Updates to our National Precertification List

These changes to Aetna’s National Precertification List (NPL) will take effect as noted below.

Reminders and updates

A new drug class, injectable respiratory drugs, will require precertification on July 1, 2016. This class includes Nucala (mepolizumab) and Xolair (omalizumab) which currently require precertification.

Because immunologic agents require precertification as a drug class (includes Xeljanz), Xeljanz XR also requires precertification.

Effective February 12, 2016, the following new-to-market drugs require precertification:

- Imlycig (talimogene laherparepvec)
- Vonvendi (von Willebrand factor, recombinant)
- Zepatier (elbasvir and grazoprevir)
- Empliciti (elotuzumab)

Effective March 1, 2016, the following new-to-market drugs require precertification:

- Uptravi (selexipag)
- Darzalex (daratumumab)

Effective April 15, 2016, the following new-to-market drug requires precertification:

- Hymovis (hyaluronan or derivative)

You can find more information about precertification under the “General information” section of the NPL.
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 advises us on issues of importance to physicians. The chart below outlines coding and policy changes:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Effective date</th>
<th>What’s changed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modifier 73 — discontinued outpatient hospital/ambulatory surgery center procedure prior to the administration of anesthesia</td>
<td>Sept. 1, 2016</td>
<td>We will follow the Centers for Medicare and Medicaid Services (CMS) recommendation to reduce payments by 50% for services billed with modifier 73 effective Sept. 1, 2016.</td>
</tr>
</tbody>
</table>
| E&M services billed by non-physician providers                             | Sept. 1, 2016  | Currently we don’t pay Evaluation and Management codes (99201–99499) for certain provider types, including audiologists; dieticians; nutritionists; and speech, physical or occupational therapists. We are expanding this list to include additional non-physician provider types based on CMS recommendation. Effective Sept. 1, 2016, we will no longer reimburse E&M services billed by the following specialties:  
  • Alcohol and drug counselor*  
  • Behavioral analyst*  
  • Christian Science practitioner  
  • Crisis diversion*  
  • Employee assistance program (EAP) counselor*  
  • Genetic counselor  
  • Home health/private duty nurse  
  • Licensed practical nurse  
  • Licensed professional counselor*  
  • Marriage and family social worker*  
  • Other mental health counselor*  
  • Pharmacist  
  • Registered social worker*  
  • Substance abuse services, alcohol & drug*  
  • Visiting nurse  
  *We will continue to reimburse for:  
    • 99408: Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes  
    • 99409: Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes |
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Effective date</th>
<th>What’s changed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemodialysis home visits 99512 — home visit for hemodialysis</td>
<td>Sept. 1, 2016</td>
<td>We are going to follow the CMS home hemodialysis frequency recommendations. As of Sept. 1, 2016, we will allow 99512 14 times per 31 days.</td>
</tr>
<tr>
<td>Modifier SL: state-supplied vaccine</td>
<td>Informational</td>
<td>Modifier SL indicates a vaccine was obtained at no cost to the provider. Vaccines obtained through a state or federal program are not separately payable, and must be billed with modifier SL.</td>
</tr>
<tr>
<td>Modifier SU: denotes use of facility equipment</td>
<td>Informational</td>
<td>Services performed in an office place of service and billed with modifier SU are not payable unless contracted.</td>
</tr>
</tbody>
</table>
Note these upcoming service code changes

Individual service codes will be reassigned within contract service groupings. Changes to an individual provider’s compensation will depend upon the presence or absence of specific service groupings within their contract. These changes are outlined below.

