



OfficeLink Updates™



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

March 2020

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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.

Changes to our National Precertification List (NPL)

Effective July 1, 2020, the following precertification changes apply:

- We'll require precertification for the following:
 - Functional endoscopic sinus surgery (FESS)
 - Revision of shoulder arthroplasty
 - Arthrodesis for spine deformity
 - Kyphectomy

- We'll require precertification for the following drugs:
 - Avastin® (bevacizumab)
 - Belrapzo™ (bendamustine HCl)
 - Bendeka® (bendamustine HCl)
 - Feraheme® (ferumoxytol)
 - Injectafer® (ferric carboxymaltose injection)
 - Mvasi™ (bevacizumab-awwb)
 - Sandostatin® (octreotide)
 - Somatuline® (lanreotide)
 - Treanda® (bendamustine hydrochloride)
 - Zirabev™ (bevacizumab-bvzr)
 - Zoladex® (goserelin)
 - Zulresso™ (brexanolone)
- We'll require precertification for the drug and site of care for the following drugs:
 - Bavencio® (avelumab)
 - Imfinzi® (durvalumab)
 - Keytruda® (pembrolizumab)
 - Libtayo® (cemiplimab-rwlc)
 - Opdivo® (nivolumab)
 - Tecentriq® (atezolizumab)
 - Yervoy® (ipilimumab)

The following new-to-market drugs require precertification:

- Rinvoq™ (upadacitinib) — precertification required, effective November 1, 2019. This drug is included in the immunologic agent class.
- Synjoynt™ (1% sodium hyaluronate) — precertification required, effective November 5, 2019. This drug is included in the viscosupplement class.
- Trilon™ (1% sodium hyaluronate) — precertification required, effective November 5, 2019. This drug is included in the viscosupplement class.
- Beovu® (brolucizumab-dblI) — precertification required, effective January 1, 2020. This drug is included in the ophthalmic medical injectable class.
- Xembify® (immune globulin-klhw) — precertification for both the drug and the site of care required, effective January 1, 2020.
- Givlaari™ (givosiran) — precertification for both the drug and site of care required, effective February 1, 2020.

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**](#).

Changes to commercial drug lists begin on July 1, 2020

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

You'll be able to view the changes as early as May 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)**.

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

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

Our new provider portal on Availity®

You told us you wanted one efficient workflow to communicate with payers. So, we teamed up with Availity to streamline the process and give you new tools, too.

Our transition to the new portal will be by state. You may have already heard from us. If not, no worries! We'll be in contact with you very soon. You'll also be hearing directly from Availity.

Want more information?

Visit the [**Aetna® landing page**](#) on Availity. You can enroll in a free webinar, where we'll show you how to register, how to get started and best practices for optimizing the tools available.

Availity will become our sole provider portal on April 30, 2020.

If you're already registered with Availity for another payer, you're all set. You can use your existing log-in credentials to get started with Aetna.

We look forward to working with you!

Individual service codes and service grouping updates

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

Unless otherwise indicated, all updates will be effective **June 1, 2020**.

