OfficeLink Updates™

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

aetna™

September 2020

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.

Changes to our National Precertification List (NPL)

Important NPL update

Effective January 1, 2021, the following precertification changes will apply:

- We require precertification for hip surgery to treat impingement syndrome, and effective January 1, 2021, we are expanding to include labral repair.

The following new-to-market drugs require precertification:

- Tepezza™ (teprotumumab-trbw) — precertification required, effective May 1, 2020. This drug is included in the ophthalmic medical injectables category.
- Sarclisa® (isatuximab-irfc) — precertification required, effective May 28, 2020.
- Vyepti ™ (eptinezumab-jjmr) — precertification for both the drug and site of care required, effective May 28, 2020. This drug is included in the calcitonin gene-related peptide receptor inhibitors category.

Effective July 9, 2020, the following new-to-market drugs require precertification:

- Sevenfact® (coagulation factor VIIa [recombinant]-jncw)
- Trodelvy ™ (sacituzumab govitecan-hziy)
- Zeposia® (ozanimod)

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

To save time, request precertification electronically — it's fast, secure and simple. You can submit most precertification requests 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**.

Technical-only services

Technical-only services are those that stand alone and describe only the technical part of a given procedure. Technical-only procedures in an inpatient hospital, outpatient hospital, emergency department or ambulatory surgical center are not separately allowed. The facility in these settings handles and bills the technical part of diagnostic tests and radiology services.

For example, CPT code 92586 is for the performance of a newborn hearing screening, which is a technical-only service. We will deny claims billed by physicians or other providers as included in the facility's reimbursement. You should not balance bill members for these services.

Convenience kits

Effective **December 1, 2020,** we will deny convenience kits as incidental to the primary procedure.

Changes to commercial drug lists begin on January 1, 2021

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

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

Ways to request a drug prior authorization

- Submit your completed request form through our **provider website**.
- For requests for nonspecialty drugs on Aetna Funding Advantage℠ plans, Premier, Premier Plus, Small Group ACA and Value Plus plans, call the Aetna Pharmacy Precertification Unit at **1-855-240-0535 (TTY: 711)**. Or fax your completed **prior authorization request form** to **1-877-269-9916**.
- For requests for nonspecialty drugs on the Advanced Control, Advanced Control — Aetna, Standard Opt Out, Standard Opt Out — Aetna, Standard Opt Out with ACSF and High Value formulary plans, call the Aetna Pharmacy Precertification Unit at **1-800-294-5979 (TTY: 711)**. Or fax your completed **prior authorization request form** to **1-888-836-0730**.
- For requests for drugs on the Aetna Specialty Drug List, call the Aetna Pharmacy Precertification Unit at **1-866-814-5506 (TTY: 711)**. Or fax your completed prior authorization request form to **1-866-249-6155**.

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)**.

New Jersey - Edits reactivated for billing modifiers 25, 59 and X series

Effective December 1, 2020, we will be reactivating edits for billing modifiers 25, 59 and X series in New Jersey for fully insured and self-insured membership claims. We may request medical records for these services as provided to your New Jersey fully insured* patient claims.

The medical records review program will not apply to self-insured membership claims. These new edits are part of our Third Party Claim and Code Review Program and will apply prior to finalizing claims for professional services and outpatient facilities.

We may request medical records for professional services provided to New Jersey fully insured* patients and billed with modifiers 25, 59 and X series. This is not a clinical review; any edit applied will be based on industry-recognized coding guidelines. We will review the service, service history, changes in condition, diagnostic tests and the medical chart to determine if these services require separate payment. We allow charges for covered services not subject to the coding review.

We want you to know the following:

- You can send medical records with your initial claim submissions for services provided to New Jersey fully insured* patients.
- If medical records are not provided and needed, Aetna® will request them.
- If a medical chart is requested but not submitted within 45 days, then the charges for the service billed with modifiers 25, 59 or X series will be denied.

Keep in mind the following:

- We follow both New Jersey claims processing timelines, and appeal rights apply to any denied charges.
- You can submit medical records/notes via the following:
  - Fax number or address on the EOB
  - The "Claim Status — Send Attachments" functionality through our provider portal on **Availity®**
- This program applies to certain claims for charges $25 or greater and billed with modifiers 25, 59 or X series.

To find out if our new claims edits will apply to your claim, log in to the provider website. Then go to Plan Central > Aetna Claims Policy Information > Policy Information > Medical Records Program.