Unless otherwise indicated all updates will be effective **September 1, 2016**.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Provider types affected</th>
<th>What’s changing</th>
</tr>
</thead>
</table>
| P9612, P9615, 23350, 31899, 38792, 91010, 91020, 91022, 92511, 97597, 97598 | Facilities including acute short-term hospitals and ambulatory surgery centers | Will be assigned to Ambulatory Surgery — Aetna Enhanced Groupers: Category 1 (AEG1). Code will remain assigned to Ambulatory Surgery: Default Rate (DEFAULTSUR).  
- If contract contains an Ambulatory Surgery — Aetna Enhanced Groupers: Category 1 rate it will be applied. If not, then the Ambulatory Surgery Default Rate will be applied. |
| 31235, 31238, 31622, 31645, 43220 | Facilities including acute short-term hospitals and ambulatory surgery centers | Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 2 (AEG2). Code will remain assigned to Endoscopic procedures (ENDO) and Ambulatory Surgery: Default Rate (DEFAULTSUR).  
- If contract contains an Endoscopic procedure rate, there will be no change.  
- If contract does not contain the above rate, but has an Ambulatory Surgery — Aetna Enhanced Grouper: Category 2 rate, then the Ambulatory Surgery — Aetna Enhanced Grouper: Category 2 rate will be applied.  
- If the contract contains neither of the above rates, the Ambulatory Surgery: Default Rate will apply. |
| 31730 | Facilities including acute short-term hospitals and ambulatory surgery centers | Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 2 (AEG2). Code will remain assigned to Ambulatory Surgery: Default Rate (DEFAULTSUR).  
If contract contains an Ambulatory Surgery — Aetna Enhanced Groupers: Category 2 rate, it will be applied. If not, then the Ambulatory Surgery Default Rate will be applied. |
| 31525, 31527 | Facilities including acute short-term hospitals and ambulatory surgery centers | Will be assigned to Ambulatory Surgery — Aetna Enhanced Groupers: Category 2 (AEG2). Code will remain assigned to Minor Surgery: All Surgery (MINSURDEF); Endoscopic procedures (ENDO) and Ambulatory Surgery: Default Rate (DEFAULTSUR).  
- If contract contain any of the following rates: Minor Surgery: All Surgery or Endoscopic rate, there will be no change.  
- If contract does not contain any of the above rates, but has an Ambulatory Surgery: Aetna Enhanced Grouper Category 2 rate, then the Ambulatory Surgery: Aetna Enhanced Grouper Category 2 rate will be applied.  
- If the contract contains none of the above rates, the Ambulatory Surgery: Default Rate will apply. |

*Washington State providers: All items listed under the “Codes” column were subject to regulatory review, and separate notification sent on or around June 1, 2016.*
<table>
<thead>
<tr>
<th>Codes</th>
<th>Provider types affected</th>
<th>What’s changing</th>
</tr>
</thead>
</table>
| 46945, 46946 | Facilities including acute short-term hospitals and ambulatory surgery centers         | Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 2 (AEG2).  
Code will remain assigned to: Minor Surgery: Medicare Groupers w/Endo (MINSURMENDO); Minor Surgery: All Surgery (MINSURDEF); Minor Surgery: Medicare Groupers (MINSURMED) and Ambulatory Surgery: Default Rate (DEFAULTSUR).  
• If contract contains any of the following rates: Minor Surgery: Medicare Groupers w/Endo; Minor Surgery: All Surgery; or Minor Surgery: Medicare Groupers, there will be no change.  
• If contract does not contain any of the above rates but does contain an Ambulatory Surgery: Aetna Enhanced Grouper Category 2 rate, then the Ambulatory Surgery: Aetna Enhanced Grouper Category 2 rate will be applied.  
• If the contract does not contain any of the above rates, then the Ambulatory Surgery: Default Rate will apply. |
| 31634, 31660, 31661 | Facilities including acute short-term hospitals and ambulatory surgery centers         | Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 3 (AEG3).  
Code will remain assigned to Endoscopic procedures (ENDO) and Ambulatory Surgery: Default Rate (DEFAULTSUR).  
• If contract contains an Endoscopic procedure rate, there will be no change.  
• If contract does not contain an Endoscopic rate, but contains an Ambulatory Surgery - Aetna Enhanced Grouper: Category 3 rate, it will be applied.  
• If the contract does not contain any of the above rates, then the Ambulatory Surgery Default rate will be applied. |
| 31254 | Facilities including acute short-term hospitals and ambulatory surgery centers         | Will be assigned to Ambulatory Surgery — Aetna Enhanced Grouper: Category 4 (AEG4).  
Code will remain assigned to Endoscopic procedures (ENDO) and Ambulatory Surgery: Default Rate (DEFAULTSUR).  
• If contract contains an Endoscopic procedure rate, there will be no change.  
• If contract does not contain an Endoscopic rate, but contains an Ambulatory Surgery — Aetna Enhanced Grouper: Category 4 rate, it will be applied.  
• If contract does not contain any of the above rates, then the Ambulatory Surgery Default rate will be applied. |
| 78071, 78072 | Facilities including acute short-term hospitals, ambulatory surgery centers, children's hospital, and diagnostic radiology centers | Will be removed from CTSCAN (CT scan).  
Codes will remain assigned to DIAGRAD, RAD, & RADHCPC (description prints as Radiology Services for all service groupings listed).  
• The CT scan rate will no longer be applied to this code. The existing Radiology Services rate will begin to apply. |
| 36600 | Facilities including acute short-term hospitals and ambulatory surgery centers         | Will be removed from Ambulatory Surgery — Aetna Enhanced Grouper: Category 1 (AEG1) and removed from the Ambulatory Surgery: Default Rate (DEFAULTSUR).  
Code will remain part of the all other outpatient rate.  
• The contract will no longer apply an Ambulatory Surgery — Aetna Enhanced Grouper: Category 1 rate or Ambulatory Surgery: Default Rate.  
• If the contract contains an all other outpatient rate, then this rate will be applied. |
Office News

