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Financial well-being
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Aetna OfficeLink Updates™

Southeast Region

Inside this issue

Options to reach us

- Select **Health Care Professionals**
- Select "Medical Professionals Log In"

Or call our Provider Service Center:

- **1-800-624-0756** for HMO-based benefits plans, Medicare Advantage plans and WA Primary Choice plan
- **1-888-MDAetna (1-888-632-3862)** for all other plans

How to work with public health insurance exchanges

On October 1, 2013, many Americans began using public exchanges to buy health insurance under the Affordable Care Act (ACA).

Aetna will offer Qualified Health Plans (QHPs), including plans sold on the individual public exchanges/marketplaces, in these states:

- Arizona
- Florida
- Illinois
- Oklahoma
- Pennsylvania
- Texas
- Virginia
- Washington, D.C.

Availability of QHPs varies state by state. Check the map on our **Health Insurance Exchange/ Marketplace website** to see if there's a QHP in your area.

Aetna also will offer small group plans on the SHOP (Small Business Health Options Program) in Maryland and Washington, D.C.

Identifying members

ID cards for members in these plans will have "QHP" on them. The product name is on the right side of the card, and the plan name on the left side. QHP designation means the plan meets certain requirements under the ACA and is certified by the Centers for Medicare and Medicaid Services (CMS).

Identifying network providers

To identify network providers participating in a QHP for individual or SHOP products, visit our **DocFind**® online provider directory.

For **Individual plans** choose "Qualified Health Plans (QHPs)" from the "Select a Plan Category" drop down box. Pick "Qualified Health Plans (for AZ, FL, IL, PA, OK, TX and VA)" from the "Select a Plan Name" drop down box that corresponds to the plan name on the ID card.

Use in-network laboratories

As a reminder, refer your Aetna members to in-network laboratories for lab services.

Your patients can use any in-network lab. However, Quest Diagnostics is our national preferred lab and your patients may save the most money when using them.

To find a full list of in-network providers, visit our **DocFind** online provider directory.

Policy and Coding Updates

Clinical payment, coding and policy changes

We regularly adjust our clinical, payment and coding policy positions as part of our ongoing policy review processes. In developing our policies, we may consult with external professional organizations, medical societies and the independent Physician Advisory Board, which provides advice to us on issues of importance to physicians. The chart below outlines coding and policy changes:

Procedure	Implementation date	What's changed
*Transcutaneous Electrical Nerve Stimulators (TENS) and supplies	3/1/2014	A4556, A4558, A4630 and A4557 will be denied when billed within 30 days of A4595. Refer to **Clinical Policy Bulletin** #0011 – Electrical Stimulation for Pain – for more information.
Transcutaneous Electrical Nerve Stimulators (TENS)	n/a	Transcutaneous Electrical Nerve Stimulators are considered experimental and investigational for chronic low back pain. Refer to **Clinical Policy Bulletin** #0011 - Electrical Stimulation for Pain -- for more information.
Durable medical equipment - capped rentals	9/1/2013	Effective 9/1/2013, the following DME items are paid on a monthly basis up to the purchase price: E0170, E0171, E0196, E0202, E0482, E0483, E0550, E0572, E0574, E0575, E0585, E0618, E0619, E0636, E0749, E0911, E0912, E1802, E1812, E1831
Manual therapy techniques (97140) billed with chiro manipulations (98940-98943)	Reminder	We communicated the following policy change in the 12/2012 issue: Procedure 97140 is not recommended for separate payment when submitted with procedure 98940-98943. Modifiers 25 and 59 do not override this edit. When manual therapy techniques are performed with chiropractic manipulation on a different spinal region, the claim must be appended with modifier 59 and medical records submitted supporting additional payment.
Clarification *Special charges and incremental nursing charges	3/1/2014 – Medicare Advantage	We will no longer roll up special charges (revenue code 221-223) and incremental nursing charges (230-239) into the room and board charges billed on facility-based confinement claims for all products. For all HMO and Traditional plans (excluding nonparticipating facilities treating Medicare Advantage Plan members and fully insured plans subject to Maryland state legislation), we will enforce the existing policy to deny inpatient private duty nursing services billed in conjunction with a confinement and add special charges to the existing policy. We previously noted this change in the 9/2013 issue of OfficeLink Updates with an effective date of 9/1/2013 (except in the state of Washington, which is excluded at this time) and 12/1/2013 for Maryland.
Correction Multiple surgical reductions – mid-level practitioners		In the 9/2013 issue, we communicated the multiple surgical reductions that will apply to mid-level provider claims effective 12/1/2013. The article should have read "Effective with this update, if a mid-level practitioner performs multiple surgical procedures for the same patient, on the same date of service: • Aetna will pay the primary procedure at 85 percent. • Aetna will pay the secondary at 42.5 percent. • Aetna will pay all subsequent services at 21.25 percent. This update aligns with multiple surgical procedure reductions currently applied to physician claims.