*New Jersey member ID cards indicate whether the member is covered under a fully insured plan or under a self-funded plan.

New York – New edits for billing modifiers 25, 59 and X series

Effective December 1, 2020, we will apply new edits for billing modifiers 25, 59 and X series in New York for fully insured membership claims. We already apply these same edits for self-insured membership claims.

These new edits are part of our Third Party Claim and Code Review Program and will apply prior to finalizing claims for professional services and outpatient facilities. This is not a clinical review; any edit applied will be based on industry-recognized coding guidelines. We will review the service, service history, changes in condition and diagnostic tests to determine if the services billed with modifiers 25, 59 and X require separate payment. We will allow charges for covered services not subject to the coding review.

Find out more about **the program**.

Angioplasty services

As of **December 1, 2020,** we'll change our related services claim handling for outpatient cardiac angioplasty services.

We require providers to get precertification for non-emergent outpatient diagnostic left and right heart catheterization services. This can be done through our Enhanced Clinical Review program with eviCore healthcare. If you don't get precertification for the cardiac catheterization, or if the cardiac catheterization is denied by eviCore, then any related angioplasty procedure will also be denied.

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

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**.

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 them the request is for urgent care.

What you should know

- Be sure 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 will determine coverage under the applicable policy according to the policy's terms and conditions and our policies and procedures.

Keep in mind

- If the service you ask for is not what eviCore healthcare approves, the facility must contact eviCore healthcare for approval before submitting claims.
- If you perform services without approval, we may deny payment.
- We base our final coverage decision on the applicable policy's terms and conditions along 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 their criteria and get request forms.

Infectious agent detection

Effective **December 1, 2020**, we will deny CPT code 87801, infectious agent detection by nucleic acid (DNA or RNA), when billed on the same DOS with CPT codes 87501–87503 or 87631–87634.

Once per lifetime edits

Effective **December 1, 2020**, we are updating our list of genomic testing codes that we pay once per lifetime.

Modifier 91 — genomic testing

Effective **December 1, 2020**, we are updating our list of genomic testing codes denied with modifier 91.

Third Party Claim and Code Review Program

Accurate claims processing with our Third Party Claim and Code Review Program

Beginning **December 1, 2020**, you may see new claim edits. These 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 prospective claims editing disclosure tool. To find out if our new claim edits will apply to your claim, log in to the provider portal. Then go to Aetna Payer Spaces > 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.

Important reminders

Proper coding of cerebrovascular accident (CVA) and congestive heart failure (CHF)

It's important to follow the ICD-10 guidelines to ensure you're coding conditions properly. Here are some important tips.

CVA

- I60–I63 codes are *rarely, if ever,* coded in the office setting, since CVA is an emergent, acute event
- For previous CVA *with* current, residual effects, code from I69._
- For previous CVA *without* current, residual effects, code Z86.73.
- Always document each CVA occurrence by date in prior medical history.
- Initially write out, in full, "cerebrovascular accident" followed by "CVA" in parenthesis, and then use just "CVA" throughout the remainder of the note.

CHF

- ICD-10-CM Category I50 "Heart failure" has "Code First" instructional notes that include:
  - Heart failure due to hypertension (I11.0)
  - Heart failure due to hypertension with chronic kidney disease (I13._)
  - Heart failure following surgery (I97.13_)
  - Rheumatic heart failure (I09.81)

  ICD-10-CM description*:
  - I50.1_ Left ventricular failure, unspecified
  - I50.2_ Systolic (congestive) heart failure
  - I50.3_ Diastolic (congestive) heart failure
  - 150.4_ Combined systolic and diastolic (congestive) heart failure
  - 150.8_ Other heart failure
  - 150.9_ Heart failure, unspecified

  *In these descriptions, the fourth character specifies the type of heart failure. The fifth character indicates acute, chronic, or acute on chronic.

  Codes categorized to I50.2_ – I50.4_:
  - Include an instructional note to code also end stage heart failure (I50.84), if applicable.