Codes	Provider types affected	What's changing
22633, 27130*	Facilities including Acute Short-Term Hospitals and Ambulatory Surgery Centers	<p>Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 6 (AEG6)</p> <p>Code will remain assigned to Ambulatory Surgery: Default Rate (DEFAULTSUR).</p> <ul style="list-style-type: none"> If contract contains an Ambulatory Surgery — Aetna Enhanced Grouper: Category 6 rate it will be applied. If not, then the Ambulatory Surgery Default Rate will be applied.
22633, 27130*	Facilities including Acute Short-Term Hospitals and Ambulatory Surgery Centers	<p>Will be reassigned to Coventry Enhanced Grouper: Grouper 6</p> <ul style="list-style-type: none"> If not listed above, then the Undefined Procedure Rate will be applied. If the contract contains none of the above provisions, the relevant terms of the contract will rule.
63266, 63267, 63268*	Facilities including Acute Short-Term Hospitals and Ambulatory Surgery Centers	<p>Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 5 (AEG5)</p> <p>Code will remain assigned to Ambulatory Surgery: Default Rate (DEFAULTSUR).</p> <ul style="list-style-type: none"> If contract contains an Ambulatory Surgery — Aetna Enhanced Grouper: Category 6 rate it will be applied. If not, then the Ambulatory Surgery Default Rate will be applied.
63265, 63266, 63267, 63268*	Facilities including Acute Short-Term Hospitals and Ambulatory Surgery Centers	<p>Will be reassigned to Coventry Enhanced Grouper: Grouper 5</p> <ul style="list-style-type: none"> If not listed above, then the Undefined Procedure Rate will be applied. If the contract contains none of the above provisions, the relevant terms of the contract will rule.
22634*	Facilities including Acute Short-Term Hospitals and Ambulatory Surgery Centers	<p>Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 1 (AEG1)</p> <p>Code will remain assigned to Ambulatory Surgery: Default Rate (DEFAULTSUR).</p> <ul style="list-style-type: none"> If contract contains an Ambulatory Surgery — Aetna Enhanced Grouper: Category 5 rate it will be applied. If not, then the Ambulatory Surgery Default Rate will be applied.

22634*	Facilities including Acute Short-Term Hospitals and Ambulatory Surgery Centers	<p>Will be assigned to Coventry Enhanced Grouper: Grouper 1</p> <ul style="list-style-type: none"> • If not listed above, then the Undefined Procedure Rate will be applied. • If the contract contains none of the above provisions, the relevant terms of the contract will rule.

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

For NC providers only: updates to imaging procedures including MRIs, CT scans and ultrasounds

Effective **June 1, 2020**, we will begin applying our existing policy on multiple imaging procedures to providers in North Carolina. Reductions may apply to technical and global charges for certain diagnostic imaging services. We allow 100% reimbursement for the scan with the highest RVUs. Reductions apply to each subsequent scan performed on the same day, for the same member, by the same provider.

Timely notification for acute rehabilitation centers and skilled nursing facilities

In December, we told you that in March we would begin requesting clinical information for an acute rehabilitation and skilled nursing facility **and administratively deny claims if the requested information was not received. We will not be implementing changes to the policy at this time.** Aetna's concurrent review nurses may request clinical records. When our nurses request the clinical records, we ask that you send the clinical information timely. This ensures that our members receive appropriate care, when admitting an Aetna member to an acute rehab or skilled nursing facility. We will notify you of any future changes.

Third Party Claim and Code Review Program

Effective **June 1, 2020**, you may see new claim edits. These new edits are part of our Third Party Claim and Code Review Program. These edits support our continuing effort to process claims accurately. You

can view these edits on our provider website.

You'll have access to our claim editing disclosure tool. To find out if our new claim edits will apply to your claim, log in to the provider website. Then go to: Aetna Payer Space > Applications > Code Edit Lookup Tools. You'll need to know your Aetna Provider ID Number (PIN) to access.

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

Update to our lab policy for in-office surgical pathology

Starting **June 1, 2020**, we are adding procedure codes 88341 and 88344 to our existing in-office surgical pathology lab policy. The current policy already allows these in-office surgical pathology procedure codes: 88300-88314 and 88342.

When can you use these codes?

You can only use these codes if you are Clinical Laboratory Improvement Amendments (CLIA) certified.



You must also have one of the following accreditations:

- College of American Pathologists (CAP)
- The Joint Commission (TJC)
- American Osteopathic Association/Healthcare Facilities Accreditation Program (HFAP)

We allow reimbursement of these services performed in the office if providers submit documentation of their CLIA certification. Or if they're listed as a specialty allowed per our published policy.

These procedure code changes do not change the requirement to follow our in-office testing requirements and use participating labs where appropriate.