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

Aetna Performance Network – updated for January 1, 2014

Employers and employees look to us for options to help better control costs. That's why we created the Aetna Performance Network.

Members pay a lower percentage of their medical costs when they use Aetna Performance Network doctors and hospitals. This tiered network aligns 20 specialties to top-performing hospitals.

Are you in the network?

To see if you're in the Aetna Performance Network or to check the status of doctors and hospitals you work with, visit our **DocFind** online provider directory. Select an Aetna Performance Network plan from the drop-down menu, and then look for the symbol on the results page.

Network criteria

To create the network, we evaluated our participating hospitals in the Aetna Performance Network 2014 markets* based on certain cost and quality criteria. In some cases, we applied other business considerations.

We then looked at specialists in 20 categories that frequently use those hospitals. In some markets, we also reviewed 12 of the 20 specialties on additional measures for clinical quality and cost. We evaluated these specialties:

- Cardiology**
- Gastroenterology**
- General Surgery**
- Orthopedics**
- Neurology**
- Neurosurgery**
- Obstetrics/Gynecology**
- Cardiothoracic Surgery**
- Vascular Surgery**
- Otolaryngology (ENT)**
- Plastic Surgery**
- Urology**
- Allergy/ Immunology
- Dermatology
- Endocrinology
- Infectious Disease
- Nephrology
- Ophthalmology
- Pulmonary Critical Care
- Rheumatology

* **Aetna Performance Network 2014 markets:** Arizona; California (Central Valley, No. Calif, Los Angeles, Orange/Inland, San Diego); Connecticut; District of Columbia (Washington, DC); Florida (Brevard County, No. FL, So. FL – Palm Beach and Broward Counties, Tampa); Georgia (Augusta, Savannah); Illinois (Chicago); Indiana (Indianapolis); Kentucky (Louisville); Maine; Massachusetts; Nevada (Las Vegas); New Hampshire; New Jersey (Northern, Southern); New York (Metro NYC, Upstate); North Carolina (Charlotte, Winston-Salem, Raleigh-Coastal- Greenville); Ohio (Cincinnati, Cleveland, Toledo); Oklahoma (Oklahoma City, Tulsa); Pennsylvania (Northeast-Scranton, Southeastern-Philadelphia); South Carolina; Tennessee (Chattanooga); Texas (Austin, Houston, San Antonio); Virginia (Hampton Roads, Richmond, Roanoke); West Virginia; Wisconsin (Southeastern).

** Specialties designated based on Aexcel criteria in the Aexcel market locations and further refined by their utilization of Aetna Performance Network hospitals.

Precert list change

Note the following change to Aetna's National Precertification List (NPL) effective 12/2/13:

- Precertification is required for Simponi® Aria™ (golimumab), Adempas® (riociguat), Opsumit® (macitentan), Actemra®SC (tocilizumab) and Xofigo® (radium Ra 223 dichloride)

View more information about **precertification**.

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How to work with public health insurance exchanges

Continued from page 1

For **SHOP plans** choose "State Based Plans" from the "Select a Plan Category" drop down box. Pick the appropriate DC or MD metallic level plan name from the "Select a Plan Name" drop down box that corresponds to the plan name on the ID card

Treating these members

- Follow the same processes you use today to check eligibility and benefits, and to submit claims.
- All referrals should be made to in-network QHP providers.

Formulary

You can check formulary information and search for a drug based on the member's **state of residence** and their individual plan. After choosing the state, you can look for a specific drug under the "pharmacy search tool" link. Formulary information is also available for Washington D.C. SHOP. (Maryland SHOP formulary information will be available January 1, 2014.)