- Include the descriptor “congestive” as a nonessential modifier (an additional word that may be present or absent in the diagnostic statement without affecting the assigned code).
- When documentation lists congestive heart failure along with either systolic or diastolic heart failure, only code for the type of heart failure noted.
- In ICD-10-CM, “heart failure” and “congestive heart failure” both are coded I50.9_ Heart failure unspecified

Subcategory I50.8:
Other heart failure: further divided into right, biventricular, high output, end-stage, other and unspecified heart failure

ICD-10-CM description:
- I50.810 Right heart failure, unspecified
- I50.811 Acute right heart failure
- I50.812 Chronic right heart failure
- I50.813 Acute on chronic right heart failure
- I50.814 Right heart failure due to left heart failure *(excludes right heart failure with, but not due to, left heart failure (I50.82))*
- I50.82 Biventricular heart failure
- I50.83 High-output heart failure
- I50.84 End-stage heart failure
- I50.89 Other heart failure

Codes I50.82 and I50.84:
Include an instructional note to code the type of heart failure as systolic, diastolic or combined (I50.2–I50.43), if known.

Diastolic or systolic dysfunction with acute or chronic heart failure: There are 12 codes in the I50.1–I50.4 range that allow for specificity of systolic, diastolic or combined heart failure with further specificity for acute, chronic, acute on chronic or unspecified. Use the default code I50.9 when the documentation does not specify the type.

Our nurse educator plays an important role by working to ensure that providers accurately document conditions. For additional information about our AAPC CEU webinars or private, non-CEU education sessions, email us at **RiskAdjustment@aetna.com**.

Let's talk: Complex spinal surgery and precertification requests

To help your patient get the most from their health benefits, it's important to submit a precertification request for complex spinal procedures.

Here are some tips to help make your request go smoothly. We'll need to see:

- A completed a Spinal Surgery Precertification Information Request form
- Details on any:
  - Implants/instrumentation/allografts (including CPT code(s), manufacturer, type of device and device name)
  - Spinal level(s) you'll treat and your surgical approach
- Medical records showing your patient's signs and symptoms, including a detailed neuro exam
- Physical therapy progress notes (at least six weeks within the last year or a discharge note from physical therapy)
- All applicable radiological and imaging reports (e.g., CT, MRI) within the last year

When to submit your request
Be sure to submit precertification requests at least two weeks before the scheduled services.

Supplies, material and equipment

Our standard payment policies do not pay for items that we consider incidental to the overall care. These items include supplies, materials (for example, sutures or suture substitutes, dressings, syringes, gauze, catheters and guidewires) and equipment (for example, stationary parenteral infusion pumps). A reminder: we don't pay for incidental items or services and we don't take separate payment for Personal Protective Equipment (PPE) (e.g., gloves, gowns, eye/face protection, etc.)

Moderate conscious sedation in a facility setting

We do not pay for monitoring of moderate conscious sedation in a facility setting billed by a physician.

News for you

Labs offer COVID-19 test options

Both Quest Diagnostics® and LabCorp offer molecular COVID-19 testing to detect a current SARS-CoV-2 infection. Both labs also offer antibody testing to detect the presence of antibodies to SARS-CoV-2. The presence of antibodies can identify who may have recovered from a recent or prior infection and may possibly have a lower risk of reinfection.

For more about COVID-19 test options, refer to these sources:

- **QuestDiagnostics.com/home/Covid-19/HCP**
- **LabCorp.com/COVID-19**

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.

Provider directory accuracy

In the June 2020 OfficeLink Updates edition, we published an article titled "Your patients deserve a provider directory they can count on." In this edition, we would like to give you a little more information about our provider directories.

Several states and Medicare have regulations that require health plans to maintain accurate and up-to-date directories. They also require the health plans to conduct audits to measure the accuracy of the directory. We comply with those requirements and conduct audits routinely. The top two types of errors we find are items you can help us avoid by keeping your information current and making updates using CAQH (Council for Affordable Quality Healthcare) or Availity® in real time as opposed to faxing a letter to Aetna® or calling our Provider Service Center.

The top error that the audits reveal is that a provider is no longer practicing at the location we have in the directory. Please remember to update CAQH or Availity if your office moves, changes the phone number for appointments, or experiences other important changes within 7 days of the change. Please do not wait until it's time for your quarterly attestation to provide the information.

The second most common error is that providers are listed at locations where they do not regularly see patients or accept appointments. Most of these are call-covering situations. In both vendor portals, there is a question you must respond to regarding the frequency of practice at that location. If the provider only call-covers there and does not accept appointments at least once a week at a location, indicate that when reviewing the service location information. We will load the location to the providers record but suppress it from printing in the directory.

