OfficeLink Updates™

Find updates on important changes to plans and procedures, drug lists, Medicare and state-specific information.

aetna™

December 2019

Inside this issue

90-day notices and important reminders

We're required to notify you of any change that could affect you either financially or administratively at least 90 days before the effective date of the change. This change may not be considered a material change in all states.

Improving how we communicate updates

We regularly review and adjust our clinical payment and coding policies. We know these changes are important to you and your staff. Beginning March 2020, we'll share updates on a monthly basis. You will receive an email notification when new information is available. Or you can go to **Aetna.com** to find the updates.

Endoscopy payment policy postponed

In the September edition of OfficeLink Updates™, we told you that we'd be implementing a new policy effective **December 1, 2019**, regarding endoscopy payments.

The policy would allow us to adjust payment for multiple endoscopy procedures in the same family when billed by the same surgeon or assistant surgeon on the same date of service for the same member.

However, due to issues that came up during our testing phase, we've decided to postpone implementation of this policy indefinitely.

Medical specialty drugs

Effective **March 1, 2020** we will enhance our daily unit limit claim edits for medical specialty drugs. We will apply diagnostic and member characteristics (age, diagnosis, gender, etc.) to determine the specialty drugs quantity limits. This enhancement will be a part of the new Novologix® online prior authorization (PA) system.

Third Party Claim and Code Review Program

As of **March 1, 2020**, you may see new claims edits. You can view these edits on our provider website. You'll have access to our prospective claims editing disclosure tool. After you log in, go to My Health Plans > Aetna > Claims > Policy Information > Expanded Claim Edits to find out if our new claims edits will apply to your claim.

These new edits are part of our Third Party Claim and Code Review Program. They support our continuing effort to process claims accurately.

This is subject to regulatory review and separate notification in Washington state.

Solid tumor panels

As of **March 1, 2020**, when a solid tumor molecular pathology service is reported with five or more related molecular pathology services and a corresponding solid tumor diagnosis code, we will allow one instance of CPT 81445 for the solid tumor targeted genomic sequence analysis panel.

We've enhanced our claims editing process

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

When appropriate, we evaluate claims against the following guidelines:

- Internal coding guidelines
- The Centers for Medicare & Medicaid Services medical coverage, payment and coding policies
- The American Medical Association Current Procedural Terminology® (CPT®) coding standards

Changes to our National Precertification List (NPL)

Important NPL updates
The following new-to-market drugs require precertification:

- Cutaquig® (IVIG) — precertification for both the drug and the site of care required effective **August 1, 2019**.
- Polivy™ (polatuzumab vedotin-piiq) — precertification required **effective September 13, 2019**.
- Kanjinti™ (trastuzumab-anns) — precertification required effective **November 1, 2019**.

The following drugs will require precertification, including Part B step therapy review, effective **January 1, 2020**, for Medicare Advantage members only:

- Abraxane® (paclitaxel)
- Orencia® (abatacept)
- Eylea® (aflibercept)
- Lemtrada® (alemtuzumab)
- Botox® (onabotulinumtoxinA)
- Myobloc® (rimabotulinumtoxinB)
- Xeomin® (incobotulinumtoxinA)
- Aranesp® (darbepoetin alfa)
- Epogen®, Procrit® (epoetin alfa)
- Xgeva® (denosumab)
- Neupogen® (filgrastim [G-CSF])
- Cuvitru™ (immune globulin)