Digital ID cards and eligibility and benefits inquiry

If an Aetna patient shows you a digital or printed copy of their ID card, you should accept it. Old member ID cards could cost you and your patients’ time and money. We’ve got you covered.

When you reference a digital ID the information is up to date. That’s why we’ve given you and our members the ability to access digital member IDs.

If a member doesn’t have a copy of their ID card, you should submit an eligibility and benefits inquiry using their name and date of birth. You should complete an eligibility and benefits inquiry for every patient at every visit. You’ll get a response with everything you need to know about your patient.

Learn more
Check out our new reference tool and tutorial. Search for “digital.” You’ll get all you need to know about digital member ID cards.

Referrals aren’t needed for Ob/Gyn and related specialties

Your patients no longer need a primary care physician (PCP) referral when seeking care from an Ob/Gyn and related sub-specialties (for example: perinatology, infertility, gyn oncology).

This change took effect January 1, 2016. It applies to your patients covered under our commercial referral-based products — Managed Choice Point of Service; Elect Choice; HMO; and QPOS.

What this means for you*

• Primary care offices: You don’t have to give referrals to patients seeking specialist care for Ob/Gyn-related services.
• Ob/Gyn and related sub-specialists: You don’t need to direct your patients back to their PCP for a referral. Also, you don’t have to contact the PCP for a referral for more services needed during your patient’s treatment.

Call us with questions
If you have questions, call us at 1-800-624-0756 for HMO-based and Medicare Advantage plans, or 1-888-MD-Aetna (1-888-632-3862) for all other plans.

*Existing precertification requirements still apply. Claims submitted before January 1, 2016 will keep the referral requirement policies in place at that time.
Reminder: inpatient timely notification requirement

To comply with our inpatient timely notification requirements, be sure to notify us of hospital admissions within one business day.* Also note:

• If observation stays are more than 24 hours, you have to tell us no more than one business day later.*
• You must precertify maternity or newborn confinement if they exceed the standard length of stay of three days or less for vaginal or five days or less for cesarean.
• You have to contact us if notification is late or if you’ve discharged the patient.

Extemporaneous situations

There may be reasons why patients can’t provide coverage information. We use the following guidelines regarding extemporaneous situations:

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage plans and Qualified Health Plans (QHPs) to maintain accurate directories. Having your up-to-date information allows us to do that.

Electronic transactions

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

• If you notify us within 14 days after the patient’s discharge we’ll make a decision based on the information we have.
• If you notify us after 14 days from the patient’s discharge, we’ll note your contact. Examples of supporting evidence we may consider upon appeal include:**
  - ID card/eligibility information was obtained before/during admission.
  - Facility face/demographics sheet (contains patient demographic information)
  - Records confirming contact with another carrier before/during admission.