Aetna takes our obligation to supply accurate directories seriously. We may suppress providers who do not attest quarterly to the accuracy of their data, providers who refuse to validate address information over the phone, and providers who are listed at multiple locations (e.g., every location of a group practice).

If you are part of a group and the group is responsible for sending Aetna a roster of the participating providers and locations, please make sure you keep them updated with the correct address, phone numbers and other important information.

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.

Electronic transactions spotlight: precertification and secondary claims

Submitting electronic transactions helps you save time **and money**. In this issue, we highlight lesser-known features of two common electronic transactions: precertification and secondary claims.

Precertification
You're probably aware you can submit and inquire on precertification requests electronically. You can do this on **our provider portal on Availity®** or using one of **our other vendor partners.*** Did you know you can also do the following on Availity?

- Upload clinical documentation
- Change the details of a previously submitted request (if the services have not occurred or been deemed not certified)
- Cancel an already submitted request
- Add an end date
- View more details on inquiry responses like expected turnaround times

To learn more about Availity, go to its **website**. Or click "Register for your free Availity account today!" to register.
Need help using electronic precertification on Availity? **Register for a webinar** to learn more.

Secondary claims
Send your secondary (or Coordination of Benefits (COB)) claims electronically. Follow these helpful tips:

- Before submitting any claims, ask the patient if they have other insurance coverage. Not all members in a family may have other coverage, so it's better to ask.
- If the patient has other coverage, complete these fields:
  - Name of other health care insurance
  - Policy ID number of other health care insurance
  - Name of employer

(If the patient doesn't have other coverage, **don't** complete those fields.)

- Include these financial details:
  - Payer paid amount — When we pay second, we need to know the amount the primary carrier paid you. This amount is equal to total charges minus claims and

line-level adjustments. Be sure you don't confuse the payer-paid amount with the patient-paid amount.

- Patient-paid amount — Refers to the amount your patient pays toward their deductible, coinsurance or copay for the service date(s) and service(s).
- Line level adjustment reason codes and associated amounts (professional claims only) — Shows why the other insurer paid less than billed. Includes deductible, coinsurance, copayments and any write-offs.

Submitting the correct information will help us determine the correct benefits and avoid over- or underpayments. It will also help avoid processing delays. Refer to **our Provider Manual** for more on COB.

*Functionality may vary.

A new year means new health plans — verify your patients' eligibility

Some of your patients may have new Medicare health plans starting in 2021. Or their existing plans may change at the start of the new year. Therefore, your patients may have different financial obligations or a new ID number beginning with "10xxxxxxxx." Remember that it's a good practice to verify patient eligibility at each visit, especially as the new year approaches.

Ask your patients for their current ID card. If they don't have one, you can still verify their eligibility using their full first and last names and date of birth. You can print an electronic copy of their ID card, if you need it. Make sure that our response matches your patients' information. And be sure to use their current ID number when submitting claims, precertifications or referrals.

And remember to verify patient eligibility at the beginning of the year, when many plan changes occur, as well as at every visit.

The right information at the right time

Share important clinical information at the right time. You can help improve your patients' care and safety by partnering with their other providers to better manage their health conditions. In a 2019 audit of our behavioral health (BH) practitioner treatment records, review results showed that:

- 41% of behavioral health providers documented a request to communicate with a PCP
  - Of those, 60% communicated with PCPs

- 58% of practitioners requested consent to communicate with another BH provider
    - Of those, 67% communicated with the other provider

Communication benefits everyone
PCPs are often unaware that their patients are getting behavioral health treatment. Communication can:

- Improve overall patient care via information regarding medication or other treatment effectiveness
- Enhance more timely and positive patient outcomes, and patient safety
- Help develop professional relationships that may provide mutual collaboration and a network of referral sources

Ask your patients to sign a release to permit these communications.

Check out these resources

- **National Quality Forum: Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination**
- **Aetna Integrated Primary Care Behavioral Health Program**

Depression in primary care

An estimated 17.3 million adults in the United States (7.1%) had at least one major depressive episode in 2017.[1] Depression is an important health problem often seen in primary care. More than 8 million doctor visits each year in the U.S. are for depression, and more than half of these are in the primary care setting. Despite this, **a national study** found that only about 4% of adults were screened for depression in primary care settings. Primary care physicians serve as the entry point to the health care system for many patients and play a critical role in recognizing and treating symptoms of depression. The **Aetna Depression in Primary Care Program** is designed to support screening for and treatment of depression at the primary care level.