Important update to presumptive or definitive drug test thresholds

We are updating our presumptive and definitive drug testing thresholds. We will require a medical necessity review of drug testing, reviewing clinical documentation to determine the member's specific plan of treatment and how the test results are used to guide clinical decision making. Please refer to Clinical Policy Bulletin #965 for additional information and criteria.

Update to our billable services

Effective **June 1, 2020**, we'll allow hemodialysis services billed with modifier KX. You can use this modifier to report services required in excess of the three times per seven-day period.

Use hemodialysis modifier KX

Be sure to include the KX modifier on your bill to us, if necessary. If you don't, you won't be paid for the hemodialysis treatments that exceed the three times per seven-day period.



News for you

Here you'll find information to help your office comply with regulations and administer plans –new services, tools and reminders.

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."

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 utilization management issues. Contact us by visiting our website, calling Provider Services at **1-800-624-0756 (TTY: 711)** 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 "Update Provider Data" on **Aetna.com**.

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.

Reminder: Check your Aetna Premier Care Network participation status

Now is a good time to check our online provider referral directory at **Aetna.com** to see if you're participating in our Aetna Premier Care Network (APCN)/Aetna Premier Care Network Plus (APCN Plus) programs for 2020. If you were added or terminated from the APCN or APCN Plus networks, you would have received a letter from us in August of last year. If you participated in APCN or APCN Plus in 2019 and you didn't get a letter, that means your status has not changed. If you have questions, call us at **1-888-632-3862 (TTY:711)** or visit **Aetna.com**.

Overview of APCN/APCN Plus

APCN is a performance network for businesses with employees in locations across the country. With this network, employers can offer a single benefits design and simplified communications to all employees, regardless of their location.

APCN Plus includes a combination of performance networks across the country, but also includes Accountable Care Organizations (ACOs) and Joint Ventures (JVs) in certain areas. Members in these networks will have APCN Plus and the name of the ACO/JV on their ID card.

Affirmative statement for financial incentives

Coverage determinations and utilization management (UM)

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

- 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.

Important information for providers who care for 1199 members

At the Benefit Funds, we support the care you provide for members of ours who are part of group 1199SEIU. You should continue reminding them to stay current with their annual preventive screenings, including mammograms for women between ages 40 and 80. As you know, a mammogram is a vital tool used to help detect cancer at an early stage, when it is most treatable. Early detection means less aggressive treatment and higher rates of survival.

No prescription or referral needed for annual mammogram

Mammograms can save lives. We want our members to know that they can get this procedure. So, we want to remind you that your 1199SEIU patients do not need a prescription or referral to schedule the procedure. They simply need to provide their radiologist with the name and contact information of their primary care physician, who will get the test results.

Let's talk: encourage mindfulness

With the constant hustle and bustle of daily life, it becomes habit for your patients to just go through the motions without being present and aware of each moment. Encouraging mindfulness can help patients take a step back. This can help them build resilience and navigate changes, think clearly, enjoy the moment and more.

Best of all, practicing mindfulness doesn't have to be a time consuming or difficult task. But, as Evgeniya Agaeva, clinical counselor, Aetna Behavioral Health, explains, developing mindful habits doesn't happen overnight.

"Much like any other new behavior, developing a mindfulness practice takes time, and, well, practice. The more you practice, the better you get at harnessing your awareness and bringing your attention to the present moment," said Evgeniya.

To begin, simply encourage patients to bring a gentler and more open mind to the present moment. They should take note of the differences that practicing mindfulness brings to their daily life.

Want to learn more?

To learn mindfulness exercises and tips from Evgeniya on developing a mindfulness lifestyle, watch the Aetna Behavioral Health **Let's Talk** video. (Or read the **Mindfulness Exercise transcript**.) It's part of a series of videos from Aetna Behavioral Health to help increase mental well-being.

Be sure your office properly documents nonparticipating referrals

Your contract with Aetna® requires you to follow the policies outlined in our provider manual. You can access **the manual** on our public website. It contains many guidelines that you and your staff should review together.

