June 2013 • Volume 10, Issue 2

Aetna OfficeLink Updates™

West Region

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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

ICD-10

What you need to know about contracting and reimbursement

We are looking at ICD-10’s effect on provider contracts and clinical operations. The purpose of the ICD-10 conversion isn’t to change reimbursement. However, the increased specificity of the code set may more accurately show patient status and/or care.

ICD-based contract provisions

If a contract includes an ICD-9 diagnosis and/or procedure code as a carve-out, we’ll recontract these provisions before October 1, 2014. And, we may start as early as mid-2013.

We won’t update contracts to use ICD-10 codes. Our current contract terms support the requirement that providers bill with Health Insurance Portability and Accountability Act (HIPAA)-compliant code sets, as of their respective HIPAA compliance dates. For ICD-10 codes, this is October 1, 2014. There is no need to change the general wording in our contracts.

Reminder: Only use participating laboratories

We understand that some provider offices may have been asked by LabCorp to sign laboratory services agreements. LabCorp and its affiliates are not contracted with Aetna and are nonparticipating. The only exceptions are Dynacare Northwest and Litholink, both in Washington state.

As a reminder:
• Only use par labs. Referrals to nonpar labs mean that your patients will have to pay more out of pocket. You can help them save money by referring them to in-network labs.

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## 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:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Implementation date</th>
<th>What’s changed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related services</td>
<td>Reminder</td>
<td>We will deny services related to an ineligible procedure or service.</td>
</tr>
</tbody>
</table>
| National Drug Code (NDC) billing | Reminder            | The NDC submitted must be the actual NDC number noted on the medication package or container. The appropriate HCPCS code and units are also required. For unclassified J codes and other HCPCS/CPT codes that do not describe the dosage per HCPCS/CPT code unit, include the NDC code, NDC units and HIPAA standard NDC unit of measure qualifier. The NDC units and NDC units qualifier must represent the dosage for the charge.  
For more information, refer to the NDC Billing Guide on the Pharmacy section of our secure provider website. |
| Using in-network providers maximizes patients’ benefits | Reminder            | When caring for your Aetna patients, remember to use or refer them to participating providers. Doing so will ensure the following:  
• They get the appropriate level of benefits available to them.  
• Their claims won’t be denied due to not having a precertification on file.  
In the rare situation where a certain medical service is not available in our network and you must use or refer an Aetna patient to a nonparticipating provider, be sure to follow the precertification process. For more details on our precertification process, go to our secure provider website and select “Transactions,” then “Precertification.” |
| Pap smears                        | Reminder            | Effective 4/23/2013, Aetna updated its Cervical Cancer Screening and Diagnosis clinical policy to only allow Pap smear screenings for female members who have reached age 21.  
Pap smear screenings are considered experimental and investigational for a woman under age 21 because it was found the practice causes more medical harm than benefit. Aetna’s policy change aligns with those of the U.S. Preventive Services Task Force, American College of Gynecologists (ACOG), and other leading medical societies that recently raised their guidelines to age 21.  
Exception: Aetna continues to allow pap smear screenings for females under age 21 that have a diagnosis of cervical dysplasia, cervical cancer, DES exposure, HIV infection, or are classified as immuno-compromised women.  
Note: This policy change does not apply to members enrolled in Medicare products, or fully-insured members in states with age-related pap smear screening mandates, including AK, AR, DE, MA, ME, NV, NJ, NY, OR, PA, RI, TX, VA and WY. |
<p>| Drug frequency                    | Reminder            | Our maximum dosage limit for medications (including injectable drugs) is based on FDA-approved guidelines and/or the manufacturers’ recommended frequency. |
| Unlisted radiology codes billed with mammograms | Reminder            | We don’t consider the generation or analysis of automated data as eligible for payment. The manipulation of data previously obtained from the performance of a test or procedure is considered incidental and integral to the test or procedure that was performed. |</p>