Program benefits:

- A tool to screen for depression as well as monitor response to treatment
- Reimbursement for depression screening and follow-up monitoring
- **Patient health questionnaire (PHQ-9)** — specifically developed for use in primary care
    - Self-administered, quick and easy
    - Specific for depression
    - Available in English and Spanish
- PHQ-9 reimbursement — Submit claim with the following billing combination: CPT code 96127 (brief emotional/behavioral assessment) or G0444 (annual screening for depression) in conjunction with diagnosis code Z13.13 (screening for depression).

To get started, you simply need to:

- Be a participating provider

- Use the **PHQ-9** tool to screen/monitor your patients
- Submit your claims using the combination coding

[1] Substance Abuse and Mental Health Services Administration (SAMHSA): National Survey on Drug Use and Health. 2017 NSDUH Annual National Report. September 14, 2018. Accessed August 5, 2020.

Refer patients to our Complex Case Management program

Our Complex Case Management program is a joint process including Aetna®, the member, the caregiver and the providers.

We offer patients with complex conditions extra help understanding their health care needs and benefits. We also help them access community services and other resources available to them.

Our goal is to produce better health outcomes while managing health care costs. We welcome referrals to the program from many sources. These include:

- Primary care physicians
- Specialists
- Facility discharge planners
- Family members
- Internal departments
- The member's employer
- Organization programs
- Vendors or delegates

You can submit a referral through the toll-free phone number on the member's ID card.

HEDIS® highlight: metabolic monitoring for children and adolescents on antipsychotics

The 2019 **State of Health Care Quality** report showed a continued upward trend in the **Metabolic Monitoring for Children and Adolescents on Antipsychotics** (APM) measure. Our behavioral health plan had similar results in this area.
Your feedback can help improve these measures. Just email your comments and suggestions to **QualityImprovement2@aetna.com**.

APM HEDIS measure description
The percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had both of the following in the measurement year:

- At least one test for blood glucose: blood glucose test, or HbA1c test

- At least one cholesterol test, or LCL-C test.

Eligible population ages: 1 to 17 years of age as of December 31 of the measurement year.

Strategies for improvement

- Use NCQA coding tips to actively reflect care rendered. Routinely tell members who are on an antipsychotic medication to have their blood glucose or cholesterol tested at least annually.
- Follow up with the parents of your patients to discuss and educate on lab results.
- Coordinate care with the behavioral health specialists treating your patients.

Numerator codes

There is a large list of approved NCQA codes used to identify the services included in the APM measure. The following are just a few of the approved codes. For a complete list, refer to the **NCQA website**.

Blood glucose test
CPT 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
LDL-C tests
CPT 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F
Cholesterol tests other than LDL
CPT 82465, 83718, 84478
HbA1c lab tests
CPT 83036, 83037, 3044F, 3045F, 3046F

Care coordination is reimbursable

Did you know coordination of care is reimbursable, with no cost share to members? With a behavioral health diagnosis, which is required, care coordination includes communication between:

- Behavioral health providers, such as therapists and psychiatrists
- Behavioral health and medical providers, such as psychiatrists and primary care physicians

Exceptions: All Medicare plans and any high deductible health plan with a health savings account, until members meet the deductible

CPT codes for collaboration	More information
99484, 99492, 99493 and 99494	• HMO: **1-800-624-0756 (TTY: 711)** • PPO and indemnity: **1-888-632-3862 (TTY: 711)**

Tools and resources
For more help, check out these links:

- **National Quality Forum: Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination**
- **Aetna Integrated Primary Care Behavioral Health Program**

Reminder: Check your Aetna Premier Care Network status

Now is a good time to check our **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 2021.

For 2021, we did not perform a designation review of provider performance. However, in some markets we have changed the underlying network configuration. For example, we converted a broad network to an Aetna Whole Health℠ arrangement.

If you have questions, call us at **1-888-632-3862**. You can also visit our provider website and send us any questions.

Notable 2021 changes
APCN Plus only
Springfield, MO: Cox Health Aetna Whole Health
Kansas City, MO: I-35 Performance Network
Georgia: VHAN ACO expansion into Murray and Whitfield counties

APCN only
Kansas City, MO: Aetna Broad Network

APCN and APCN Plus
South Carolina: Aetna Broad Network
Utah: Utah Connected Network

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 for identification.