Documenting nonparticipating referrals

Our members often expect that you will use participating doctors when they visit you, chiefly because you are a participating doctor. When you refer a member to a nonparticipating provider, your office should use a consent form designed by you. The form should ensure that members completely understand the financial obligation required and the full context for your referral. The provider manual outlines the elements of the member consent form that all Aetna providers must use when making nonparticipating referrals (see page 35). All consent forms should make the following points:

- The referred hospital, facility or provider is not a participating provider.
- The member's plan may provide reduced benefits.
- The nonparticipating provider will not be restricted to seeking payment only from Aetna. The provider may bill the member for amounts other than deductibles, copayments, coinsurance and medical services not covered under the plan.
- The provider has an affiliation with, or financial ownership interest in, the nonparticipating provider. (If this is not the case, do not include this point on the form.)

Review your office's forms today to ensure compliance with our policies

Please ensure that you are collecting consent forms that contain this information every time you make a referral to a nonparticipating provider, laboratory, facility or hospital.

Our mailing address is changing for Texas, Oklahoma and New Mexico

Please submit contract mailings to the following address:

Aetna | South Central Network
Network Management
2777 N. Stemmons Frwy, #1450
Dallas, TX 75207

Physicians and other health care professionals should use this address for any notices as specified in Section 6.0 or other notice provision of your Physician Agreement. Hospitals should use this address for any notice as specified in Section 9.8 or other notice provision of their Hospital agreement.

Aetna[®] 2020 HEDIS[®] data collection is underway

Our staff or our contracted representatives (CIOX, Verscend) will soon contact your office to collect medical record information on behalf of our members. We appreciate your understanding and cooperation as we complete required quality reporting with minimal disruption to your practice.

Why is this necessary?

Healthcare Effectiveness Data and Information Set (HEDIS¹) 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.

We must regularly send health care quality data to The Centers for Medicare & Medicaid Services (CMS) for our Aetna and Coventry Medicare Advantage organizations. We collect most of the data from claims and encounters. We also gather data on services provided and member health status from member medical records.

What we may need from you

If we contact you, please cooperate with our request for timely access to our members' medical records. Our representatives will work with you and give you options for sending medical records.

Meeting HIPAA guidelines

Our representatives serve us in a role that the Health Insurance Portability and Accountability Act (HIPAA) defines and covers. According to the HIPAA, Aetna is a "Covered Entity," and our representative's

role is as a “Business Associate” of a “Covered Entity.” Giving medical record information to us or our representatives meets HIPAA regulations.

We appreciate your help in our data collection efforts.

¹HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

We’re making it more convenient to obtain basic claims status/inquiries

We have provided self-service tools that allow providers and their representatives to pull basic claim status at their own convenience. Starting **April 1, 2020**, we will guide providers to use the Aetna Voice Advantage or our provider portal for basic claim status/inquiries. We will continue to assist and service claim issues and more complex questions.

What is the difference between basic claim status/inquiry and claim issues?

Basic claim status/inquiry	Claim issues
When did the claim pay?	I was expecting more of a payment. Can you tell me how my payment was calculated?
What is the EFT number?	
Why did line ___ not pay?	What if I don't agree with how the claim was paid/denied?
How much did the claim pay?	Can you tell me what information is being requested?
I didn't get my EOB on this, can you tell me how it paid?	

Need access to the provider portal?

- Go to **Availity.com/aetnaproviders** to register or login **Aetna.com**
- Go to Claims & Payment > Claim Status

Why is this change happening?

Providing exceptional service to our members and participating providers is very important to us. To this end, we are always looking to deliver more efficient solutions to meet your needs. This change will allow for shorter wait times and less time waiting for a response to your written claim status requests.