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<th>Procedure</th>
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<tbody>
<tr>
<td><strong>Durable medical equipment modifiers:</strong></td>
<td>Reminder</td>
<td>Durable medical equipment items eligible for purchase or rental must be submitted with a modifier designating whether the item billed is a rental or purchase. We will deny claims submitted without the appropriate modifier.</td>
</tr>
<tr>
<td>• Modifier NU (New DME purchase)</td>
<td></td>
<td></td>
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<tr>
<td>• Modifier RR (Rental)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Durable medical equipment supplies and accessories</strong></td>
<td>Reminder</td>
<td>Refer to the following <a href="#">Clinical Policy Bulletins (CPBs)</a> to determine the medically necessary quantities for the related DME supplies and accessories:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Positive airway pressure devices – CPB #0004 – Obstructive Sleep Apnea in Adults</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Transcutaneous electrical nerve stimulators (TENS) – CPB #0011 – Electrical Stimulation for Pain</td>
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<tr>
<td></td>
<td></td>
<td>• Nebulizers – CPB #0065 - Nebulizers</td>
</tr>
<tr>
<td><strong>“Global surgical days for procedures with CMS global value of YYY</strong>**</td>
<td>9/1/2013</td>
<td>Effective for dates of service on or after 9/1/2013, global surgery periods will be applied to codes listed on the CMS physician fee schedule with a value of YYY. Refer to Claim Payment Policy, Evaluation and Management (E&amp;M) Services during the Global Surgery Period on our <a href="#">secure provider website</a>.</td>
</tr>
<tr>
<td><strong>“CCI outpatient code editor (OCE) edits for OP facility and ASCs</strong>**</td>
<td>9/1/2013</td>
<td>Effective for dates of service on or after 9/1/2013, we will apply CMS CCI OCE edits (Outpatient Code Editor) to claims for OP Facility and ASC (Ambulatory Surgery Centers). Refer to our <a href="#">secure provider website</a> and select Claim Payment Policy, CCI OCE edits for more information.</td>
</tr>
<tr>
<td><strong>Precertification will not override codes considered “never effective”</strong></td>
<td>9/1/2013</td>
<td>Precertification will not override the denial of codes considered never effective. Refer to the Code Editing, Clinical &amp; Payment Policy Code Lookup on our <a href="#">secure provider website</a> to determine if a code is considered “never effective.”</td>
</tr>
<tr>
<td><strong>High cost drug discounts and rebates</strong></td>
<td>9/1/2013</td>
<td>We will not pay the portion of services covered by a manufacturer’s rebate. We will pay the lesser of our negotiated rate or the cost of the covered service minus the rebate and the provider will be responsible for obtaining the rebate from the manufacturer. For example, the manufacturer for the drug Ziv – Aflibercept (Zaltrap) has published rebate instructions for providers. When providers are entitled to this rebate, our covered services will be reduced by the rebate amount.</td>
</tr>
<tr>
<td><strong>Special charges and incremental nursing charges</strong></td>
<td>9/1/2013</td>
<td>Aetna 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 processed on the Strategic platform. For all HMO and Traditional plans (excluding Medicare Advantage), we will enforce the existing inpatient private duty nursing payment policy for inpatient private duty nursing services billed in conjunction with a confinement and add special charges to the existing policy.</td>
</tr>
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</table>

* Washington providers: This item is subject to regulatory review and separate notification.
Proper mid-level practitioner billing requirements

We define mid-level practitioners as nurse practitioners, physician assistants, nurse midwives and clinical nurse specialists/registered nurses*.

Under our requirements and following the Centers for Medicare and Medicaid Services’ (CMS) “incident to” and “split/shared services” guidelines, you must bill “incident to” or “split/shared” services as follows:

• Submit claims with the supervising physician’s name as the servicing provider. You should also use the SA modifier.

For claims that are not “incident to” or “split/shared services” you must list the mid-level practitioner’s name as the servicing provider when filing claims for services they provide. We reserve the right to take appropriate action for any violation of policy.