For more information, visit the **Exchanges page** on our **Health Reform Connection** website. Or, go to the **Health Insurance Exchange/Marketplace website**.

*"Statewide" mean that Aetna plans are available in every rating area in that state. Within a rating area, however, we may not have plans in all counties.

Electronic Solutions

Post-n-Track® – our new no-cost direct-connect solution

Post-n-Track delivers your transactions directly to us and back to you quickly and efficiently. You'll get an immediate receipt for every claim you send, showing receipt and delivery.

You'll also have access to online reports for claims sent, financial totals, errors and payer responses for all your transactions.

Post-n-Track offers:

- The ability to access other payers free of charge without any additional software
- Easy-to-use tracking/transparency tools for the life cycle of your transactions
- The ability to easily download your 835 electronic remittance advices
- Fast and easy submission of your
  - Claims
  - Eligibility/claim status transactions
  - Precertification/referrals
  - Clinical lab results
  - Encounters

Easy to install and use

Installation of this desktop application is easy. It doesn't require any interfaces to your existing practice management system.

Sign up now

- Enroll directly in **Post-n-Track**. Type Aetna in the Initial Interest field.
- Questions? Call **1-860-257-2030** or e-mail us at **support@post-n-track.com**.

Get electronic member ID cards online

As a reminder, you can access electronic copies of your Aetna patients' ID cards right from our **secure provider website**.

Here's how to get the electronic image of your patient's ID card:

- First, submit an eligibility request for the member.
- When you get a successful eligibility response, a generic ID card image will display on the response screen.
- Click the image to get a copy of the actual ID card.

You can download and print the image to a local computer or network. You'll save both time and the additional work of scanning or photocopying ID cards.

We've also posted an Electronic Member ID Card Help Document in the NaviNet® User Support section.

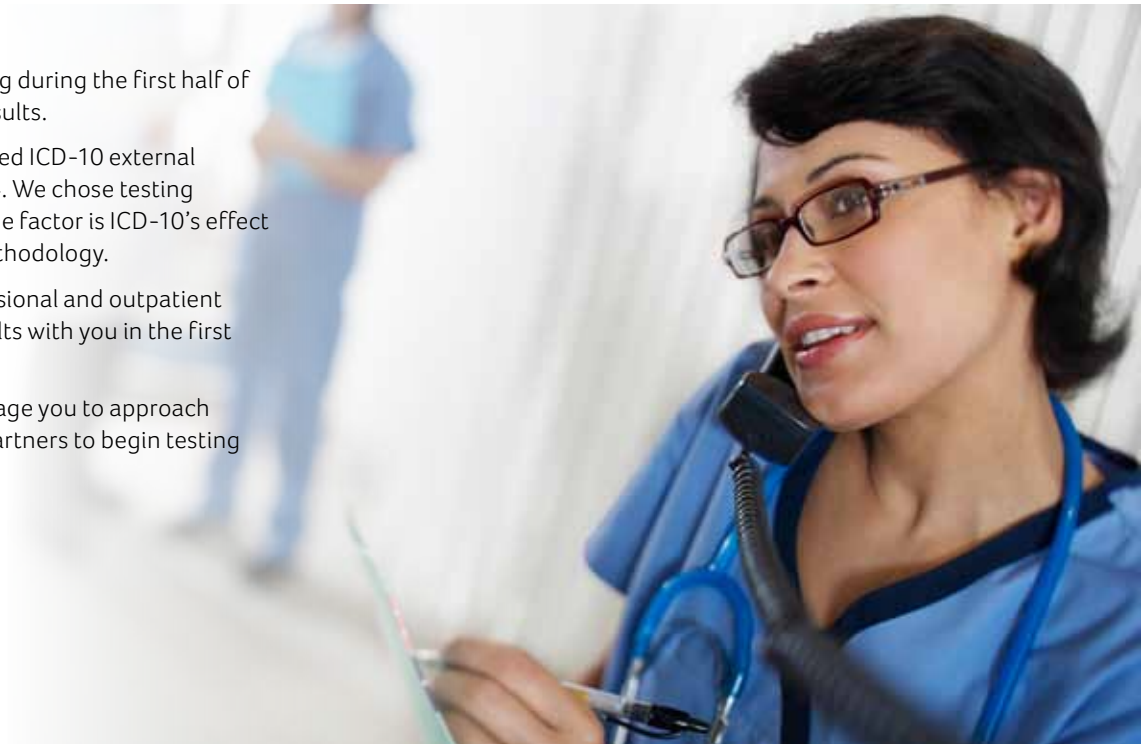
Update on ICD-10 testing

We started large scale, internal testing during the first half of 2013, and continue to analyze our results.