- Bivigam® (immune globulin)
- Gammaplex® (immune globulin)
- Gamunex®-C/Gammaked® (immune globulin)
- Carimune NF® (immune globulin)
- Octagam® (immune globulin)
- Gammagard® (immune globulin)
- Flebogamma®/Flebogamma® DIF (immune globulin)
- Hyqvia® (immune globulin/hyaluronidase)
- Panzyga® (immune globulin)
- Remicade® (infliximab)
- Tysabri® (natalizumab)
- Neulasta® (pegfilgrastim)
- Lucentis® (ranibizumab)
- Ilumya™ (tildrakizumab)
- Actemra® (tocilizumab)
- Stelara® (ustekinumab)
- Entyvio® (vedolizumab)
- Remodulin® (treprostinil sodium)
- Durolane® (hyaluronan or derivative)
- GenVisc® (hyaluronan or derivative)
- Hyalgan® (hyaluronan or derivative)
- Hymovis® (hyaluronan or derivative)
- Euflexxa™ (hyaluronan or derivative)
- Orthovisc® (hyaluronan or derivative)
- Synvisc® or Synvisc-One® (hyaluronan or derivative)
- Monovisc® (hyaluronan or derivative)
- Gelsyn-3™ (hyaluronan or derivative)
- TriVisc® (hyaluronan or derivative)
- Rituxan® (rituximab)
- Herceptin Hylecta™ (trastuzumab, 10 mg; and hyaluronidase-oysk)
- Inflectra® (infliximab-dyyb, biosimilar)
- Renflexis® (infliximab-abda, biosimilar)
- Fulphila™ (pegfilgrastim-jmdb, biosimilar)
- Nivestym™ (filgrastim-aafi, biosimilar)

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

To save time, request precertification electronically — it's fast and simple. Most precertification requests can be submitted electronically through the provider website or by using your Electronic Medical Record (EMR) system portal.

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

Emergency Room Level of Care

Effective **March 1, 2020**, the Emergency Room Level of Care payment policy will apply to all outpatient facility bill types.

Changes to commercial drug lists will occur on April 1, 2020

On **April 1,** we'll update our pharmacy drug lists.

You'll be able to view the changes as early as February 1, 2020. They'll be available then on our **Formularies & Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug prior authorization

- Submit your completed request form through our **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 (TTY: 711)**.

The changes, including precertification requirements, quantity limits and step-therapy programs, will affect all Pharmacy Management drug lists, subject to applicable state restrictions.

For more information, call the Aetna Pharmacy Management Provider Help Line at **1-800-238-6279 (TTY: 711) (1-800-AETNA RX)**.

Timely notification for acute rehabilitation centers and skilled nursing facilities

To ensure that our members receive appropriate care in an acute rehabilitation center or a skilled nursing facility, our concurrent review nurses will request clinical information in order to secure an admission or a continued stay for a Medicare member.

When clinical information is requested, it's important that you submit the requested information within one or two calendar days of the request. If we do not receive the requested information within this time frame, coverage for the days will be denied administratively for lack of precertification. If the member is in

an approved facility and a continued stay review is requested but no clinical information is received, we'll deny uncovered days administratively.

Healthcare Common Procedure Coding System (HCPCS) code updates to specific drug contract service groupings

Individual service codes will be assigned within contract service groupings. Changes to an individual provider's compensation will depend on the presence or absence of specific service groupings within the contract. The changes are outlined below.

All updates will start on **March 1, 2020**, unless otherwise noted.

This is subject to regulatory review and separate notification in Washington state.

Codes	Provider types affected	What's changing
J1095, J2186, J2787	Facilities including acute short-term hospitals, free-standing ambulatory surgery centers, skilled nursing facilities	These codes will be **added** to the following contract service groupings: • All drugs or drug agents without specific rate set forth above or herein • Drugs • Chemotherapy and All Other Drugs • Chemotherapy & All Oth Drg • All Other Drugs
Q5109, Q5111	Facilities including acute short-term hospitals, free-standing ambulatory surgery centers, skilled nursing facilities, infusion facilities, dialysis facilities, physician providers, home health providers	These codes will be **added** to the following contract service groupings: • All drugs or drug agents without specific rate set forth above or herein • Drugs • Chemotherapy and All Other Drugs • Chemotherapy & All Oth Drg • All Other Drugs • All Drugs, agents, inj. Drugs • Injectable Drugs • All Outpatient Drugs including C, J, Q and S codes
J9022, J9023, J9203, J9285	Facilities including acute short-term hospitals, free-standing ambulatory surgery centers, skilled nursing facilities	These codes will be **added** to the following contract service groupings: • Drugs • Chemotherapy and All Other Drugs • Chemotherapy and All Oth Drg • Chemotherapy Drugs • All drugs or drug agents without specific rate set forth above or herein