Confirm network participation

Confirm that your mid-level providers are listed as participating in our network by calling our Provider Service Center:

• 1-800-632-3862 for HMO-based plans
• 1-800-624-0756 for all other plans

If your mid-level practitioners are not listed as participating in our network, visit our website for more guidance.

If credentialing is not required, you can load the mid-level practitioner directly by following directions on the link. The mid-level practitioners appear as participating in our DocFind, online provider directory.

* Clinical nurse specialists may be nurse practitioners (NPs) or registered nurses (RNs). If an RN is providing services as a clinical nurse specialist, the billing requirements will apply.

Experimental or investigational lab tests are not covered

We sometimes hear from members who unexpectedly had to pay for laboratory tests they believed were covered under their health plan.

In these instances, their physicians ordered these tests. However, the tests were experimental or investigational, based upon evidence-based standards. As a result, they were not covered under the terms of the member’s health plan and we denied the claim. Your patient then had to pay out of pocket for these services.

So, if you order a non-covered test, we ask you to make sure your Aetna patients are aware of this.

What tests are affected

We list laboratory tests that are not covered or that may be conditionally covered on our secure provider website. To see what these tests are, select “Claims” from the Aetna Plan Central home page, then “Clinical & Payment Policy Code Lookup,” then the “Select a code by Category” drop-down menu.

If you have questions about these procedures, refer to the corresponding Clinical Policy Bulletin to review the medical evidence we use to base our position.

Precert for lumbar laminectomy and laminotomy procedures

Last year we notified you that the treating surgeon is required to obtain precertification for inpatient and outpatient cervical, thoracic, or lumbar laminectomy and laminotomy procedures. These procedures require medical review, which means you must submit the necessary supporting clinical information. We’ll make a decision after we receive and review all the needed clinical information.

We are also asking you to get us this information well before the date of service. We need at least 7 days when the procedure is scheduled well ahead of time.

This will allow time for us to conduct the medical necessity review and avoid changes or delays to the scheduled procedure date.

View these Clinical Policy Bulletins online. Search for 16, 591 and 743.
Office News

Certain Medicare Advantage plans cover annual physicals

The March issue of Aetna OfficeLink Updates noted that our Medicare Advantage (MA) plans now cover an annual wellness visit, and no longer cover annual routine physical exams. However, we will cover the annual routine physical exam for some plan sponsors that elected to offer coverage for these exams under their group MA plan in 2013.

A partial list of these employers includes:

• Aetna, Inc.
• Barnes
• Cabot Corporation
• Dow Chemical
• Frontier Communications
• GE
• IBM
• Phoenix Companies

Applicable CPT codes

The CPT codes for routine physicals are 99381-99397 and 99401-99404, or 99201-99205 and 99211-99215 with primary diagnosis of preventive. The preventive diagnosis codes are:

• V03.0-V03.9
• V04.0-V04.89
• V05.0-V05.9
• V06.0-V06.9
• V70.5

Check patient eligibility

Find out if an Aetna MA plan member has coverage for annual routine physical exams, and check eligibility and cost sharing information before you see them through either:

• Our secure provider website, or
• Our Aetna Voice Advantage® (AVA) telephone system

Reprocessing denied claims

We will automatically reprocess any denied claims for an annual routine physical exam if the exam meets both of these criteria:

• Performed on or after January 1, 2013
• Performed for a patient enrolled in an Aetna group MA plan that includes coverage for the exam

CHOOSING WISELY

Talk with patients about appropriate tests

The American Board of Internal Medicine (ABIM) Foundation and several leading medical organizations last year unveiled Choosing Wisely®. This program encourages doctors and patients to talk about tests and procedures that may be duplicative or unnecessary – and that can sometimes cause harm.

We support this initiative because:

• There is no single solution to improve health care quality and reduce its cost.
• We believe that every segment of the health care system plays a role.
• We support the creation of safer, more effective and more affordable health care. We do this through clinical evidence and collaboration with all those involved in our health care system.