We're now well underway with targeted ICD-10 external testing, which will continue into 2014. We chose testing partners based on several factors. One factor is ICD-10's effect on a provider contract's payment methodology.

We are including institutional, professional and outpatient claims in our testing. We'll share results with you in the first half of 2014.

In the meantime, we strongly encourage you to approach clearinghouses and other business partners to begin testing as well.



Medicare

Use new fax for Medicare expedited precert requests

We have a new dedicated fax number for Medicare providers. Use this number to submit expedited (or urgent) requests for precertification, also known as expedited organization determinations (EODs).

The new dedicated fax number for EODs is **1-860-754-5468**.

Do not use this number for:

- Standard precertification requests
- Requests for Part B medical injectables

We still encourage you to submit precertification requests electronically through our **secure provider website** or your own electronic vendor. However, if you need to submit a Medicare EOD by fax, submit your request using the new fax number.

Submitting expedited or urgent requests

The Centers for Medicare & Medicaid Services (CMS) provides for expedited (or urgent) Medicare precertification reviews in certain situations. These include times when the patient or their physician believes that waiting for a decision under the standard time frame could place the patient's life, health or ability to regain maximum function in serious jeopardy.

If your request does not meet the definition above, submit a standard request.

Although we encourage providers to submit requests electronically, if you choose to submit your EOD request by fax, review your fax cover sheets to ensure that requests are only marked "Urgent," "Fast" or "Expedited" when the request meets the definition above.

New CMS billing requirements for HCCs, SNFs

Starting July 1, 2014, CMS is requiring all home health care (HHC) and skilled nursing facilities (SNF) to put Health Insurance Prospective Payment System (HIPPS) codes on all claims for patients with Medicare Advantage benefits. This is in agreement with Chapter 25 of the **Medicare Claims Processing Manual** guidelines.

To get your claims paid accurately:

- Bill all HIPPS codes with a $0.00 charge on HHC and SNF claims.
- A HIPPS code is needed for all claims, regardless of billing cycle.
- If the HIPPS code changes during treatment, the new HIPPS code should be sent with the change.
- Precertification is still required for these patients.

We will follow CMS instruction that all Medicare Advantage plans reject any HHC or SNF claim that does not contain a HIPPS code.

If you have questions, call our Provider Service Center at **1-800-624-0756**.

Use revised HCFA 1500 forms

Starting January 6, 2014, we will accept the revised CMS HCFA 1500 paper claim form version 02/12. We will continue to accept and process paper claims submitted on the CMS HCFA 1500 paper claim form version 08/05.

The HCFA 1500 claim form was revised to support various coding requirements and prepare for the conversion to ICD-10 diagnosis coding effective date of October 1, 2014.

Collect all Medicare Advantage plan member cost sharing

The Centers for Medicare and Medicaid Services (CMS) reviews and approves all Medicare Advantage (MA) benefit packages. The statutes, regulations, policy guidelines and requirements in the Medicare Managed Care Manual and other CMS instructions are the basis for these reviews and approvals.

Compliance is key

To comply, Medicare Advantage organizations must be sure that their MA plans do not discriminate in the delivery of health care services, including source of payment.

The rules regarding collection of Medicare beneficiary cost-share applicable in traditional Medicare apply to Medicare Advantage as well. Therefore, providers must collect all applicable cost share amounts from Aetna Medicare Advantage plan members.

Waiving the cost share is a direct violation of federal laws and regulations. This action puts Aetna and your compliance at risk. We request your compliance with this requirement.