New screening program addresses opioid overdose risks

In our Opioid Overdose Risk Screening (OORS) Program, behavioral health clinicians screen behavioral health cases to identify patients at risk of death due to opioid overdose. The program started in January 2016.

Help patients with opioid dependence

When opioid dependence is diagnosed, we recommend that providers consider naloxone as part of the patient’s ongoing treatment plan.

Naloxone is a rescue medication that reverses the effect of an opioid overdose. Countering the effects of overdose in the event of relapse allows the patient to continue the recovery process. The Centers for Disease Control and Prevention estimates that over 10,000 opioid overdoses were reversed nationwide between 1996 and 2010, in response to emergency naloxone administration.

Other elements supporting this potentially life-saving intervention include giving patients and their family/support network information about:

• Signs of overdose
• How to administer naloxone as a rescue medication

Coverage of naloxone rescue kits varies by individual plan. You can verify this by calling the number on your patient’s ID card

Resources for you

• Centers for Disease Control and Prevention: Providing naloxone to lay persons
• SAMHSA: Opioid overdose toolkit

*PA and IN allow alternate timeframes for notification.
**We’ll review supporting evidence along with all available information to make a correct appeal decision.
Beginning Right® helps patients and their babies grow healthy

Do you have a patient who’s an Aetna member with a high-risk pregnancy? Our Beginning Right Maternity Program can help you manage their care, including those who are at risk for a preterm birth or who may require coordination of their post-discharge care.

How the program works

Our goal is to identify pregnant members with conditions that put them and their babies at risk for unfavorable outcomes. Members participate throughout their pregnancy, as well as after their babies are born. The program provides services, information and resources to help these members get off to a healthy start and improve their pregnancy outcomes. It offers the support they need to:

• Avoid elective delivery prior to 39 weeks
• Stop smoking
• Get a referral for behavioral health services

The program features:

• Early risk identification
• Educational materials
• A preterm labor and delivery program
• Care coordination by obstetrical nurses
• Information on pregnancy and postpartum health issues, such as labor and delivery, dental health and depression

To find out more, visit our website.

Depression in Primary Care Program supports screening and treatment

Depression can accompany other serious medical conditions like heart disease, stroke, cancer, HIV/AIDS, diabetes and Parkinson’s disease. Due to the stigma associated with depression, most people don’t seek treatment. And many who are treated don’t get appropriate or continued treatment.

Our Depression in Primary Care Program is designed to support the screening for — and treatment of — depression at the primary care level. It offers your practice:

• A tool to screen for depression and monitor response to treatment
• Payment for depression screening and follow-up monitoring
• Patient health questionnaire (PHQ-9), specifically developed for use in primary care
• PHQ-9 reimbursement

To participate, you just need to be a participating primary care provider, use the PHQ-9 tool to screen your patients, and submit claims with CPT code 99420 (administration and interpretation of a health risk assessment) along with diagnosis code Z13.89 (screening for depression).

Visit our website to learn more.

Learn about our new Commercial Risk Management program

Our commercial risk management program is for patients who enrolled as an individual or part of a small group plan, either on or off the health insurance exchange. The objective is to identify your patients who currently have or may be at risk for acute and chronic conditions. The goal is to help better manage patient care through proper medical record documentation, coding and billing.

How you can help

We’ll begin sharing a patient list with you in order for you to understand your population. Once you have your list, you can:

• Schedule health assessments for your Aetna/Innovation Health patients
• Participate in medical records requests sent out by our contracted vendors — Your Home Advantage (YHA), Episource, Verisk and ArroHealth
• Evaluate all health conditions and document them thoroughly in medical records and claims submissions
Protect your patients and yourself from cyber attacks

One of the greatest risks facing medical practices and the healthcare industry are cyber attacks that target personal information. Our Social Security Number, Protection, Elimination and Remediation plan can help reduce the use of SSNs. You can work with us in this initiative.