The importance of promoting the flu vaccine this fall

The COVID-19 pandemic has reiterated the important role that vaccines play in reducing the impact of infectious diseases in the community. As the regular influenza season approaches, Texas Health Aetna encourages providers to promote the flu vaccine especially during the current pandemic. The Centers for Disease Control and Prevention (CDC) indicates that about 68% of people got the flu vaccine during the 2019–2020 flu season, which says something about the challenge ahead of us. How do we do better? What are you and your clinical partners doing to encourage your membership and patients to go and get the vaccine, and how can Texas Health Aetna assist?

What you can do

- Strongly recommend getting the flu vaccine
- Know when and where to go to get flu vaccines
- Follow CDC guidelines for flu prevention
- Share information on prevention methods, such as good handwashing, not touching the eyes, nose or mouth, and avoiding close contact with people who are sick

How we can help

- **Information sharing:** Members will receive communications on the importance of getting the vaccine and ways to keep safe.
- **Access:** Members may receive a vaccine at your office, pharmacies, CVS® MinuteClinic® locations, or a CVS® HealthHUB® location.
- **Plan sponsor event:** Larger plan sponsors and hospitals plan to hold flu clinics at work to support members receiving their flu vaccine.
- **Resources:** Recommendations on how to prepare for the flu season can be found on the **CDC's website**.

We appreciate your support of our flu vaccine initiative

COVID-19 interrupts 2020 HEDIS® medical record collection

We annually collect Healthcare Effectiveness Data and Information Set (HEDIS®) * data from claims, encounters, administrative data, and medical records.

This year, however, we paused our provider outreach activities in March because of the COVID-19 pandemic. The Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) eliminated HEDIS data collection requirements for 2020.

During the remainder of 2020, we will continue to partner with you on closing HEDIS gaps in care. One example is our new Member In-Home Kit Campaign. The kit process will provide an opportunity to close gaps in care for colorectal cancer screening, diabetes hemoglobin A1c and diabetes nephropathy attention. We'll be contacting you to answer any questions you may have and to help you order the kits.

Also, as your practice moves to more telehealth visits, we'll give you more guidance on how you can close several key HEDIS measures virtually.

SmartChoice radiology program offered in select markets

The Aetna SmartChoice program provides cost transparency to members who need high-tech radiology services. Effective **August 1, 2020,** the ECR SmartChoice radiology program will be expanding its footprint to the following markets/states:

- Missouri
- Oklahoma
- New York
- Northern New Jersey

As part of the program and when appropriate, eviCore, a medical management services company, will contact our members to discuss radiology options and help them schedule radiology services.

Pharmacy updates

Aetna Specialty Pharmacy® is being combined with CVS Specialty®

We're excited to share a recent change that provides the highest quality care and experience for both you and your Aetna® patients. In late June, we began a gradual transition of patients and prescriptions from Aetna Specialty Pharmacy to CVS Specialty. We expect to complete the transition by the end of September.

What's new for your patients
Your patients can expect the same great service plus these new features:

- The choice to drop off and pick up their specialty medication at a local CVS Pharmacy® or have it delivered to any location, at no extra cost*
- Dedicated support from a member of our Customer CareTeam specializing in their condition
- Access to **CVSspecialty.com** and the CVS Specialty mobile app to manage their medication anytime, anywhere

What you need to do
You can help ensure that your patients do not experience delays. Be sure to update your systems with this information for CVS Specialty:

- e-Prescribe: NCPDP ID **1466033**
- Fax: **1-800-323-2445**
- Telephone: **1-800-237-2767**

* Where allowed by law. In-store pickup is currently not available in Oklahoma. Some states require first-fill prescriptions to be transmitted directly to the dispensing specialty pharmacy. Products are dispensed by CVS Specialty, and certain services are only accessed by calling CVS.

Important pharmacy updates

Medicare

Visit our **Medicare Drug List** 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** 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

State-specific updates

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

Arkansas updates

Notice of material amendment to healthcare contract

Arkansas providers: The articles below are your notice of Material Amendment to Healthcare Contract. It is being sent pursuant to Ark. Code Ann. § 23-99-1205(a) and shall apply to all Provider, Physician, Ancillary, Facility and Hospital healthcare contract(s).

