Updates to our National Precertification List

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

Precertification updates effective January 1, 2017:

Note the following change to dialysis precertification:

• We’ll only require precertification when a participating provider requests services at a nonparticipating dialysis facility. Services at a participating dialysis facility will no longer need precertification.

We’ll still require precertification for cochlear device and ventricular assist device (VAD) services. However:

• Replacement items for use with the cochlear implant won’t require precertification. This includes replacement headset/headpieces, microphones, coils, cables, external speech processors and external controller components. Quantity limits may still apply. For more information, see Clinical Policy Bulletin (CPB) #0013 - Cochlear Implants and Auditory Brainstem Implants.

• Miscellaneous VAD replacement supplies and accessories won’t require precertification. For more information, see CPB #0654 - Ventricular Assist Devices.

Ophthalamic medical injectables will require precertification. This includes Eylea (aflibercept), Macugen (pegaptanib) and Lucentis (ranibizumab).

continued on page 2
The following drugs/medical injectables won’t require precertification:

- Aloxi IV (palonosetron HCl)
- Anzemet IV (dolasetron mesylate)
- Jevtana (cabazitaxel)
- Aredia (pamidronate)
- Boniva (ibandronate)
- Reclast (zoledronic acid)
- Zometa (zoledronic acid)

Reminders and updates

Effective May 16, 2016, the name of the drug “Gel-Syn” was replaced on the NPL with the drug’s new name “Gelsyn-3.” The drug still requires precertification.

Effective June 3, 2016, the following new-to-market drugs require precertification:

- Cinqair (reslizumab)
- Idelvion (antihemophilic factor [recombinant])
- Inflectra (infliximab-dyyb)
- Kovaltry (antihemophilic factor [recombinant])
- Taltz (ixekizumab)

Effective September 1, 2016, we will no longer require precertification for the following services:

- Elective non-emergent transportation by ambulance or medical van
- Repair of entropion and ectropion
  - Note: blepharoplasty, canthopexy and canthoplasty procedures will still require precertification

More information about precertification is available under the “General information” section of the NPL.

Correction

An article in the March 2016 issue about Health Insurance Exchange premium grace periods for subsidized members incorrectly stated that if we don’t get full payment by the end of the third month, the member’s coverage will be terminated retroactively to the beginning of the grace period. Instead, if we don’t get full payment by the end of the third month, the member’s coverage will be terminated retroactively to the last day of the first month of the grace period.
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. Our standard payment policies identify services that may be incidental to other services and, therefore, ineligible for payment. 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>Placement of permanent, hysteroscopically placed tubal implant devices intended for female sterilization on the same date of service as an endometrial ablation</td>
<td>September 1, 2016</td>
<td>The U.S. Food and Drug Administration and American College of Obstetricians and Gynecologists advise against placement of permanent, hysteroscopically placed tubal implant devices intended for female sterilization on the same day as an endometrial ablation. We no longer pay for device placement when performed on the same day as an endometrial ablation.</td>
</tr>
<tr>
<td>Delay in implementation: Modifier 59 — distinct procedural service</td>
<td>November 15, 2016</td>
<td>We previously communicated that our Modifier 59 Policy will apply to facilities. This will be effective November 15, 2016. When a procedure or service is billed with Modifier 59 on the same date of service as another procedure, we may consider both codes as eligible for payment. Refer to our <a href="#">secure provider website</a> under the Claim Payment and Coding Policies; the “Modifier 59 - Distinct Procedural Service” Payment Policy for exceptions and additional information.</td>
</tr>
<tr>
<td>Add-on codes billed without the primary code</td>
<td>December 1, 2016</td>
<td>In accordance with standard coding guidelines, add-on codes should not be billed without the corresponding primary service code. For facilities, as of December 1, 2016, we will deny an add-on code if it is not billed with the appropriate primary service code.</td>
</tr>
<tr>
<td>Noninvasive prenatal testing</td>
<td>December 1, 2016</td>
<td>Noninvasive prenatal testing codes are used to detect chromosomal abnormalities. There are currently an additional 35 lab codes that test for chromosomal abnormalities aside from the noninvasive prenatal testing codes. We will no longer pay for the 35 lab codes when billed with noninvasive prenatal testing codes as these procedures differ in technique or approach but lead to the same outcome. Modifier 59 will be restricted from overriding these edits.</td>
</tr>
<tr>
<td>Modifier SU — denotes use of facility equipment</td>
<td>September 1, 2016</td>
<td>The June 2016 issue stated that modifier SU would only be denied if billed with an office place of service. The policy will be updated to state that modifier SU will be denied if billed in any place of service unless contracted.</td>
</tr>
<tr>
<td>ER level of care</td>
<td>December 1, 2016</td>
<td>CPT code 99285 is used to indicate medical conditions that are of high severity, are potentially life threatening, and require the immediate attention of a physician. Services for constipation, earaches and colds, for example, should not be billed using CPT code 99285. When a hospital or physician bills a level 5 emergency room service (CPT 99285) with a designated minor diagnosis code, we will down code 99285 to a level 4 emergency room service (CPT 99284).</td>
</tr>
</tbody>
</table>
Reminder: use of correct billing codes