Adhering to antidepressant medication treatment

Depression in adults is the most treatable behavioral health condition when patients follow their medication program. Behavioral health providers can help increase adherence by educating patients at the start of treatment about:

- How antidepressants work
- The benefits of antidepressant treatment
- Expectations about symptoms remission
- How long medications should be used
- Coping with medication side effects

Remind patients to:

- Speak to their health care professional about medication side effects.
- Let their health professional know about their current medical conditions and medications they're taking, including nonprescription drugs, herbs and supplements. This will help to assess potential drug interactions.
- Schedule regular follow-up appointments to see if a certain medication is working.
- Expect that they may need to try several different medications before finding the one that works best.
- Keep taking their medication as prescribed for at least six months after they feel better. This will reduce their chances of feeling depressed again.

Monitoring adherence

The National Committee for Quality Assurance (NCQA) has established two measures to monitor patients' adherence to their medications. You should monitor the percentage of patients who stay on their antidepressant medication for at least three months and for at least six months.

Guidelines to help you treat ADHD

We encourage you to use evidence-based clinical practice guidelines (CPGs) to help screen, assess and treat common disorders, such as Attention-Deficit/ Hyperactivity Disorder (ADHD). These guidelines can help you give the best health care possible.

The American Academy of Pediatrics (AAP) **guidelines** state that children who are treated with medication for ADHD should have at least one follow-up visit with a prescribing practitioner within 30 days of the initial prescription fill and every quarter thereafter. We monitor compliance monthly through Healthcare Effectiveness Data and Information Set (HEDIS®)* data collection and review.

Learn more online

You can find more information on the Centers for Disease Control and Prevention's **website**.

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

Consult Clinical Practice Guidelines as you care for patients

The National Committee for Quality Assurance (NCQA) requires health plans to regularly let providers know about the availability of Clinical Practice Guidelines (CPGs).

Our CPGs and Preventive Service Guidelines (PSGs) are based on nationally recognized recommendations and peer-reviewed medical literature. They are on our **secure provider website**. Look under "Aetna Support Center," then "Clinical Resources."

Preventive Service Guidelines	Adopted 2/12
*USPSTF Hepatitis C screening recommendation	Adopted 7/13
*USPSTF HIV screening recommendation	Adopted 6/13
*USPSTF intimate partner violence screening recommendation	Adopted 3/13
**CDC tdap vaccine for pregnant women	Adopted 3/13
*USPSTF perinatal recommendations	Adopted 11/12
*USPSTF prostate cancer screening recommendations	Adopted 7/12
*USPSTF cervical cancer screening recommendations	Adopted 3/12
**CDC tdap vaccine for adults over 65 years of age	Adopted 3/12
Behavioral Health	
• Helping Patients Who Drink Too Much	Adopted 2/12
• Treating Patients With Major Depressive Disorder	Adopted 2/12
Diabetes	
• Treating Patients With Diabetes	Adopted 2/13
Heart Disease	
• Treating Patients With Coronary Artery Disease	Adopted 4/12

For a hard copy of PSGs, or a specific CPG, call our Provider Service Center at **1-888-632-3862**.

*U.S. Preventive Services Task Force **Centers for Disease Control and Prevention

Learning Opportunities

Log in or register at **AetnaEducation.com**

New and updated courses for physicians, nurses and office staff

Courses

- **New** 2013 Medicare Fraud, Waste and Abuse (FWA) Attestation
- Member ID card tools

Reference Tools

- **Updated** ID Cards: Standard member ID card tool
- **Updated** Patient Safety: Patient safety in the physician's office
- **Updated** Health Literacy: Health Literacy essentials

CMS requires Fraud, Waste and Abuse training

The Centers for Medicare & Medicaid Services (CMS) requires providers and administrative staff to complete Fraud, Waste and Abuse (FWA) training* annually.

CMS offers a web-based training module that satisfies the FWA training requirement. You should first review the **instructions** to access CMS' FWA course. Some Medicare Advantage organizations also offer training that satisfies this requirement.

Submitting FWA Attestation

Once your organization completes the training, an authorized representative must submit our 2013 FWA Attestation. The attestation is located on our **Education Site**. It is a confirmation that your staff meets CMS FWA training requirements.

Aetna Medicare Compliance

We take Medicare compliance seriously, and have incorporated it into the Aetna **Code of Conduct**. We encourage you to share it with your employees. For questions about our Medicare Advantage plans, contact our Provider Service Center at **1-800-624-0756**.