J3591	Facilities including acute short-term hospitals, free-standing ambulatory surgery centers, skilled nursing facilities, infusion facilities, dialysis facilities, physician providers, home health providers	These codes will be **added** to the following contract service groupings: • Drugs • Chemotherapy and All Other Drugs • All Other Drugs • Chemotherapy & All Oth Drg • All drug or drug agents without specific rate set forth above or herein
J0185, J0517, J0567, J0584, J0599, J0841, J1301, J1454, J1628, J1746, J2062, J2797 J3245, J3304, J3397, J3398, J7170, J7177, J7203, J7318, J7329 Q9991, Q9992, Q5105, Q5106, Q5108, Q5110	Facilities including acute short-term hospitals, free-standing ambulatory surgery centers, skilled nursing facilities	These codes will be **removed** from the following contract service grouping: • Chemotherapy Drugs

Reminder – experimental and investigational labs

We consider certain laboratory tests to be experimental and investigational. These noncovered laboratory tests are not covered by most of our plans. This means your patient may be responsible for the full cost of these laboratory tests.

There are several tests that Aetna® may not cover, but the most common are:

- Lyme Disease (CPB #0215)
- Vitamin D Assay (CPB #0945)
- Lipoprotein Cholesterol Test (CPB #0381)
- Homocysteine Test (CPB #0381)

Information you should share with patients

It is important that your patients understand that they are financially responsible for these tests, as they are noncovered services. Please remind them at the time you order the test that they are responsible for the full cost of the laboratory tests.

You can verify if we cover a lab test

We provide an online reference tool listing laboratory tests that are considered experimental and investigational or that may be conditionally covered. Access this tool on our provider website. You can also view our corresponding Clinical Policy Bulletins (CPBs), which we post alongside the CPT® code descriptions.

Timely notification required

To comply with our inpatient timely notification requirements, be sure to notify us of hospital admissions within one business day.* Failure to comply means that charges could be subject to a denial of up to a maximum of $10,000.

Also note:

- You must precertify maternity or newborn confinements, if they exceed the standard length of stay of three days or less for vaginal or five days or less for caesarean.
- You must contact us if notification is late or if you've discharged the patient.

*Maine, Pennsylvania and Indiana allow alternate time frames for notification.

Extenuating situations

There may be reasons why patients can't provide coverage information. Note the following guidelines regarding how we handle extenuating situations:

- If you notify us within 14 days after the patient's discharge, we'll make a decision based on the information we have.
- If you notify us after 14 days from the patient's discharge, we'll note your contact. Examples of supporting evidence we may consider upon appeal include:

    - ID card/eligible information was obtained before/during admission
    - Facility face/demographics sheet (contains patient demographic information)
    - Records confirming contact with another carrier before/during admission

We'll review all available information when making an appeal decision.

How we handle certain ASC/APC edits —update to our June communication

In the June OfficeLink Updates™ (OLU) newsletter, we said that we would make changes to how we handle (reimburse for) certain Ambulatory Surgery Center (ASC) and Ambulatory Payment Classification (APC) edits under the ASC and APC payment methodologies. The June article stated that we would implement these changes in November 2019. However, the implementation of these changes will be delayed. We will provide you with the actual implementation date in a subsequent communication/OLU newsletter.

News for you

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 (if you don't have Internet access, call our Provider Service Center for a paper copy) as well as information on the following:

- Policies and procedures
- Patient management and acute care
- Our complex case management program and how to refer members
- Additional health management programs, including disease management, the Aetna Maternity Program, Healthy Lifestyle Coaching and others
- Member rights and responsibilities
- How we make utilization management decisions, which are based on coverage and appropriateness of care, and include our policy against financial compensation for denials of coverage
- Medical Record Criteria, which is a detailed list of elements we require to be documented in a patient's medical record and 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 **Consumer Business Preferred Drug List**, also known as our formularies.