It’s important that you’re using the correct billing codes so we can pay the correct benefits with the initial claims adjudication.

Proper preventive care diagnosis

If routine physical/office visit and related labs are coded with something other than a preventive care diagnosis, we will not pay the charges under the preventive care benefits. You also must submit a preventive care diagnosis for related preventive services (i.e. x-ray, radiology, laboratory, etc.).

What this means to you

We need you to make sure that the correct diagnosis and billing codes are on the claims submission so charges are paid correctly the first time. This also will help us reduce the need for clarifying calls, resubmissions and reprocessing claims.

If you have questions on the diagnosis or CPT codes, visit our secure provider website on NaviNet®. Select “Claims” from the “Workflows for this Plan” menu. Then select “Policy Information.” Scroll down and select “Benefits Guidance Statements” from the STEP 2 – Policy Information section. Select “Routine Preventive Care Services – BGS 016” from the Active Benefit Guidance Statements list.

We’re here to help

If you have questions, call our Provider Service Center at 1-888-632-3862.

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Change to unknown diagnosis codes for electronic precert transactions

We’re changing how we handle diagnosis codes for electronic precertification and notification transactions.

Later this year we’ll reject transactions containing only an “unknown” diagnosis code. You’ll see this message:

Not Certified - Service Inconsistent with Diagnosis

PLEASE RESUBMIT YOUR TRANSACTION WITH A DIAGNOSIS CODE THAT CAN BE USED TO ASSIST WITH THE UTILIZATION MANAGEMENT REVIEW PROCESS

Here are some examples of unknown diagnosis codes:

R09.01, R09.02, R09.2, R45.0, R45.4, R45.86, R45.89, R53.81, R64, R41.840, R41.841, R41.842, R41.843, R41.844, R41.849, R41.850, R41.851, R41.853, R41.854, R68.82, R68.13, R69, R99

We’ll also continue to reject these transactions if we don’t receive a diagnosis code. We encourage you to include the chief complaint diagnosis when you submit transactions to us.

Note our new policy for telemedicine

We’re introducing a new policy that will cover telemedicine services for members enrolled in certain Aetna plans.

Under the policy, we’ll pay for two-way, real-time audiovisual interactive communication between the patient and health care practitioner. The patient must be present and take part throughout the interaction.

This new policy will take effect on January 1, 2017. At that time, it will impact only members enrolled in an Aetna LeapSM plan. (We’ll announce the 2017 Aetna Leap plan states in an upcoming newsletter.)

What is telemedicine?

Under the policy, we’ll pay for two-way, real-time audiovisual interactive audio and visual communication between the patient and health care practitioner. This interaction doesn’t involve direct patient contact.