How you and your patients benefit

The only requirement for health care services is member ID. You don’t need to collect patient SSNs. By not collecting the SSN, you’re reducing the risk of false accounts, identity theft and medical fraud.

Protect yourself and your patients by not using your SSN as the TIN in your business. Also, don’t use, store or transmit your patient’s SSN.

Be sure to refrain from using SSN, Tax Identification Numbers (TIN), Health Insurance Claim Numbers (HICN) and the last four digits of the SSN whenever possible.

We’re here to help

To find out more, email questions to SPEaR_Support@Aetna.com.

Our Office Manual keeps you informed

Our Office Manual for Health Care Professionals (Manual) is available on our website. For Innovation Health, once on the website select “Physicians & Providers,” then “Practice Resources.”

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

• Our adopted Clinical Practice Guidelines and Preventive Services Guidelines address preventive, acute and chronic medical and behavioral health services. They can be found on our secure provider website. Select “Clinical Resources” from Aetna Support Center.
• Policies and procedures.
• Patient management and acute care.
• Our complex case management program and members can be referred through multiple avenues. Learn how to refer members.
• How to use disease management services and how we work with your patients in the programs.
• Special member programs/resources, including the Aetna Women’s Health℠ Program, Aetna Compassionate Care℠ and others.
• Member rights and responsibilities.
• How utilization management decisions are made and how they are based on coverage and appropriateness of care. It includes our policy against financial compensation for denials of coverage.
• Medical record criteria: A detailed list of elements we require to be documented in a patient’s medical record is available in the Manual.
• Improving medical record keeping: An overview of the 2015 biennial medical record audit results — including our performance goal, overall national compliance score and opportunities for improvement — can be found on page 8 of the March 2016 issue of OfficeLink Updates, which is on our website.

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. You can find details on the program goals and the progress toward those goals on line. If you don’t have Internet access, call our Provider Service Center for a paper copy.
Learning Opportunities

New and updated courses for physicians, nurses and office staff

Visit www.aetnaeducation.com. Log in or registration may be required for some content.

Courses

• **NEW** – Check eligibility without a patient’s member ID number (tutorial)
• **NEW** – Behavioral Health Continuing Education Courses:
  - Understanding Mental Illness: What Individuals and Families Living with the Illnesses Want Professionals to Know
  - Substance Use Disorders Overview; including Opioids and ASAM

Reference tools

• **NEW** – CAQH ProView™ Fact sheet
• **NEW** – CAQH ProView™ Practice Manager Quick Reference Guide
• **NEW** – CAQH ProView™ Provider Quick Reference Guide
• **NEW** – Health Literacy Universal Precautions Toolkit, second edition
• **NEW** – Digital member ID card guide
• **UPDATED** – Nonparticipating Aetna Medicare PPO overview
• **UPDATED** – Provider Webinars
• **UPDATED** – Standard Member ID Card tool
• **UPDATED** – Specialized member ID card tool
• **UPDATED** – Medicare Member ID Card tool
• **UPDATED** – Care Advocacy and Accelerated Death Benefit
• **UPDATED** – Vaccination Recommendations for Health Care Professionals
• **UPDATED** – Quick reference guide – Aetna Leap℠ plans – Southeastern Pennsylvania
• **UPDATED** – Quick reference guide – Aetna Leap℠ Plans – Carolinas HealthCare System
• **UPDATED** – Quick reference guide – Aetna Leap℠ plans – Maricopa County, Arizona
• **UPDATED** – Quick reference guide – Aetna Leap℠ plans – CaroMont Health
• **UPDATED** – Quick reference guide – Innovation Health Leap℠ plans – Northern Virginia
Medicare compliance news: action required in 2016

If you’re contracted with us to provide health care services for our Medicare Advantage plans, you are considered a “First Tier Entity.” The Center for Medicare & Medicaid Services (CMS) requires you to fulfill specific Medicare compliance program requirements. We describe those requirements in our First Tier, Downstream, and Related Entities (“FDR”) Medicare Compliance Program Guide (FDR Guide).