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** or calling patient management and precertification staff using the Member Services number on the member's ID card.

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, and we encourage you to take a look at the program goals.

Make sure your demographic information is valid

The Centers for Medicare & Medicaid Services (CMS) requires that Medicare Advantage (MA) organizations ensure the validity of provider demographic information.

We need to reach out to providers every quarter to validate their information. Our current vendors — CAQH® and Availity® — perform this outreach. And you are obligated, as an MA provider, to comply with this validation.

Have you recently moved your office or changed your phone number, email address or any demographic information? If so, simply go to our vendors' websites and update your profile within seven days of the change. Don't wait for the quarterly attestation process, and don't call or fax the information to Aetna. We'll get the update from the vendors and process it.

If you're not a Medicare provider or if you have not received vendor communications, you can always go to our provider website on NaviNet®. NaviNet users have access to Aetna's "Update Provider Demographics" function, through which they can submit demographic changes.

We take this compliance obligation seriously. If you don't reply, we may *suppress your information* in our directory. This means that patients and providers won't see you listed as our participating provider. And we may even terminate the participation of providers that don't comply.

Important message for Massachusetts providers
In November 2018, we expanded our relationship with CAQH to improve our provider directory accuracy. This expanded relationship was necessary to address guidance from both the Commonwealth of Massachusetts and the Centers for Medicare & Medicaid Services (CMS). Massachusetts commercial and Medicare providers are asked to validate their demographic information quarterly in CAQH. This process helps us improve the accuracy of our Massachusetts provider directories. We appreciate your cooperation with this program.

Properly coding acute myocardial infarction (AMI) and chronic kidney disease (CKD)

It's important to follow the **International Classification of Diseases, Tenth Revision (ICD-10)** guidelines to ensure that you are coding both conditions properly. Here are some important tips.

AMI

- Use codes from category I21 for AMI *only if* less than 4 weeks (28 days) of acute onset.
- Use codes from I21 or I22 for subsequent AMI within 4 weeks (28 days) of initial AMI.
- Use code from category I23 for certain complications within 4 weeks (28 days) of initial AMI.
- If AMI onset is more than 28 days ago, use I25.2, regardless of any ongoing treatment.
- Always document each AMI occurrence by date in prior medical history.
- Initially, write "acute myocardial infarction" followed by "AMI" in parentheses, and then use just "AMI" throughout the remainder of the note.

CKD

- Document the specific stage, if known, and always use a code from category N18.
- Document acute or chronic CKD.
- Coding CKD with other conditions:
    - Code first any associated diabetes (E08.2, E09.22, E10.22, E11.22, E13.22).
    - CKD and hypertension (HTN) are presumed linked unless otherwise documented; assign code from category I12.
    - Assign code from category I13 when there is HTN, CKD and heart disease.
- Dialysis status — Z99.2.

Contact us at **RiskAdjustment@Aetna.com** for additional information.

Appointment availability surveys

We measure member access to care every year. We do this in many ways. For example, we review:

- Member satisfaction survey results
- Complaint data
- Phone surveys we conduct

The phone surveys include a random sampling of primary care and specialty care providers.

We appreciate your participation in these phone surveys. We do all this to comply with the National Committee for Quality Assurance (NCQA) accreditation standards and various state regulations.

You'll find the access standards we measure in the **Office Manual for Health Care Professionals**.

Coding advice to earn maximum revenue for the HEDIS® measure "Controlling High Blood Pressure (CBP)"

For patients diagnosed with hypertension, be sure to submit claims or encounter data with Current Procedural Terminology® (CPT®) II codes for blood pressure results. Please do this for each office visit.

Why CPT II codes are important for you

- As HEDIS rates for this measure go up, you may earn more revenue through Value Based Services and other pay-for-performance models.
- HEDIS reports can help you identify and address gaps in the quality of care of patients.
- Use of these CPT II codes will decrease the amount of medical records we ask for during HEDIS hybrid data collection. We usually ask for this data every year from February through May.