You’ll need to report a modifier GT along with an eligible CPT/HCPCS code. You can find a list of eligible CPT/HCPCS codes on our secure provider website. When reporting modifier GT, you’re certifying that you’re offering services to a patient through an interactive audio and visual telecommunications system.
Learn more about our process for disputes and appeals

Providers can use our dispute and appeal process if they don’t agree with a claim or utilization review decision.

The process may include three phases; reconsideration, level 1 appeals and level 2 appeals. Facilities aren’t eligible for level two appeals. To help us resolve the dispute we’ll need a few items from you to review. You can visit our Disputes & Appeals page for more information.

Note that not all services are eligible for reconsideration.

Visit our FAQ section for a quick overview of the appeals process. For more helpful information be sure to visit the dispute and appeals forms section.

Prompt response

It’s important that you follow our timeline for submitting an appeal on a claims denial. If you have questions, call our Provider Service Center:

• 1-800-624-0756 for HMO-based benefits plans and WA Primary ChoiceSM plans
• 1-888-632-3862 for indemnity and PPO-based benefits plans

We have a new form for complaints and appeals

We’re using a new Practitioner and Provider Complaint and Appeal Request Form. Using this form and providing the specific information we request will help us more clearly identify the issue in dispute. It also helps us quickly review and respond to your request.

You can find out more information on the appeal process. If you have questions, call our Provider Service Center at 1-888-632-3862.

Credentialing change for mental health providers

With Aetna’s acquisition of MHNet/Coventry, we’re consolidating our contracting and credentialing processes.

To apply for participation with MHNet, fill out and submit our Behavioral Health Provider Application. MHNet no longer sends out or accepts MHNet credentialing applications.

MHNet’s panel is not closed. However, our goal is to get all our participating mental health providers onto Aetna’s panel and ready for integration.

If you have questions, call MHNet’s national provider relations team at 1-855-995-4086. Choose option 5 to reach a representative who can help you with the application.
How to find out which network(s) you’re in

Use our provider online referral directory to find out which network(s) you’re a part of. Just because you accept Aetna insurance or are in some Aetna networks, doesn’t mean you’re in network for all Aetna plans. You could be out of network for a patient’s specific plan.

If you need help, our provider directory guide gives step-by-step guidance on how to check your network status.

How this impacts your patients

Once you check your status, you can help patients figure out if they’re in or out of network. Your patients may pay higher out-of-pocket costs if you’re not part of their plan/network. Or, they may have no out-of-network benefits.

We’re here to help

If you have questions, call our Provider Service Center about your plan/network participation:

- HMO-based plans and all Medicare Advantage plans: 1-800-624-0756
- Indemnity and PPO-based plans: 1-888-632-3862

Help patients save by staying in network

The Aetna Premier Care Network is a network for businesses with employees in locations across the country. With this network, employers can offer a single benefits design to all employees, regardless of their geographic location.

Open enrollment is coming

Many of your existing patients will be participating in open enrollment and selecting a new medical plan. If your patient selects the Aetna Premier Care Network, it’s important to know your network participation status. In certain geographic areas, these patients will have a limited provider network for specific types of care, so they should stay in network for their care. If not, they may pay more.

Check your status

Starting in October, you can check our provider online referral directory to see if you’re participating in the Aetna Premier Care Network. You’ll also see changes for 2017.

For questions, call our Provider Service Center at 1-888-MDAetna (1-888-632-3862). Or log in to our secure provider website and send us questions through a secure connection.

Balance billing of Qualified Medicare Beneficiary individuals is prohibited

The Qualified Medicare Beneficiary (QMB) program is a Medicaid program for Medicare beneficiaries that exempts them from being charged for Medicare cost sharing.

State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. However, federal law allows states to limit provider reimbursement for Medicare cost sharing under certain circumstances. Dually eligible individuals may qualify for Medicaid programs that pay Medicare Part A and B premiums, deductibles, coinsurance and copays to the extent provided by the state Medicaid plan.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services to a QMB individual. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions.