Depression screening for pregnant and postpartum women

Aetna Medical Management assists pregnant members by identifying depression and getting them behavioral health support. Our Aetna Maternity Program nurses provide educational and emotional support and case management to eligible members, helping them 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 assessments, case formulation, care planning, and focused follow-ups.
- The Aetna Maternity Program nurses, who have high-risk-maternity experience, refer pregnant members with positive depression or general behavioral health screens to Behavioral Health Condition Management if the members have the benefit and meet the program criteria.
- A behavioral health specialist is part of the Aetna Maternity Program team. They help enhance effective engagement and identify members with behavioral health concerns.
- Aetna Maternity Program nurses reach out to members who have experienced a loss in their pregnancy, if appropriate. They offer condolences and behavioral health resources.

How to contact us

- Members and providers can call **1-800-272-3531 (TTY: 711)** to verify eligibility or register for the program. Members can enroll in the Aetna Maternity Management program with a representative at this number or enroll online at **Aetna.com** under “Stay Healthy.”
- Members can also enroll online through their member website.

Behavioral health clinical practice guidelines

Clinical practice guidelines from nationally recognized sources promote consistent application of evidence-based treatment methods. This helps provide the right care at the right time. For this reason, we make them available to you to help improve health care.

These guidelines are for informational purposes only. They aren't meant to direct individual treatment decisions. And they don't dictate or control your clinical judgment about the right treatment of a patient in any given case. All patient care and related decisions are the sole responsibility of providers.

Guidelines adopted by Aetna Behavioral Health

- **American Academy of Pediatrics (AAP) Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents**
- **American Psychiatric Association (APA) Guideline for the Treatment of Patients with Major Depressive Disorder**
- **APA Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder**
- **APA Guideline for the Treatment of Patients with Substance Use Disorders**
- **Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain**

More resources:

- **SAMHSA Treatment Improvement Protocol (TIP) Series**
- **TIP 45: Detoxification and Substance Abuse Treatment**

- **TIP 63: Medications for Opioid Use Disorder**
- **ASAM Criteria**
- **National Institute on Alcoholism and Alcohol Abuse**
- **National Institute on Drug Abuse**

Opioid overdose risk screening program

Our behavioral health clinicians screen members to identify patients at risk for an opioid overdose. Any patient receiving a diagnosis of opioid dependence may be at risk. You can learn more about the **opioid epidemic**.

How you can help

Consider naloxone for patients at risk for an opioid overdose. Naloxone reverses the effects of an opioid overdose. Giving naloxone kits to laypeople reduces overdose deaths, is safe and is cost effective. You can also tell patients and their families and support networks about signs of overdose and administering medication.

Coverage of naloxone varies by individual plan. Call the number on the member's ID card for more information on coverage. We waive copays for the naloxone rescue medication Narcan® for fully insured commercial members.

Resources for you and your patients

- **Aetna opioid resources**
- **Health and Human Services: Naloxone: The Opioid Reversal Drug that Saves Lives**
- **SAMHSA: Opioid Overdose Prevention Toolkit**
- **Seeking treatment for abuse — Aetna video**
- **CVS/Aetna: Our Opioid Response**

Screening, brief intervention and referral to treatment (SBIRT)

Aetna® will reimburse you when you screen your patients for alcohol and substance use, provide brief intervention, and refer them to treatment. SBIRT is an evidence-based practice designed to support health care professionals. Overall, the practice aims to improve both the quality of care for patients with alcohol and substance use disorder conditions, as well as outcomes for patients, families and communities.

Screen and refer your patients

Use of the SBIRT model is encouraged by the Institute of Medicine recommendation that calls for community-based screening for health risk behaviors, including alcohol and substance use. Our participating practitioners who treat patients with Aetna medical benefits can provide this service and be reimbursed. Go to [Aetna.com](https://www.aetna.com) to learn more.

Get started today

The SBIRT app is now available as a **free download** from the iTunes® Store* online store. The app provides questions to screen for alcohol, drug and tobacco use. 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.

*The iTunes Store is a trademark of Apple Inc., registered in the U.S. and other countries.