Diastolic < 80
CPT II
3078F

Diastolic 80–89
CPT II
3079F

Diastolic ≥ 90
CPT II
3080F

Systolic < 130
CPT II
3074F

Systolic 130–139
CPT II
3075F

Systolic ≥ 140
CPT II
3077F

We heard you. And enhanced our precertification status messages.

We heard you, and we've made changes to our precertification status messages. Thanks to your feedback, you'll now get more details. If you want to know the status of your precertification request as it goes through the review process, you'll have more information.

When you use online self-service options, you can:

- Check the status of your request
- Confirm if we've received your clinical documents
- See if your request is with a medical director

No more guessing games — when we change the status, your message status will change with it.

You can get updated status messages:

- On the website when you submit and inquire about precertification
- When you call our automated self-service phone solution

You'll have more time in your day — and not on the phone.

Genetic testing services available

Our two preferred labs, Quest Diagnostics® and LabCorp, offer a comprehensive array of high-quality genetic testing and related services to meet your patients' diverse needs.

The two companies offer:

- Hundreds of genetic tests for prenatal, cancer, cardiovascular, neurogenetic and other indications
- More than 40 years of genetic testing experience
- Professional consultation from hundreds of staff MDs, PhDs and genetic counselors

Online, you can reach:

- Quest at **QuestDiagnostics.com**
- LabCorp at **LabCorp.com**, **IntegratedGenetics.com** and **IntegratedOncology.com**.

You can call a medical geneticist or lab-based genetic counselor at:

- Quest — **1-866-GENE-INFO** (**1-866-436-3463**) **(TTY: 711)**
- LabCorp — **1-800-345-4363 (TTY: 711)**

Plan sponsor benefits may vary. Members should check their plan document for details about their specific plan. Please also refer to Aetna's Clinical Policy Bulletins for coverage information.

Our updated telemedicine policy

We're introducing an updated policy that will cover telemedicine services for members enrolled in all Aetna® commercial plans.

Under the policy, we'll reimburse for two-way, real-time audiovisual interactive communication between the patient and the health care practitioner. This interaction does not include direct patient contact, but the patient must be present and take part throughout the interaction.

This updated policy will take effect as of January 1, 2020. At that time, you will be able to review the payment policy and approved codes on the provider website.

Billing

When billing for eligible services rendered via telemedicine, as explained above, you must bill them using the appropriate telemedicine modifier representing two-way, real-time audiovisual interactive communication.

New pre-approval requirements for Alabama, Arkansas, Idaho, Louisiana, Mississippi and South Dakota members

Our Enhanced Clinical Review program with eviCore healthcare will require authorization for certain procedures. The program will start on **January 1, 2020**. This affects Alabama, Arkansas, Idaho, Louisiana, Mississippi and South Dakota members in our Medicare Advantage HMO/PPO Aetna® products.

Services that require pre-approval

- High-tech outpatient diagnostic imaging procedures such as MRI/MRA, nuclear cardiology, and PET scan and CT scan, including CTA
- Non-emergent outpatient stress echocardiography
- Non-emergent outpatient diagnostic left and right heart catheterization
- Insertion, removal and upgrade of elective implantable cardioverter defibrillator, cardiac resynchronization therapy defibrillator and implantable pacemaker
- Polysomnography (attended sleep studies)
- Interventional pain management
- Musculoskeletal large joint (hip and knee) arthroplasty procedures
- Radiation therapy services:
    - Complex and 3D conformal
    - Stereotactic radiosurgery (SRS)/Stereotactic body radiation therapy (SBRT)
    - Brachytherapy
    - Hyperthermia
    - Intensity-modulated radiation therapy (IMRT)/Image-guided radiation therapy (IGRT)
    - Proton beam therapy
    - Neutron beam therapy and radiopharmaceuticals

Precertification won't be required for

- Emergency departments
- Inpatient radiology services
- Outpatient radiology services other than those listed above

Visit eviCore healthcare at **eviCore.com** for a complete list of procedures requiring an authorization.