Clarifications about balance billing

Be aware of these policy clarifications to help ensure compliance with QMB balance billing requirements:

- All Original Medicare and Medicare Advantage providers — not only those that accept Medicaid — must abide by the balance billing prohibitions.
- QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers can’t charge QMB individuals even if the patient’s QMB benefit is provided by a different state than the one where care is rendered.

More information

For more information about dual eligible categories and benefits, visit CMS’ Medicare-Medicaid General Information website. For more on the QMB program and other individuals dually eligible for Medicare and Medicaid benefits, see the Medicare Learning Network® publication “Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs.”
Program supports patients recovering from mental health conditions

Our OnTrak™ program integrates evidence-based medical and psychosocial treatment with 52 weeks of care coaching. It supports recovery for members with certain behavioral health conditions such as substance use disorders, depression and anxiety.

Patients may face barriers that can make them difficult to engage and keep in treatment. They may have multiple care providers, and often have co-occurring medical conditions intensified by their behavioral health condition.

The program includes:
- Member engagement and enrollment
- Select trained provider network
- Pharmacotherapy
- Behavioral therapy
- Care coaching

Data shows that an intensive, prolonged effort is necessary for successful treatment of behavioral health conditions.\(^1\) Integration and coordination among all providers involved in the member’s care can help eliminate fragmentation of care, increase the likelihood that patients will stay in treatment and maintain healthy lifestyles.

Call **1-855-840-3627** with questions or to make a referral.

Members in the contraceptive service program have separate ID cards

You may see some of our members with a Contraceptive Services Payment Program ID card.

A member enrolled in this program must present the separate ID card for contraceptive services. These cards have a different member “W” number and group number.

Using this card will help ensure we correctly process claims for covered contraceptive services.

This program is only for members of reproductive age, covered by the qualifying group health plan or student health insurance coverage. This includes any female dependents also covered under the medical plan.

Identifying these members

Look for “Contraceptive Services Payment Program” on the top front of the ID card.

View our 2016 HEDIS® results

We annually collect Healthcare Effectiveness Data and Information Set (HEDIS)\(^*\) data from claims, encounters and other administrative data. We also collect data from chart reviews for certain clinical measures. We analyze these results to find opportunities for improvement, and design and implement quality improvement activities.

We submitted our data for 2016 according to the National Committee for Quality Assurance (NCQA) reporting requirements.

View our 2016 HEDIS results.

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\(^*\)HEDIS is a registered trademark of the NCQA.

Refer patients to our Complex Case Management program

Patients with complex cases often need extra help understanding their health care choices and benefits. They may also need support navigating the community services and resources available to them.

Our Complex Case Management program is a collaborative process. It involves the member, their provider and Aetna. Our goal is to produce better health outcomes while efficiently managing health care costs.

We may receive referrals for the program from a variety of sources. These include the primary care physician, specialists, utilization management team members, an Aetna medical director, family members, internal departments or the member’s employer. You can submit a referral through the toll-free phone number on the patient’s Aetna ID card.

Managing osteoporosis in women who’ve had a fracture

We encourage providers to follow recommendations for preventing and treating osteoporosis, especially in patients who’ve had a recent fragility fracture.

Roughly one-third of all postmenopausal women have osteoporosis. At least 40 percent of these women will sustain at least one fragility fracture in her lifetime. And a hip fracture has a 1-year mortality of 10 to 35 percent.

Prevention and treatment

The National Osteoporosis Foundation recommends that all postmenopausal women who’ve sustained a fracture undergo an assessment for osteoporosis. This includes measuring bone mineral density (BMD).

The American Orthopaedic Association’s Own the Bone program is designed to address the osteoporosis treatment gap and help prevent secondary fragility fractures. Its recommendations include prescribing calcium and vitamin D, exercise and fall prevention measures as well as BMD testing and pharmacologic treatment. Visit the Fragility Fracture Network website to learn more.

Coverage determinations and utilization management

We use evidence-based clinical guidelines from nationally recognized authorities to make utilization management (UM) decisions. Specifically, we review any request for coverage to determine if members are eligible for benefits and if the service they request is covered under their plan. We also determine if the service delivered is consistent with established guidelines.