ADHD clinical practice guidelines updated

The American Academy of Pediatrics (AAP) has updated its guidelines for the treatment and care of children with attention deficit hyperactivity disorder (ADHD or ADD). The guidelines now stress the need to identify comorbidities in children with ADHD. No major changes were made to how ADHD is managed. This is the first update to the clinical practice guideline since 2011.

The changes highlight barriers to care and call on doctors to screen and begin treatment for comorbidities. The guidelines provide information on how to address conditions such as:

- Anxiety
- Depression
- Oppositional defiant disorder
- Autism spectrum disorders, and more

CVS/Aetna will adopt the updated guidelines in early 2020.

You can help improve the quality of care for children with ADHD. **[Learn more about the updated ADHD guidelines.](#)**

Reminder to use spelling of name from member ID card

Use of the complete patient name found on the member ID card for lab requisitions is vital.

We use the ID card name as a match point when lab vendors submit electronic results for tests such as Hemoglobin A1c. A misspelled name, use of a nickname or use of initials can cause a lab result to be rejected during the result submission process.

These results are invaluable during discussions with our diabetic members. They are also used as an indicator of care in HEDIS and Star ratings. They can enhance your performance as a provider if you are part of a value-based contract.

Finally, using the member ID card name on lab requisitions should help decrease our manual requests for you to retrieve lab results found in your medical records. This means more time for *you* — the office staff — to care for your patients.

March Colorectal Cancer Awareness Month

When it comes to colorectal cancer screening, early detection is essential. Expert medical groups, including the American Cancer Society and the U.S. Preventive Services Task Force (USPSTF), strongly recommend screening for colorectal cancer. Although recommendations vary, medical groups generally recommend that people at average risk of colorectal cancer get screened at regular intervals starting at some point between the ages of 45 and 50.

A key to effective screening is compliance with the recommended interval of screening. We encourage members to have colorectal cancer screenings at the recommended intervals.

Quest Diagnostics® and LabCorp provide:

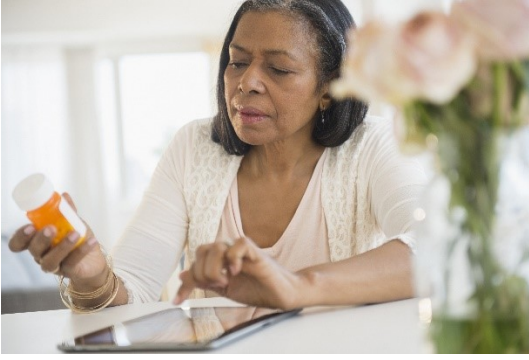
- Electronic delivery of results to your EMR, making documentation of screening results easier for you and your office staff
- Patient-friendly in-home collections
- High sensitivity and specificity, resulting in a high-quality test
- Member screening reminders that can be coordinated with preferred labs or by Aetna

Learn more

For more information, contact your local Quest Diagnostics* or LabCorp** sales representative. You can also visit [QuestDiagnostics.com/TestCenter](https://www.questdiagnostics.com/TestCenter) or [LabCorp.com/Tests](https://www.labcorp.com/Tests) for additional ordering details.

*Quest test codes: 11290 Fecal Globin by Immunochemistry (InSure®), 11293 Fecal Globin by Immunochemistry (InSure®), Medicare Screen

**LabCorp test code is 182949 Occult Blood, Fecal, Immunoassay



Pharmacy updates

Here you'll find pharmacy updates including changes to commercial drug lists and formulary information at your fingertips.

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 added monthly
- Clinical Policy Bulletins with the most current prior authorization requirements for each drug



State-specific updates

Here you'll find state-specific updates on policies and regulations.

Current California updates – March 2020

California providers: use our interpretation service at no cost

Need help giving care to non-English-speaking Aetna® members? Just use our Language Assistance Program (LAP). **There is no charge for this interpretation service.** You can call **1-800-525-3148 (TTY: 711)** to reach a qualified interpreter directly. Members can also request interpretation services from our LAP by calling the number on their ID card. Members can also contact our LAP to get answers to general questions, to file a grievance or to get a grievance form.

