drug List**, also known as our formularies
- How our quality management program can help you and your patients

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

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



Quest Diagnostics[®] benefits you and your patients



As our national preferred provider, Quest Diagnostics is committed to improving efficiency. So you’ll get the diagnostic information you need.

This lab:

- Offers a complete menu, from high-quality, routine laboratory testing to advanced genetic, molecular and other specialty tests
- Can perform more than 3,500 tests, with expertise in cancer, cardiovascular and infectious diseases, neurology and more
- Employs more than 700 MDs, PhDs and genetic counselors
- Helps patients lower their out-of-pocket costs
- Offers new access in retail locations, like Safeway and Walmart, in some regions

Quick tips

- Get fast, easy access to patient test information with **Quanam[™] eLabs**. Just get started **here**.
- Call **1-866-MY-QUEST (1-866-697-8378)** to set up an account or to get **more information**.
- Check our **Clinical Policy Bulletins** before ordering tests to see if we cover them. This may help your patients avoid out-of-pocket costs.

Aetna 2018 HEDIS® data collection is under way

Our staff or our contracted representatives — CIOX and Verscend — will soon be contacting your office to collect medical record information on behalf of our members. We appreciate your cooperation.

Why this is necessary

Healthcare Effectiveness Data and Information Set (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 the National Committee for Quality Assurance (NCQA) specifies.

How to update data about your office

To update your office's demographic information, go to our **secure provider website** or use one of our vendors (Availity or CAQH) that have reached out to your office. You should notify us whenever the following information changes:

- Email and mailing addresses
- Phone or fax numbers
- Name changes due to marriage or another life event
- Whether 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 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. This includes submitting claims, checking patient benefits and eligibility, and requesting precertifications.

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.

What we may need from you

If we contact you, we'll ask you for timely access to our members' medical records. Our contracted representatives will give you options for sending medical records.

We appreciate your help in our data collection efforts.

Ordering genetic tests in the correct sequence will result in fewer denials

We want to remind you about our **policy on comparative genomic hybridization (CGH)**. We cover CGH, but only if it meets certain criteria.

Often we see providers ordering CGH and targeted genetic testing at the same time. But one of the criteria for covering CGH is a negative result for the targeted test. A common example of a targeted genetic test is FMR1 gene analysis for Fragile X. We often see FMR1 ordered at the same time as CGH. Without a negative FMR1 result, and without also meeting the other criteria, we won't cover CGH, and the member will end up with a significant bill.

Ordering these tests in the correct order should lead to fewer denials and appeals.

Read more about our **CGH policy**.



Tips to help you spot — and prevent — fraud



These days, everyone has to stay on top of their game to avoid being a victim of fraud. Yes, even providers. Follow these helpful tips.

Pharmacies can get patient IDs

That's right — through phishing schemes. Don't assume that the request you get means the pharmacy has an established relationship with your patient.

- When you get a fax, check the patient's records to confirm that the patient uses the pharmacy.
- Contact patients when you get requests from unknown pharmacies.
- Watch for requests for excessive quantities.
- When there are questions regarding formulary interchange and alternatives, contact the plan.

With diabetic supplies, beware of faxes that:

- Require your office to uncheck unwanted supplies
- Don't indicate your patient's type of machine or strips

Review requests for topical products carefully

Lidocaine 5 percent ointment is for acute use only. But many pharmacies are requesting excessive amounts. Beware of:

- Preprinted forms requiring you to pick a compound
- Preprinted faxes with multiple topical products prepacked
- Faxes for compounds or products comprised of several medications available as individual products

Take extra precautions with prior authorizations

Sometimes third parties may give misleading clinical codes or clinical support for prior authorization. If you're in an agreement with a third party to perform prior authorization, confirm that the information is correct before you sign anything.

2017 medical record audit

Our overall national compliance score for 2017 is 92.1%, which exceeds our performance goal of 85.0%. All regions met the goal.

Audits are conducted every two years to ensure primary care providers' compliance with medical record documentation.

Criteria:

- Medical record content and organization of the records
- Confidentiality of patient information
- Performance goals for participating practitioners

The following opportunities for improvement were identified:

- Current immunization records for children or immunization history for adults
- Follow-up care, calls or visits with the specific time of return noted (e.g., weeks, months)
- Advance directives, located in a prominent part of the medical record, for patients 18 years and older
- Documentation that preventive screenings and services are offered

You can find the specific documentation criteria in the Office Manual for Health Care Professionals, found on our provider website at aetna.com.