You can support this effort by:

• Talking with patients about why you’re prescribing certain tests, procedures or courses of treatment
• Reviewing and using the latest clinical evidence
• Understanding how your recommendations can affect your patients’ physical and financial health

Submitting claims for Supplemental Retiree Medical Plan

The Aetna Supplemental Retiree Medical Plan is a fully insured, non-network-based commercial retiree group health product.

For members enrolled in this plan, claims for Medicare-covered services should be submitted to Original Medicare. Aetna will receive any claim with a balance bill from Original Medicare. The only claims you should submit directly to Aetna for this plan are those relating to non-Medicare-covered services.

Plan eligibility

This plan is offered only to retirees and their eligible dependents enrolled in Original Medicare. It offers supplemental benefits and coverage that is similar to true Medicare Supplement (Medigap) plans. However, in most states, this product is not a Medicare Supplement plan.

Aetna Supplemental Retiree Medical Plan members must seek any Medicare-covered services from licensed health care professionals who are eligible to receive payment under Original Medicare, unless otherwise noted in plan documents.

It is important to confirm member benefits as multiple benefits plans are available. Call 1-800-557-5078 (TTY/TDD: 1-888-200-6124) with questions.
Verify dependent eligibility in advance to reduce claim rejections

To prevent dependent claims from being rejected, you should verify dependent eligibility before submitting your claims. Use our eligibility and benefits inquiry transaction, which are available on our secure provider website.

If you submit a claim for a dependent that’s not on the subscriber’s plan, you’ll see the following codes on your rejected claims report:

- **Category Code A3**
  - Acknowledgement/Returned as un-processable claim. The claim/encounter was rejected and has not been entered into the adjudication system.
  - **Status Code 109**
    - Entity not eligible.
    - **Entity Code:**
      - **D0:** Data Search Unsuccessful
      - The payer is unable to return status on the requested claim(s) based on the submitted search criteria.

Claims tips

- Parents of newborns generally get up to 31 days to add newborns to their plan.
- Don’t enter information for dependents (whether newborns or other dependents) in the indicated fields for the subscriber. During eligibility verification, we look for a combination of member name and ID number to match in our eligibility system before we can accept the claim.

Maternity inpatient precertification reminder

Precertification is required for newborn and maternity inpatient confinements if the total length of stay exceeds:

- **3 days** for a vaginal delivery
- **5 days** for a Cesarean section

Precertification is **not** required for newborn and maternity inpatient confinements related to routine delivery if:

- **The total length of stay is 3 days or less** for a vaginal delivery
- **The total length of stay is 5 days or less** for a Cesarean section

**What to do**

Call Aetna for precertification when the confinement exceeds the standard length of stay for maternity/newborn confinements. Precertification is the participating provider’s responsibility when confinement exceeds the standards. If you don’t precertify, Aetna, employers and members are not responsible for any costs for services that require precertification. Precertification requirements apply to all Aetna plans, other than Traditional Choice.

Note this CMS address change

The Centers for Medicare and Medicaid Services (CMS) has a new address for facilities to submit approvals and recertification letters for **percutaneous transluminal angioplasty (PTA)** of the carotid artery concurrent with stenting.

Be sure to use this new address when submitting approval requests and recertification letters for PTA.

The address is:

Director, Coverage and Analysis Group
7500 Security Boulevard
Mailstop S3-02-01
Baltimore, MD  21244

**We’re here to help**

If you have any questions, call us at **1-888-247-1029**.
Learning Opportunities

Log in or register at AetnaEducation

New and updated courses for physicians, nurses and office staff

Courses

Continuing Education
• New Cultural Competence, Mental Health and Depression (CME)
• New Cultural Competence, Mental Health and Depression for Case Managers (CCM)
• New Cultural Competence, Mental Health and Depression for Nurses (CE)

Accountable Care
• New Accountable Care - A Rising Solution

Credentialing
• Updated Credentialing Made Easier

Reference Tools
• New Products, Programs and Plans: Care Considerations
• New Products, Programs and Plans: Accelerated Death Benefit Fact Sheet
• New Products, Programs and Plans: Accelerated Death Benefit Real Case
• Updated The Health Care Professional Toolkit
• Updated Products, Programs and Plans: Aetna Supplemental Retiree Medical Plan

• Updated Claims/Coding: CPT/HCPCS Claim Entry – quick tips
• Updated Claims/Coding: CPT/HCPCS Coding Tools – quick tips
• Updated Credentialing/Recredentialing: CAQH reference guide

Mental health cultural competency training at no cost

Effective communication is important in the diagnosing, treating and ongoing management of individuals with mental health conditions. This is especially true in the case of depression.