Review the guide and make sure you have processes in place to comply with all the requirements. You can also find it at www.aetnaeducation.com.

Training changes for 2016
As of January 1, 2016, FDRs must have their employees complete CMS’ training modules to satisfy general compliance and fraud, waste and abuse (FWA) training requirements.

You can find CMS’ general compliance and FWA training modules on the CMS Medicare Learning Network (MLN). They can be completed after registration. The general compliance module is titled Medicare Parts C and D General Compliance Training, and the FWA course is titled Combating Medicare Parts C and D Fraud, Waste, and Abuse Training. You can also download CMS’ general compliance training and FWA training and incorporate them, unchanged, into your existing trainings/systems.

Complete your 2016 attestation
Each year you must confirm you’ve met the Medicare compliance program requirements by completing an attestation. One attestation meets both Aetna and Coventry compliance obligations. Not complying could impact your participation status with us.

The attestation is available on NaviNet, our secure provider website. If you’ve never used NaviNet, you must register first.

• New users: Register for NaviNet
• Existing users: Log in to NaviNet

Once you log in, visit Aetna Plan Central. Hover over “Compliance Reporting” and then click “Medicare Attestation.”

We’re here to help
If you need more information, go to www.aetnaeducation.com and type “FDR” in the search box. Or, call 1-800-624-0756.

Disregard this notice if you have completed your 2016 Medicare attestation.
**Medicare**

**Enroll by August 1 to prescribe Medicare Part D drugs**

The Centers for Medicare & Medicaid Services (CMS) requires prescribers to enroll in Medicare or opt out by **August 1, 2016**. This deadline will provide CMS contractors with enough time to process both the prescriber applications and opt out affidavits. The program implementation will begin **February 1, 2017**. At that time we’ll no longer cover claims for Medicare Part D drugs from prescribers who haven’t enrolled or who chose to opt out. This may cause your patients to have a disruption in therapy if you have not enrolled.

**How to enroll**

Visit the [CMS Prescriber Enrollment](#) website to:

- Enroll immediately
- Check your enrollment status
- Learn more about opting out

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**No copay for Medicare member’s first eye exam in a 12-month period**

Members in many Aetna Medicare plans don’t have a copay for their first routine eye exam within a 12-month period.

**First exam as a preventive service**

Sometimes it’s not clear if a copay is due, such as when you have to bill an eye exam with a diagnosis code instead of as a preventive service.

We’ll process the first eye exam for a Medicare member as a preventive service. As long as it’s the first eye exam in a 12-month period, we won’t require a copay. This is true even if there is a diagnosis.

When you see an Aetna Medicare member, you should first confirm that they are eligible for a routine eye exam with no copay. Then determine if this is their first eye exam in a 12-month period. If so, there’s no copay.

If a true routine eye exam is later billed (as a preventive service) within the same 12-month period, we’ll re-work the first claim and note that you may collect a copay for it.
Pharmacy

Use electronic prior authorization services for Aetna Specialty drugs

Aetna partners with CoverMyMeds to offer free electronic prior authorization (ePA) services for drugs on Aetna’s National Precertification List. You can use this online service for commercial and Medicare members for all health plans.

Benefits of ePA

When you submit ePA requests you can:

• Spend more time with patients and less time on paperwork and phone calls
• Auto-fill your patient and prescriber information on each form
• Verify if your patient is eligible
• Access prior authorization status, and receive faster approvals directly in your account
• Have a secure, HIPAA-compliant transaction

Ways to use ePA

1. NaviNet: Current users can log in to NaviNet, Aetna’s secure provider website. Select “Drug Authorizations,” then select “Create New.” Enter the drug name and enter Aetna in the “Plan” field.

2. CoverMyMeds: Visit our Aetna Specialty CoverMyMeds website to log in or to register for a free new account. Select “New Request,” enter the drug name and then enter Aetna in the “Plan” field.

Questions?