Behavioral health

Alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) program

Our SBIRT program is designed to support primary care physicians (or other specialty physicians such as ob/gyn physicians or internal medicine physicians) in screening patients for alcohol abuse, providing brief intervention and referring individuals to treatment. Overall, the program aims to improve both the quality of care for patients with substance abuse conditions, as well as outcomes for patients, families and communities.

Our goal is to help increase the adoption of alcohol screening, brief intervention and the referral to treatment process in primary care physician practices. The program incorporates the evidence-based protocol established by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). We reimburse you for screening and brief intervention. This program is open to Aetna participating physicians treating any patient who is 18 years of age or older and has Aetna medical benefits. [Click here](#) to get started.

There is an app for that

The **SBIRT app** is now available as a free download on the App Store for iOS devices.

The app provides evidence-based questions to screen for alcohol, drugs and tobacco use. If warranted, a screening tool is provided to further evaluate the specific substance use. The app also provides steps to complete a brief intervention and/or referral to treatment for the patient based on motivational interviewing.

Opioid overdose risk screening program



Our behavioral health clinicians screen behavioral health members to identify patients at risk of opioid overdose. Any patient receiving a diagnosis of opioid dependence is considered to be at risk. Learn more about the [opioid epidemic](#).

How you can help

Consider naloxone as part of the treatment plan for patients at risk of an opioid overdose. Naloxone reverses the effects of an opioid overdose. Giving naloxone kits to laypeople reduces overdose deaths,¹ is safe² and is cost effective.³ Other elements supporting this potentially life-saving intervention include telling patients and their family/support network about signs of overdose and about administering medication.

Coverage of naloxone rescue kits varies by individual plans and can be verified by calling the number on the member ID card. Note that as of **January 1, 2018**, we'll waive copays for the naloxone rescue medication Narcan® for self-insured commercial members.

Resources to help you and your patients

- [Aetna opioid resources](#)
- [Centers for Disease Control and Prevention: providing naloxone to laypersons](#)
- [SAMHSA: opioid overdose toolkit](#)

¹Kerensky T and Walley A. [Opioid overdose prevention and naloxone rescue kits: what we know and what we don't know](#). Addiction Science & Clinical Practice. January 7, 2017; 12(4). <https://doi.org/10.1186/s13722-016-0068-3>.

²Walley A, Xuan Z, Hackman HH, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013; 346: 1 – 12.

³Coffin PO, Sullivan SD. Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. Ann Intern Med. 2013; 158: 1 – 9.

Depression screening for pregnant and postpartum women

Aetna Behavioral Health works with Aetna Medical Management to assist in identifying depression and behavioral health factors for pregnant women. Aetna's **Beginning Right® maternity program** provides educational support to members and providers. The program helps women reach their goal of a healthy, full-term delivery.

Program elements

- The clinical case management process focuses on members holistically. This includes behavioral health and comorbidity assessment, case formulation, care planning and focused follow-ups.
- Beginning Right refers members with positive depression or general behavioral health screens to Behavioral Health Condition Management if they have the benefit and meet the program criteria.
- A behavioral health specialist supports the Beginning Right team. They help enhance effective engagement and identify members with behavioral health concerns.
- Beginning Right nurses reach out to members who have lost their babies to offer condolences and behavioral health resources.

How to contact us



- Members and providers can call **1-800-CRADLE-1 (1-800-272-3531)** to verify eligibility or register for the program. Members can complete enrollment with a representative at this number.



- Members can also enroll online through their member website.

Medicare

Reminder: Don't balance bill Medicare beneficiaries

Under the Qualified Medicare Beneficiary (QMB) program for Medicare beneficiaries, providers can't charge for cost sharing.

State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. But federal law allows states to limit provider reimbursement for Medicare cost sharing under certain conditions. Dually eligible individuals may qualify for Medicaid programs that pay Medicare Part A and B premiums, deductibles, coinsurance and copays to the extent the state Medicaid plan provides.

Medicare providers must accept the Medicare and Medicaid payment (if any) in full for services given to a QMB beneficiary. Medicare providers who don't follow these billing rules are operating against their provider agreement. And they may be subject to sanctions.

Tips

- All Original Medicare and Medicare Advantage providers — not just those that accept Medicaid — must follow the balance billing rules.
- Providers can't balance bill these members when they cross state lines for care, no matter which state provides the benefit.