The requested services are reviewed in accordance with applicable Medicare National Coverage Determinations and Local Coverage Determinations; nationally recognized clinical and billing guidelines

of the American College of Radiology (ACR), the American College of Radiation Oncology and the American Society of Radiation Oncology; guidelines from other recognized medical societies; any state regulations or mandates; and Aetna's Clinical Policy Bulletins (CPBs).

Submitting authorization requests
Before services are performed, eviCore healthcare's board-certified physicians will review authorization requests for medical necessity. For you to get paid for services, you must send authorization requests before providing services.

If treatment starts before **January 1, 2020**, and you haven't already called Aetna®, contact eviCore healthcare to request continuity of care authorization. This will allow claims for dates of service after **January 1, 2020**, to be considered.

To review our CPBs, visit us at **Aetna.com** and look under the "Helpful Links" section.

Asking eviCore healthcare for approval

- Go to **eviCore.com.**
- Call **1-888-693-3211 (TTY: 711)** (7 AM to 8 PM CT, Monday through Friday).
- Fax a request form (available online) to **1-844-822-3862.**

For radiation therapy services only

- Go to eviCore.com (after logging in, choose the CareCore National tab).
- Call **1-888-622-7329 (TTY: 711)** (7 AM to 8 PM CT, Monday through Friday).
- Fax a request form (available online) to **1-888-693-3210**.

Urgent requests
If a member needs services in less than 48 hours due to medically urgent conditions, please call eviCore healthcare for a fast review. Tell the representative the request is for urgent care.

What you should know
- We recommend that ordering physicians get authorizations and share the approval numbers with the facility performing the procedure when it is scheduled.
- eviCore healthcare will fax its approval decision to the ordering physicians and requested facilities.
- Approvals have authorization numbers and one or more CPT® codes specific to the approved services.
- If the service you ask for is different from what eviCore healthcare approves, the facility must contact eviCore healthcare for review and approval before submitting claims.
- If you perform services without approval, we may deny payment.
- We'll determine coverage under the applicable policy in accordance with the policy's terms and conditions and with our policies and procedures.

We're here to help

If you have questions, call eviCore healthcare at **1-888-693-3211 (TTY: 711)**. Or you can call Provider Services at:

- **1-800-624-0756 (TTY: 711)** for HMO and Medicare Advantage benefits plans
- **1-888-MD-AETNA (1-888-632-3862) (TTY: 711)** for all other plans

At **eviCore.com**, you can see eviCore healthcare's criteria and get request forms.

Check out our provider manual's new look

Looking for information on our policies and procedures? Check out **our streamlined, more user-friendly manual**, now available on **Aetna.com**.

Try a new and improved online prior authorization system powered by Novologix®

Use the new Novologix online prior authorization (PA) system to request a PA.

Why use Novologix? You'll get:

- An efficient intake process through a web-based application
- A self-service experience and access to real-time status updates
- *Instant approvals* for many of your submissions — *new* for 2020

When to use Novologix
This new program is available for commercial members when requesting a medication on Aetna's National Precertification List (NPL). Visit **Aetna.com** to view our current NPL.

Where to find the Novologix tool
You can find the Novologix tool on NaviNet® or Availity®.

- NaviNet users: Have your security officer enable your access.
- Availity users: Have your administrator enable your access.

How to get help
For help using Novologix, call them at **1-866-378-3791** or **send them an email**. And watch for training webinars in the coming months.

For help using Novologix on NaviNet, call them at **1-888-482-8057**.

For help registering for or using Novologix on Availity, call them at **1-800-AVAILITY (282-4548)**.

Pharmacy updates

Formulary information at your fingertips

Want to select a preferred drug for your patient from your cell phone? It's fast and easy. You can access our commercial formulary on your mobile devices. Just go to the Google Play™ store* and type in "formulary search" — then download the Formulary Search app for free.