- Changes to commercial drug lists begin on January 1, 2021
- Important pharmacy updates
- Convenience kits
- Angioplasty services
- Infectious agent detection
- Once per lifetime edits
- Modifier 91 — genomic testing
- Third Party Claim and Code Review Program
- Changes to our National Precertification List (NPL)
- Technical-only services
- Supplies, material and equipment
- Moderate conscious sedation in a facility setting

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), 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.

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

Delaware updates

A word about benefits for GHIP members in Delaware

The State of Delaware Group Health Insurance Program (GHIP) wants employees to get the best value *from* their benefits. This means choosing the right care. Employees should:

- Understand their care options
- Know where to go for services
- Be aware of how much services cost
- Make informed decisions

Paying attention to these elements can help ensure that employees get high-quality, safe and affordable care. Making informed choices about care is an important step in helping control rising health care costs and maintaining high-quality, affordable benefits options.

Maine updates

Allowing referrals from direct primary care providers

Based on Maine law **Title 24-A M.R.S. § 4303(22)**, we must allow a referral from a direct primary care (DPC) provider to a network provider.
DPC providers do not submit referrals or claims to Aetna®. In the event a DPC provider refers a member to a participating provider, we may initially deny the claim. We do this because the referral must be from a network provider. If a denial occurs, call us at the number on the back of the member's ID card. We will reevaluate the claim.

We review monthly reports of claims denied due to no referral. We're looking to see if a DPC provider is the referring physician. If so, we will reprocess the claim at the appropriate benefits level without the need for you to call us.

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.

New York updates

Care coordination for patients with complex chronic illnesses

Aetna® has recently engaged Landmark Health to deliver in-home-care coordination and care delivery for Medicare patients with complex chronic illnesses. Landmark professionals will complement the care that you provide and will work closely with you to coordinate your patient's care.

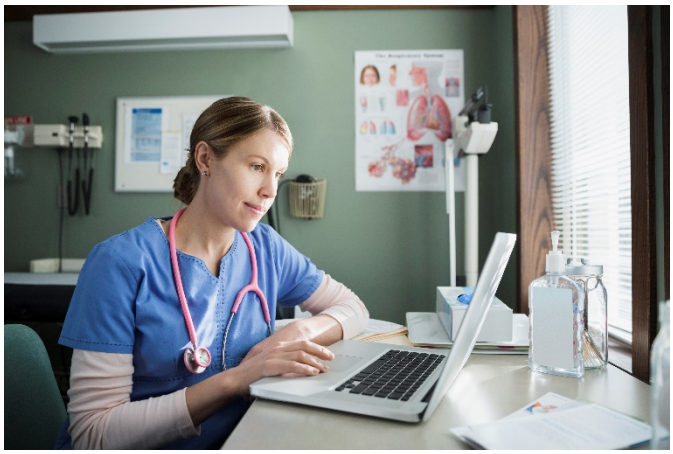
How this service helps your patients

- Home-based medical care is provided by MDs, nurse practitioners or physicians' assistants.
- Visits include well, palliative, postacute and urgent care.
- It's available 365 days/24 hours/7 days a week.
- An interdisciplinary care team includes a behavioral health specialist, a palliative care specialist, a pharmacist, a nurse care manager, a dietitian and a social worker.
- Education is provided to both patients and caregivers.
- Care is coordinated with a patient's primary care physician and/or specialist.

Who qualifies

- Patients with Medicare Advantage HMO and PPO plans
- Patients with six or more chronic health conditions

The Landmark program is provided by Landmark Health, LLC, and its affiliated medical groups, which are all independent companies, on behalf of Aetna.



Medicare updates

Get Medicare-related information, reminders and guidelines.

Where to find Dual Eligible Special Needs Plans (DSNPs) information and resources

Check out our **DSNP page** for helpful information on DSNPs, including frequently asked questions, service area information, cost share guidelines and more!

Don't let your network status change — complete your Medicare compliance training

If you are a participating provider (individual, group, facility or ancillary, etc.) in our Medicare Advantage (MA) plans, Medicare-Medicaid plans (MMPs) and/or Dual Special Needs Plans (DSNPs), 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 find training materials and complete your attestation
You'll find the attestation and training resources you need to ensure your compliance on **Aetna.com/medicare** under "Important: Medicare Compliance Program Requirements Due by December 31, 2020" section. We've combined the DSNP MOC and FDR attestations. So that means if you are a dually contracted MA and DSNP provider, you need to complete just one.

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.

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