More information

- [**Medicare-Medicaid general information**](#)
- [**Dual eligible beneficiaries under Medicare and Medicaid**](#)

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

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



How to complete your attestation

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

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

Where to get more information

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

Round out clinical care with community resources — the Resources For Living® service

Our Medicare Advantage members, their family members and their caregivers have access to **Resources For Living**, which connects them to resources in their community.

Our consultants do research for you

We supplement your treatment plan by solving those everyday needs that sometimes get in the way of health. We'll work with your patients to recommend services that meet their needs and help save time. For example, we can arrange transportation to physical therapy appointments. Or help a caregiver find adult day care services. Or research senior living options (short term and long term).

Members enjoy these conveniences

- Members get a complete view of their options.
- Our service can help them during emergencies or unexpected events.
- There's no cost to call Resources For Living. If members choose services with associated costs, like cleaning services, they'll need to pay those costs.

Think of us as an addition to your toolkit to help patients achieve their best health.



Aetna Medicare Advantage plans

Below is a summary of how our Aetna Medicare Advantage plans work with primary care physician (PCP) selection, referrals and out-of-network benefits.

Aetna MedicareSM Plan (HMO) and Aetna Medicare Prime Plan (HMO)

- Patients *must* choose and use a participating PCP.
- Patients *must* get referrals from their PCP before getting non-emergency care from other participating providers. Exception: Behavioral health routine outpatient visits.
- Services received outside of Aetna's participating provider network are *not* covered, except emergency/out-of-area urgent care or out-of-area renal dialysis — unless approved by Aetna in advance of receiving services.

Aetna MedicareSM Plan (HMO) Open Access

- Patients are encouraged, but not required, to choose and use a participating PCP.
- PCP referrals are not required.
- Services received outside of Aetna's participating provider network are *not* covered, except emergency/out-of-area urgent care or out-of-area renal dialysis — unless approved by Aetna in advance of receiving services.

Aetna MedicareSM Plan (PPO) and Aetna Medicare Prime Plan (PPO)

- Patients are encouraged, but not required, to choose and use a participating PCP.
- PCP referrals are not required.
- Patients receiving covered services from a nonparticipating provider are subject to out-of-network deductibles and coinsurance, and potential balance billing.

Visit the [Provider Education & Manuals](#) page for more information. If you need Provider Services, call **1-800-624-0756** for all Aetna Medicare Advantage plans.

Contracted Medicare providers must complete an annual Medicare Compliance Attestation by December 31 of each year.

Pharmacy

Changes to commercial drug lists begin on July 1, 2018

On **July 1, 2018**, updates will be made to our pharmacy plan drug lists. Starting on **April 1, 2018**, you can view the list of upcoming changes on our [Formularies & Pharmacy Clinical Policy Bulletins](#) page. For the Aetna Standard Plan only, the July changes will be available in May 2018 instead of on April 1, 2018.

Ways to request a drug prior authorization

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

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

Updates for granulocyte colony-stimulating factor products

- As of July 1, 2018, **Zarxio**[®] will be considered the least costly short-acting **granulocyte colony-stimulating factor** (G-CSF) product.
- All **G-CSFs** will remain on the National Precertification List and require precertification.
- Coverage for **Neupogen**[®] and **Granix**[®] will require a trial of **Zarxio**[®]. They will also need to meet the clinical precertification criteria. **Neulasta**[®] will not be affected by this change.

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

Important pharmacy updates

Medicare

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

Commercial — notice of changes to prior authorization requirements

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

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

Formulary information at your fingertips



Want to select a preferred drug for your patient from your cell phone? It's fast and easy. You can access our commercial formulary on your mobile devices. Just go to the Google 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 also select "Download on the App Store" to access this information on your phone.