Questions? Get help from your state. Just call the:

- CA Department of Insurance Consumer Hotline at **1-800-927-4357** for traditional plans
- CA Department of Managed Health Care Help Center at **1-888-466-2219 (TDD: 1-877-688-9891)** for HMO and DMO plans

You can reach the **CA Department of Managed Health Care Help Center** 24/7. The **CA Department of Managed Health Care** provides written translation of independent medical review and complaint forms in Spanish and Chinese as well as other languages. You can get paper copies of the forms by submitting a written request to:

Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725

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 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 – March 2020

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**
- **Clinical payment and coding policy changes**

Current Maryland updates – March 2020

How to ID providers no longer in the network

Maryland Insurance Code 15-112 — Provider Panels requires Aetna® to notify primary care physicians of the termination of a specialty referral services provider. To comply, we offer access to the Maryland Provider Terminations (Quarterly Report). This report lists specialists in HMO-based plans whose participation in the Aetna network terminated during the specified timeframe.

You can find this report in the Southeast Regional section of our Office Manual for Health Care Professionals. Review the report periodically to see which providers no longer participate with us.

To view a current listing of providers who participate in our network, go to our provider online referral directory. Referring your Aetna members to in-network providers helps them control their out-of-pocket costs.

If you have questions about the Aetna network or making specialty referrals to in-network providers, please contact our Provider Service Center at **1-800-624-0756 (TTY: 711)**.

Current Florida updates – March 2020

Prior authorizations Custodial care authorizations

These are applicable to members who are *not* receiving skilled services and are waiting for long-term care benefits.

Next steps:

- Complete the **Prior Authorization form**. For custodial requests, we need the actual date of admission and prior coverage payer information.
- Fax it with clinical documentation and completed Preadmission Screening and Resident Review (PASRR) to our prior authorization fax line at **1-860-860-8056** for review.

We'll respond with the authorization as quickly as possible.

Current Massachusetts updates – March 2020

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.

Current New Jersey updates – March 2020

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 New Jersey **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 New York updates – March 2020

New law and CPT® code for maternal depression in New York

New York has a new law that requires carriers to reimburse for maternal depression screening and cover the service under a newborn's plan if the mother does not have insurance. We were advised that this service will be paid if billed with CPT code 96161.

Current North Carolina updates – March 2020

Updates to imaging procedures including MRIs, CT scans and ultrasounds

Effective **June 1, 2020**, we will begin applying our existing policy on multiple imaging procedures to providers in North Carolina. Reductions may apply to technical and global charges for certain diagnostic imaging services. We allow 100% reimbursement for the scan with the highest RVUs. Reductions apply to each subsequent scan performed on the same day, for the same member, by the same provider.

Current Texas updates – March 2020

New Texas Medicare Advantage program starting March 1, 2020

We're pleased to announce a new program and important changes to our Medicare Advantage home health provider network in Texas. We're working with myNEXUS® to manage the network and the claims payment and pre-certification/prior authorization programs for home health services. myNEXUS is a technology-enabled care management company.

Important changes

- **Pre-approval:** Starting **March 1, 2020**, the home-health-related requests for in-home skilled nursing, which will be listed at [aetna.com/health-care-professionals/precertification/precertification-lists.html](https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html) before March 1, will *require* advance approval from myNEXUS. This applies to services administered in a home or residence for Aetna Medicare Advantage members in Texas. These services include:
 - Physical therapy
 - Occupational therapy
 - Speech therapy
 - Home health aide services

- Medical social work
- **Claims payment:** Starting **March 1, 2020**, for Texas Medicare Advantage members, claims for covered home health services filed with an authorization issued on or after March 1, 2020, will be paid by myNEXUS under the rates and terms of your myNEXUS contract.

This change applies only to home health care services for:

- Aetna Medicare Advantage members
- Members residing in the state of Texas

About the new program

More details are available at mynexuscare.com/aetna.