If we deny a coverage request the member, a member’s representative, or a provider acting on the member’s behalf can appeal our decision through our complaint and appeal process. Our UM staff helps members access services covered by their benefits plans.

How we make decisions

We don’t make employment decisions or reward physicians or individuals who conduct UM reviews for creating barriers to care or for issuing coverage denials. We use nationally recognized guidelines and resources to make our decisions. We base our decisions entirely on appropriateness of care and service and the existence of coverage. We don’t pay or reward practitioners, employees or other individuals for denying coverage or care. In fact, our UM staff is trained to focus on the risks of members not adequately using certain services.

Our medical directors are available 24-hours a day for specific UM issues. Physicians can contact patient management and precertification staff at the phone number on the member’s ID card. When the card only shows a Member Services number, we’ll direct you through a phone prompt or a Member Services representative.

CPBs and Pharmacy Clinical Criteria

Clinical Policy Bulletins (CPBs) and Pharmacy Clinical Criteria explain and guide our determination of whether certain services, medications or supplies are medically necessary, experimental and investigational, or cosmetic. CPBs and Pharmacy Clinical Criteria can help you assess whether patients meet our clinical criteria for coverage. They can also help you plan a course of treatment before calling for precertification, if required.

Where to learn more

More information about our UM criteria, CPBs and Pharmacy Clinical Criteria is on our website. Or call our Provider Service Center if you:

• Don’t have Internet access and want a paper copy
• Need a copy of the criteria upon which we base a specific determination
Consult CPGs and PSGs as you care for patients

We adopt evidence-based Clinical Practice Guidelines (CPGs) and Preventive Services Guidelines (PSGs) from nationally recognized sources. You’ll find them on our secure provider website. On the site, go to My Health Plans > Aetna Health Plan > Support Center > Clinical Resources. For help getting hardcopies from the nationally recognized sources, call our Provider Service Center. The guidelines below were adopted in March 2016.

Clinical Practice Guidelines

- Diagnosis, Evaluation and Treatment of Attention Deficit Hyperactivity Disorder in Children and Adolescents
- Helping Patients Who Drink Too Much
- Treatment of Patients With Major Depressive Disorder
- Standards of Medical Care in Diabetes
- Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease

Preventive Services Guidelines

- U.S. Preventive Services Task Force Grades A and B for Healthy People With Normal Risks

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 “Health Care Professionals,” 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 the Aetna Support Center.
- Policies and procedures.
- Patient management and acute care.
- Our complex case management program, including how members can be referred through multiple avenues.
- 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 HealthSM program, the Aetna Compassionate CareSM program and others.
- Member rights and responsibilities.
- How utilization management decisions are made and 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 Aetna OfficeLink Updates, which is on our website.
- The most up-to-date Aetna Medicare Drug Lists, commercial (non-Medicare) Preferred Drug Lists and the Aetna LeapSM Preferred Drug List. These lists are also known as our formularies.
- 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 online.

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** — Behavioral Health Continuing Education Courses:
  - Substance Use Disorders Overview; Including Opioids and ASAM
  - Evidence Based Practices for PTSD

Reference tools:
• **NEW** — July FDR Compliance Newsletter
• **NEW** — Provider Payment Estimator helpful hints
• **NEW** — 2016 African American History calendar
• **NEW** — Getting started with using ERA & EFT
• **NEW** — Contraceptive Services Payment Program
• **UPDATED** — Vaccination Recommendations for Healthcare Personnel
• **UPDATED** — Aetna Signature Administrators®

Complete your 2016 Medicare compliance attestation

If you are contracted with us to provide health care services for our Medicare Advantage plans, you are considered a “First Tier Entity.” 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).

You should review the guide and make sure you have processes in place to comply with all the requirements. You can then complete your attestation. To learn more, go to www.aetnaeducation.com and search “attestation.”