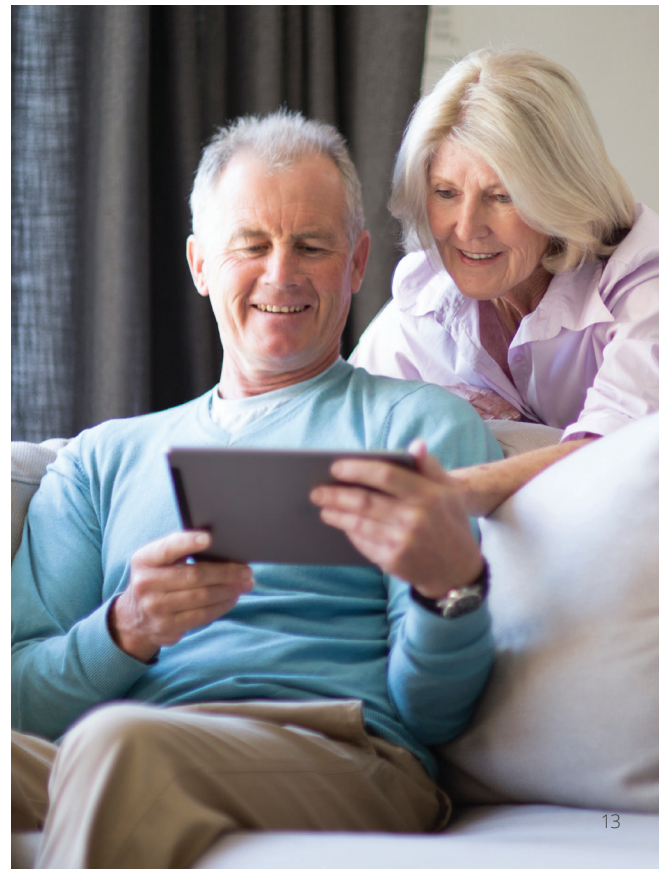
State-specific articles

California

How to access your fee schedule

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

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



California (continued)

Some plan names are changing under provider directory accuracy law

Some of our plan names have changed to comply with California's provider directory accuracy law. Under this law (Senate Bill 137), we must use consistent plan naming in all our materials and online tools for fully insured plans in California.

What does this mean for you and your practice?

It means that you, your office staff and your patients will start seeing different names for some of our plans in our materials. Just keep in mind that the change in plan names will not impact the benefits that members receive under their plans. For example, this change does not affect any current authorizations that you may have received from us under the current plan name.

Minnesota

New plan starts in expanded Minneapolis/St. Paul metro market — Allina Health | Aetna

Allina Health and Aetna have established a jointly owned health plan called Allina Health | Aetna.

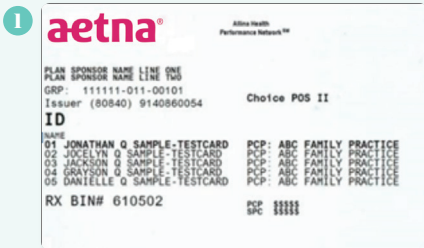
The plan is available to employer groups primarily based in the greater Minneapolis/St. Paul market. Please verify eligibility before seeing a member on the Allina Health | Aetna plan. Some plan options under Allina Health | Aetna offer a limited provider network.

Aetna's policies and procedures will apply to Allina Health | Aetna members.

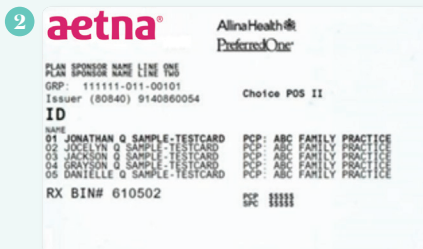
Members will have a distinct ID card based on plan/network selections.

There are four card options:

Aetna members accessing the **Allina Health Performance NetworkSM** (payer ID 60054)



Aetna members accessing **PreferredOne** through Allina Health (payer ID 60054)



Need more information?

- Visit the [Allina Health | Aetna website](#).
- Call the number on the member's ID card.

You can view the new plan names at aetna.com/dse/cms/codeAssets/pdf/California_Modul.PDF.

To minimize confusion, we are also notifying our members about these changes. If they still have questions, they can always call us at the number on the back of their ID cards.

Colorado

Notice of material change to contract

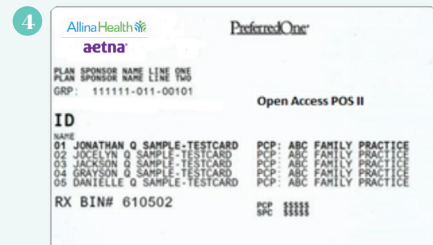
For important information that may affect your payment, compensation or administrative procedures, see the following articles in this newsletter:

- Upcoming service code changes — [pages 2 - 3](#)
- Clinical payment and coding policy changes — [page 4](#)

Allina Health | Aetna members accessing the **Allina Health Performance NetworkSM** (payer ID 54398)



Allina Health | Aetna members accessing the broad network through **PreferredOne** (payer ID 54398)



New Jersey

Where to find our appeal process forms

We have updated the information about internal and external **provider appeal processes** on our public website.

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

Ohio

Notice of material amendment to contract

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

- Upcoming service code changes — **pages 2 - 3**
- Clinical payment and coding policy changes — **page 4**



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