You can also search at **FormularyLookup.com**. Enter the drug name, state and channel (plan type). Then, under "Payer/PBM," select "Aetna Inc." to view the drug coverage information. At the bottom of the page, you can also select "Download on the App Store" to access this information on your phone.

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

Important pharmacy updates

Medicare

Visit our **Medicare drug list** web page to view the most current Medicare plan formularies (drug lists.) We update these lists at least once a year.

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 the most current prior authorization requirements for each drug

The right NPI can cut down on delivery delays

Avoid prescription delivery delays by confirming that your system has the right National Provider Identifier (NPI) for CVS Caremark Mail Service Pharmacy™ mail-order prescription drug service.

The correct NPI for CVS Caremark Mail Service Pharmacy is: **1881952851**.

Mail-order pharmacy services recently transitioned from Aetna Rx Home Delivery® service to CVS Caremark Mail Service Pharmacy.

State-specific updates

Current California updates

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) or a Physician Hospital Organization (PHO), contact your IPA or PHO 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 use the **FeeSchedule@Aetna.com** email address to send it to us.

- If your hospital is reimbursed through Medicare Groupers, visit the **Medicare website** for your fee schedule information.

Current Colorado updates

Notice of material change to contract

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

- Updates to our **National Precertification List**
- 90-day notices and important reminders for all **clinical payment and coding policy changes**

Current New Jersey updates

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.

Current Rhode-Island updates

Complaint and grievance process reminder

Rhode Island Rule 230 RICR 020-30-9 requires that we annually give providers a description of the complaint and grievance process that is available to both members and providers. Our description also provides guidance for distinguishing a complaint/grievance from a benefits determination appeal, and the rights associated with each. If you prefer a paper copy of the annual notice, please contact the Provider Service Center at **1-888-MD-AETNA (1-888-632-3862) (TTY: 711)**. For a full description of the Aetna provider appeals process, see the following:

- **Rhode Island grievance and appeals process**

Medicare updates

Don’t let your network status change — complete your FDR attestation to comply with CMS requirements

If you are a participating provider (individual, group, facility or ancillary, etc.) 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 FDR Attestation page**. Once on the page, take a look at the documents in the “Need More Information on the Medicare FDR Program” section.

Once you review the information and ensure that you’ve met the requirements, complete your 2019 attestation by clicking the link provided. A single annual attestation meets all your Aetna, Coventry and/or MMP compliance obligations.

Where to get more information
If you have attestation-completion or compliance-related questions, please review all supporting materials published on our **Aetna.com/medicare** site. Just email us at **FDRAttestation@Aetna.com** if you don’t find the answers you need. Email us at **Medicaidmmpfdr@Aetna.com** if you’re an MMP-only provider. You’ll find more information in our quarterly **FDR Compliance Newsletter**, too.

2020 market expansion: Dual Special Needs Plans (DSNPs)

We're excited to announce the expansion of our DSNPs into more markets for 2020.

If you are contracted for Medicare Advantage HMO products, you are in our DSNP network.*

The DSNP network is available in **limited states and counties**. Check your participation status using our **Provider Search tool**.

Policies and procedures
All DSNPs are required to have an approved Model of Care. The Centers for Medicare & Medicaid Services (CMS) requires **Model of Care training** upon initial participation and annually thereafter.

Member eligibility and benefits
Members should follow these steps to become eligible for benefits:

1. Show their DSNP member ID card and state-issued Medicaid card
2. Select a primary care physician
3. Follow the approval process for out-of-network benefits (they need to contact Member Services directly)

Provider claims processing
Member cost sharing: Depending on the member's Medicare Savings Program (MSP) eligibility, they may have a cost share responsibility. *You may not balance bill* members (including Qualified Medicare Beneficiary-only members) who do not have cost share responsibility. For more information, go to the **2020 DSNP Provider Cost Share Grid**.

To contact us, go to the **2020 DSNP Service Area Guide**.

*VA only: Please review your contract or contact our Provider Service Center at **1-855-463-0933 (TTY: 711)** to find out about your network participation.