*Providers are considered First Tier Entities, as they have a contractual relationship with Aetna to deliver covered health care services to our Medicare Advantage plan members. Aetna's employees (including temporary workers and volunteers) and governing body members, as well as employees of our First Tier, Downstream & Related Entities (FDR) who are involved in the administration or delivery of benefits with Aetna's Medicare Advantage plans, must, at a minimum, receive FWA training within 90 days of initial hiring (or contracting in the case of FDRs), and annually thereafter.

The only exception to this rule is with FDRs who have met the FWA certification requirements through enrollment in Parts A or B of the Medicare program, or through accreditation as a supplier of point-of-sale durable medical equipment, and who are, therefore, deemed to have met the FWA training and education requirements.

Pharmacy

Submit drug prior authorizations online

It's easy to request approval for drugs that require prior authorization through our **secure provider website**. There's no cost to you and it's compliant with the Health Insurance Portability and Accountability Act (HIPAA).

You can:

- Eliminate phone calls and minimize faxing.
- Manage drug prior authorization forms and follow up in one place.
- Store data about your patients, their pharmacies and prescribers.
- Receive completed requests from pharmacies, such as Aetna Specialty Pharmacy® medicine and support services.
- Get faster approvals for your patients.
- Send electronically for drugs in all Aetna, Medicare, Medicaid and most other health plans.

How to get started

- Log in to our **secure provider website**
- Choose the "Services" tab at the top of the page
- Select "Drug Authorizations"

We'll fax the authorization response directly to you.

Preferred drug, precert, quantity limit and step-therapy list changes

Effective January 1, 2014:

- Omnitrope will be the only preferred growth hormone. We'll require a three-month trial of this drug before we'll cover another growth hormone drug (step therapy).
- Rebif will be the only preferred interferon for multiple sclerosis.
- Step therapy will be required on all non-preferred products used to treat multiple sclerosis.
- Copaxone will remain a preferred product.

View the **2014 formulary changes**.

Help patients save money with generics

As a result of benefit plan changes, some of your patients will have a new formulary tier. In that tier, they'll pay a lot more if you prescribe a brand-name drug when a generic equivalent is available.

Generic drugs can provide quality, safe and effective medication while controlling costs. They include the same medications as the brand-name drug, but at a much lower cost for your patients. Consider prescribing generic medications, whenever appropriate.

Where to find our Medicare and Commercial formularies

We update our Medicare and Commercial (non-Medicare) preferred drug lists (formularies) at least annually and throughout the year.

- View our **Medicare preferred drug list**
- Go to our **Commercial preferred drug list**

Use our secure site to update demographic data

If you need to update your office's demographic information – new e-mail addresses, mailing address, phone or fax numbers – use our **secure provider website**. Also update your demographic information if your name changes due to marriage or another life event.

If you've been calling our Provider Service Center for demographic changes, we ask that you use the secure site instead. The site lets you confirm the information you submit and prevents unauthorized individuals from submitting wrong information about your office or facility.

Electronic transactions

You also can do most electronic transactions through this website. This includes submitting claims, checking benefits and eligibility, and requesting precertifications.

NaviNet Security Officers have access to Aetna's "Update Provider Profiles" function, through which they can submit demographic changes. They also can authorize other users' access to this feature as appropriate. To use the secure website you must first **register**.

Southeast News

Maryland

How to ID providers no longer in the network

Maryland Insurance Code 15-112 – Provider Panels requires Aetna to notify primary care physicians (PCPs) 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 Aetna's network terminated during the specified timeframe.

You can find this report in the Southeast Region section of our Health Care Professional Toolkit, located on our **secure provider website**. To access the Toolkit, go to Aetna Support Center, then Doing Business with Aetna. Review the report periodically to see which providers no longer participate with us.

To view a current listing of providers who participate in the Aetna network, go to our **DocFind** online provider 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, contact our Provider Service Center at **1-800-624-0756**.

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Contact us at: OfficeLinkUpdates@aetna.com

Route this publication to:

- ○ Office Manager
- ○ Referral and Precertification Staff
- ○ Business Staff
- ○ Front Desk Staff
- ○ Medical Records/Medical Assistants
- ○ Primary Care Physicians
- ○ Specialists
- ○ Physician Assistants/Clinical Nurse Specialists
- ○ Nurses

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