For pre-approval requests:

- File **online** (registration required).
- Fax the **authorization request form** to **1-866-996-0077**.

Questions about pre-approval? Call myNEXUS Intake (Monday to Friday, 8 AM to 8 PM ET) at **1-833-585-6262**.



Medicare updates

Get Medicare-related information, reminders and guidelines.

Don't let your network status change — complete your required Medicare Compliance training to comply with CMS requirements

If you are a participating provider (individual, group, facility or ancillary, etc.) in our Medicare Advantage (MA), Medicare-Medicaid (MMP) and/or Dual Eligible Special Needs (DSNP) plans, you must meet the

Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related (FDR) entities and/or the DSNP Model of Care (MOC) training and attest to that training by December 31, 2020.

How to complete your attestation

The Medicare FDR & MOC Attestation(s) will be released in second quarter of 2020. You'll find the attestation and training resources you need to ensure your compliance on **Aetna.com** under "Need More Information on the Medicare FDR Program" section. For dually contracted MA and DSNP providers, we will combine the DSNP MOC & FDR Attestations requiring only one to be completed. The MOC training and attestation will be found at **<http://www.aetna.com/healthcare-professionals/documents-forms/dsnps-model-of-care.pdf>**.

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.

Centers for Medicare & Medicaid Services (CMS): CY 2019 Medicare Communications and Marketing Guidelines (MCMG)

In July 2018, CMS released **new guidelines**. Review **Section 60 — Activities in a Healthcare Setting** for complete details.

Provider-initiated activities are those conducted by a health care professional at the request of the patient or as a matter of a course of treatment, when meeting with the patient as part of the professional relationship.

Permissible activities include:

- Distributing unaltered, printed materials created by CMS
- Providing the names of plans in which patients participate
- Answering questions or discussing the merits of a plan or plans, including cost sharing and benefits information (these discussions may occur in areas where care is delivered)
- Referring patients to other sources of information, such as a State Health Insurance Assistance Program (SHIP), plan marketing representatives, their state Medicaid or Social Security office, or Medicare (**Medicare.gov** or **1-800-MEDICARE**).
- Referring patients to plan marketing materials available in common areas
- Providing information and help applying for the low-income subsidy (LIS)

Contracted providers may:

- Make communication materials available, including in areas where care is delivered

- Make plan marketing materials and enrollment forms available outside of the areas where care is delivered (such as common entryways or conference rooms)

Distributing or making plan marketing materials available is allowed as long as the provider does this for *all* plans with which they participate. **Providers must remain neutral when helping beneficiaries with enrollment decisions.**

A friendly reminder: You can't balance bill Medicare beneficiaries who have extra benefits

Some dual-eligible Medicare beneficiaries have extra benefits. You can't charge these members 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.

Dual-eligible individuals may qualify for Medicaid programs that pay Medicare Part A and B premiums, deductibles, coinsurance and copays to the extent that the state Medicaid plan provides. These programs include:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualified Disabled and Working Individuals (QDWI)
- Qualifying Individual (QI)

What happens if you don't comply?

Medicare providers must accept the Medicare and Medicaid payment (if any) in full for services given to a beneficiary who is part of one of these Medicare Savings Programs. Failure to follow these billing rules may result in sanctions from the Centers for Medicare & Medicaid Services (CMS). And failure to follow these billing rules is not permitted by your provider agreement.

Helpful 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. This is true no matter which state provides the benefit.

Where to go for more information

- [Medicare-Medicaid general information](#)
- [Additional Dual Eligible Special Needs Plans \(D-SNPs\) resources](#)

Medicare Advantage plan members can now get one wellness visit per calendar year

Beginning **January 1, 2020**, Medicare Advantage plan members can now get their annual wellness visit once per calendar year instead of once every 366 days. This means even your patients who had their annual wellness visits late in the calendar year can be scheduled early in the next calendar year. This gives patients more time to focus on their health during the year.

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