Annual requirement

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.**

The attestation is now available on our secure provider website. If you’ve never used NaviNet, log in or register today:
• **New users:** Register for NaviNet
• **Existing users:** Log in to NaviNet

Once you log in, go to Aetna Health Plan. Go to “Compliance Reporting” (on the left) and then click “Medicare Attestation.”

We’re here to help

If you need more information, you can find educational content on www.aetnaeducation.com by typing “FDR” in the search box. Or you can call 1-800-624-0756.

Disregard this notice if you have completed your 2016 Attestation.
Medicare

How to update data about your office

To update your office’s demographic information, go to our secure provider website and sign in. You should notify us whenever the following information changes:

• New email and mailing addresses
• New phone or fax numbers
• Name changes due to marriage or another life event
• Indicating hospital and group affiliations

If you’ve been calling our Provider Service Center to make these changes, we ask you to use the secure site instead. The site lets you confirm the information you submit. It prevents unauthorized individuals from submitting wrong information about your office or facility.

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.

NaviNet Security Officers have access to the “Update Provider Demographic” 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 register.
ABNs aren’t valid for Medicare Advantage members

Provider organizations should be aware that an Advanced Beneficiary Notice of Noncoverage (ABN) is not a valid form of denial notification for a Medicare Advantage member.

ABNs — sometimes referred to as “waivers” — are used in the Original Medicare program. However, you can’t use them for patients enrolled in Aetna Medicare Advantage plans because CMS prohibits use of ABNs.

What is and isn’t covered

Providers who have elected to participate in the Medicare program are expected to understand which services are covered by Original Medicare and which are not.

Aetna Medicare Advantage plans are required to cover everything that Original Medicare covers. In some instances, it may provide coverage that is more generous or otherwise goes beyond what’s covered under Original Medicare.

CMS mandates that providers contracted with a Medicare Advantage plan, such as Aetna, can’t hold a Medicare Advantage member financially responsible for paying a service not covered under the member’s plan unless that member received a preservice organization determination (OD) notice of denial from Aetna before such services are rendered. If the member doesn’t have a preservice OD notice of denial from Aetna on file, you must hold the member harmless for the noncovered services. This means you can’t charge the member any amount beyond the normal cost-sharing amounts (that is, copayments, coinsurance and/or deductibles).

However, where a service is never covered under Original Medicare or is listed as a clear exclusion in the member’s Evidence of Coverage (EOC) or other similar plan document, a preservice OD isn’t required for you to hold the member financially liable for such noncovered services. Note that services or supplies that are not medically necessary or are otherwise determined to be not covered based on clinical criteria do not constitute “clear exclusions” under the member’s plan, as the member is not likely to be able to ascertain on the face of the EOC that such services will not be covered.

ODs can be initiated either by you or by the member to determine if the requested/ordered service is covered prior to a member receiving or prior to scheduling a service, such as a lab test, diagnostic test or procedure.

Holding members responsible

Unless a service or supply is never covered under Original Medicare, you’ll only be able to hold an Aetna Medicare member financially responsible for a noncovered service if the member received a preservice OD denial from Aetna and decides to proceed with the service knowing they will be financially liable.

Enroll with CMS soon to prescribe Medicare Part D drugs in 2017

Make sure your patients have access to the drugs they need. After February 1, 2017, we can no longer cover claims for Medicare Part D drugs if you don’t have an approved Medicare enrollment or have a valid opt-out affidavit on file.

CMS encourages prescribers to enroll in Medicare or opt out as soon as possible. This will ensure the CMS contractors have enough time to process applications and opt-out affidavits. It will also allow us time to update our systems, so members won’t be impacted.

If you don’t enroll, we can only provide members a 3-month provisional supply of a medication. We won’t be able to cover additional prescriptions or refills of the same drug after the 90-day time period has ended.

How to enroll

Visit CMS’ Part D Prescriber Enrollment site to:

• Enroll immediately
• Check your enrollment status
• Learn more about opting out
Pharmacy

Changes to our commercial drug lists begin on January 1, 2017

On January 1, 2017, our pharmacy plan drug lists (formulary) will change. Starting on September 1, 2016, you can view these changes on our Guides for prescription drug coverage web page.