You can contact CoverMyMeds by:

• Phone: Call 1-866-452-5017 Monday – Friday 8 a.m. – 11 p.m. and Saturday 8 a.m. – 3 p.m. ET.
• Email: help@covermymeds.com
• Live chat: Log in to CoverMyMeds

Where to find our Medicare and Commercial Formularies

At least annually, and from time to time throughout the year, we update the Aetna Medicare and Commercial (non-Medicare) Preferred Drug Lists. These drug lists are also known as our formularies.

• Go to our Medicare Preferred Drug Lists
• Go to our Find a Medication for the Commercial Preferred Drug Lists

For a paper copy of these lists, call the Aetna Pharmacy Management Provider Help Line at 1-800-AETNA RX (1-800-238-6279).
Northeast News

Southeastern Pennsylvania

Digital ID cards for Aetna Leap™ plan members now on NaviNet and Availity®

Great news — You can now go to our secure provider website or Availity to see digital ID cards for our Aetna Leap plan members. You can easily upload the ID card image to your practice management system. And you’ll get easy, step-by-step instructions in our new reference tool and tutorial (link below).

Helpful resources to treat these members

• Check out our new digital member ID card guide and tutorial. You’ll get all you need to know about digital member ID cards (even for non-Aetna Leap plans).
• Keep referring to our Quick reference guides.

General reminders

• To check your participation and tier with our Aetna Leap plans, visit our provider online referral directory. Be sure to choose an Aetna Leap plan.
• When an exchange member is in the mandated grace period and didn’t pay their premium, the status on the eligibility response is “Inactive-Pending Eligibility Update.” There’s also this message: “HIX Grace Period.” You’ll get this message until either they pay their premium or the grace period ends. If we still don’t receive their payment after grace period ends, the response will be “inactive.”

And don’t forget:

• Don’t issue referrals for Aetna Leap plan members. They’re enrolled in an Open Access HMO plan, even though they appear as “HMO” members when you check eligibility and benefits. It’s easy to identify them since their member ID# begins with “10.”
• They don’t have to choose a primary care physician.
• Members are in Qualified Health Plans (QHPs) and will have the “QHP” logo on their member ID card.

We’re here to help

• If you have questions or need more information, call us at 1-888-MDAetna (1-888-632-3862).
• If your patients have questions, they can call 1-844-241-0208.
Northeast News

Maine

Reminder: balance billing is not allowed
Maine law and Aetna contracts don’t allow participating providers to balance bill members.
Participating providers may bill or charge members only if:
• Valid copayments, coinsurance and/or deductibles weren’t collected when covered services were provided.
• A plan sponsor is unable to pay debts or fails to pay the participating provider according to related federal law or regulation.
• Services that aren’t covered services only if:
  - The member’s plan confirms that the specific services are not covered; and
  - The member was advised in writing before their service that the specific services may not be covered; and
  - The member agreed in writing to pay for such services after advisement.

Avoid member confusion or misunderstanding
Providers may want to have members sign a separate document that only contains the agreement to pay for non-covered services (as opposed to a form that contains other information, including the waiver agreement). This will help give members clarity as to what they’re signing.

More about this law
You can visit Maine legislature website to get more information about balance billing.

New Jersey

Where to find our appeal process forms
We have updated the information about internal and external provider appeal processes on our public website.
If you use the NJ Health Care Provider Application to Appeal a Claims Determination Form when submitting certain claims appeals, you should make sure your claim is eligible. You can find this form and the correct procedures on our public website.
PCPs: Helping you care for patients suffering from alcohol abuse

We designed our Alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) Program to support primary care physicians (PCPs). The program helps PCPs to:

• Screen patients for alcohol abuse
• Provide brief intervention, and
• Refer individuals to treatment.

The program aims to improve the quality of care for patients with substance abuse conditions. It also focuses on outcomes for patients, families and communities.

Key program facts

• Our goal is to help increase the adoption of alcohol screening, brief intervention and the referral to treatment in PCP practices.
• We reimburse PCPs for screening and brief intervention.
• The program is open to Aetna participating PCPs treating any patient 18 years of age or older with Aetna medical benefits.
• It incorporates the evidence-based protocol established by the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Get started today.