We're expanding our Aetna® Medicare Advantage (MA) plans to 264 new counties

We're expanding our MA plans to 264 new counties for 2020. Depending on your contract, you may be listed as a participating provider in our MA networks.* On **Aetna.com**, you can view our **2020 expansion counties**. If you're not currently contracted for our MA plans, please call our Provider Service Center at **1-800-624-0756 (TTY: 711)**.

The Annual Enrollment Period (AEP) for Medicare is **October 15, 2019,** through

December 7, 2019. We believe that Medicare beneficiaries will be interested in our plans due to our healthy Star Ratings. For 2020, our overall enrollment-weighted rating is 4.3 out of 5 stars (measurement period FY 2018 and early 2019). These ratings reflect the care you give to your patients.

Learn more about our MA products

View our **Aetna Medicare Advantage plans quick reference guide**.

Visit our Health Care Professionals page on **Aetna.com** to:

- View the **At a Glance** reference guide

*Not all plans are offered in all service areas.

New Aetna® logo and Medicare plan name changes

Starting **January 1, 2020**, you'll see the new Aetna logo, shown below, on company communications and member ID cards for Medicare plans.

Always ask for the member's ID card and send claims to the payor ID or address on the back of the card.

Also, see the following Excel spreadsheet for 2020 plan name changes. They are sorted by H contract and PBP.

Medicare Plan Name Changes for O

In 2020, Independent Living Systems (Florida only) and GA Foods will manage benefits for some of our Medicare members

In 2020, Independent Living Systems (Florida only) and GA Foods will provide post-inpatient hospital discharge meals to some of our Medicare members.* This delivery process happens automatically once the hospital discharges the member. The vendor will contact the member to schedule meal delivery.

- Members are eligible for meals delivered to their requested location.

- Meals are guaranteed within 72 hours of the order.

How to make changes to this service

The vendor will send PCPs a fax with more details on this service. The fax will include instructions on how to change the meal content or cancel this service, if the PCP deems it necessary.

*This benefit is not available to all Medicare Advantage members. To check eligibility, members should check their Evidence of Coverage (EOC) document.

In 2020, HCS to continue managing services for some of our Medicare members

Hearing Care Solutions (HCS) will continue to administer all *routine* hearing-related services for *some** of our Medicare members. These services include:

- The no-charge hearing exam used to determine hearing aid candidacy
- All hearing aid benefits (hearing aid cost varies by plan)

What you need to know
*Not all of our Medicare Advantage members have this benefit. To check eligibility, members can check their Evidence of Coverage document. Your office should verify eligibility through our Provider Service Center.

For HMO plans that have the HCS benefit, members *must* go to an HCS provider for coverage.

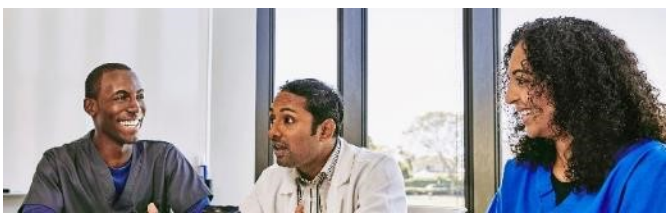
For PPO plans that have an HCS benefit, members have the option to go out of network for a hearing exam and will be responsible for any applicable out-of-network cost share, but all hearing aid instruments orders and purchases *must* go through HCS for coverage.

If your Aetna Medicare patient is a candidate for hearing aids, tell them to call HCS at **1-855-268-6118 (TTY: 711)**. HCS is available Monday through Friday from 8 AM to 8 PM local time.

Exams provided as part of your patients' hearing benefit are separate from the diagnostic hearing exams and related charges covered by Medicare. You may continue to bill us for hearing testing directly related to a medical condition.

Join the HCS network
If you are not currently part of the HCS network and would like to join their network, you can apply online at **HearingCareSolutions.com**.

To submit a paper application, please contact HCS at Applications@HearingCareSolutions.com. Or call **303-407-6862**.



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