The changes may affect:
- All 2017 Pharmacy Management drug lists
- Precertification program
- Quantity limits program
- Step-therapy program

Three ways to request a drug precertification:
1. Call the Aetna Pharmacy Precertification unit at 1-800-414-2386.
2. Fax your completed prior authorization request form to 1-877-269-9916.
3. Submit your completed form through our secure provider website.

For more information call us at 1-800-238-6279 (1-800-AETNA RX).

Specialty drugs — precertification update

For pharmacy covered specialty drugs on the National Precertification List (NPL), we’ve updated our contact information for making your requests. Beginning October 1, 2016, you can reach us in either of the following ways:
- Call the Aetna Pharmacy Precertification Unit at 1-855-240-0535.
- Fax the completed Specialty Pharmacy Precertification request form to 1-877-269-9916.

Links to find our:
- New fax forms in the Specialty Pharmacy Precertification section of our Find a form web page
- Updated NPL

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.

To find them, go to our:
- Medicare Drug List
- Find a Medication page 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

New Jersey

Administrative changes to mandated diabetic supply benefit

To comply with New Jersey law, we’re changing the way we manage the diabetic supply benefit.

Effective on the dates listed below, we’ll require members to buy disposable diabetic supplies (such as needles and syringes) at their retail pharmacy or through their mail-order pharmacy. This applies to members enrolled in fully insured New Jersey health plans that include prescription drug benefits.

This change will help ensure that members are charged the correct pharmacy cost share.

Effective dates
• Large group members: effective January 1, 2017
• Individual and Small Group members: upon plan renewal starting on January 1, 2017

Key points to know
• Members affected by this change will be notified 90 days before their plan renews.
• Refer these members to their retail or mail-order pharmacy to buy disposable diabetic supplies.
• Members who buy these supplies from a provider other than their pharmacy will no longer have these supplies covered after the dates noted above.
• The services and items for other requirements under the state’s diabetic education and supply mandate will not change. For example, we’ll still cover diabetic counseling services from a physician or other medical provider.
• Durable medical supplies (such as certain non-disposable insulin pumps) will be covered under the plan’s durable medical equipment benefit.
• For members without a pharmacy benefit, diabetic supplies will continue to be covered under the medical plan, subject to the medical cost share.

More information
After October 1, we’ll send more information to those providers whose patients have submitted non-pharmacy claims for disposable diabetic supplies. This communication will include instructions on how to determine if a member’s plan includes prescription drug benefits.

New Jersey

Where to find our appeal process forms

We’ve 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.
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 aren’t covered only if:

• The member’s plan confirms that the specific services are not covered
• The member was advised in writing before their service that the specific services may not be covered
• The member agreed in writing to pay for such services after advisement

Avoiding confusion or misunderstanding

Providers may want to have members sign a separate document that only contains the agreement to pay for noncovered 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.

You can visit the Maine legislature website for more information about balance billing.
Help improve communication between treating providers

The results of a recent survey indicated that primary care physicians (PCPs) are concerned they don’t get regular reports about their patients’ ongoing evaluation and care from other treating providers. This breakdown in communication can pose a threat to quality patient care. We know that coordinating care with many physicians, facilities and behavioral health care professionals can be a challenge. And we appreciate your efforts to improve communications.

Tools to share information

Comprehensive patient care includes communicating with your patients’ other treating health care professionals. To promote collaboration and comprehensive care, it’s critical that PCPs and specialists talk openly with each other.

Our website has resources and forms to help make this process easier. For example, our Eye Care Professional Report for Dilated Retinal Eye Exam, Physician Communication Report and Specialty Consultant Report forms promote communication during care transitions.

*Each year we survey primary care practices contracted for all Aetna products. The surveys assess the practices’ attitudes and perceptions on key interactions with us. We use the Center for the Studies of Services, a third-party vendor, to administer the surveys. They perform the surveys at market levels accredited by the NCQA.