To address this need, we are offering three mental health cultural competence and cross-cultural communication training courses for mental health physicians, nurses and case managers. You can take the free courses – Cultural Competence, Mental Health and Depression – on our Education Site.

Medical doctors, nurses and case managers can earn up to one hour of continuing education credit. After completing this program, you should:
• Better understand how depression impacts the health of diverse populations
• Be able to describe the key social, cultural, and external factors important in caring for diverse populations and racial and ethnic minorities with depression
• Apply what you’ve learned to better understand and manage mental health conditions across cultures

How to get started
• Log in or register at our Education Site
• Type Mental Health in the search field
• Click “Go”

* This CME course meets state licensure requirements for physicians in CT, MA, NV, PA, NJ and TX.

Plain language helps people better understand their health care

You want to reach your patients with health information they can easily understand and use. We want that too. Here’s an easy way to achieve this – avoid large, complex words (medical jargon) when simpler ones will do. For example, just say “heart attack” instead of myocardial infarction.

Making materials easier to understand
We strive to write simply because we want our customers to understand the first time they read our materials. To achieve this, we write communications at a 5th grade reading level for members and 9th grade for providers, plan sponsors and brokers.

Our internal Writers’ Center for Excellence (WCFE) website was recently named best website in the private sector from the Center for Plain Language at its annual ClearMark® competition. The WCFE is a new website that gives our employees tools to write clearer messages. These materials help guide our members through a complex health care system.

To learn more about plain language, visit the National Institutes of Health website.

* The ClearMark awards celebrate the best in clear communication and plain language from government, non-profits, and private companies.
Electronic Transactions

How to submit Medicare coverage requests using EDI

We want you to submit your Medicare precertification/notification coverage requests via Electronic Data Interchange (EDI) for Aetna Medicare Advantage (MA) plan members. When using electronic precertification, you have three choices for service level indicators: elective, urgent and emergency. Follow these instructions for using EDI to submit these requests:

- Submit routine requests (that don’t meet the definition for a Medicare expedited request) with the **elective** level of service indicator. You may add “Medicare Standard Request” in the comments field.
- If you select **urgent**, we classify the request as a “Medicare expedited request.” These requests must meet the CMS definition for an expedited or time-sensitive situation: *A situation where the time frame of the standard decision-making process could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee’s ability to regain maximum function.*
- Select **urgent** when your Aetna MA plan patient needs care within 24 to 72 hours from the time of your request (e.g., your patient is admitted directly to the hospital at the request of the attending or primary care physician). You may add “Medicare Expedited Request” in the comments field.
- Choose **emergency** when your Aetna MA plan patient is admitted to the facility after receiving services in the emergency room.

Using the appropriate level of service indicator will help facilitate this process and help ensure that we quickly handle truly emergent and urgent patient situations.

Get answers to your claims and policy questions

Our [secure provider website](#) offers a wide array of online tools and resources. You can find the answers you need online.

Here are just a few things you can do on our site:
- **Claims and account management tools** – Submit your claims at no cost. You can also inquire about individual claims, run claims reports and access claims policies.
- **Access Claim Explanation of Benefits** anytime. All of your EOB Activity is two clicks away.
- **Our Electronic Precertification** transaction makes submitting your precert requests easier than ever. Go [here](#) to learn more.

Check out these resources

Our [Resources](#) section links to content such as Clinical Policy Bulletins, Precertification Lists and Aetna Benefits Products. We also offer many customer support resources in the [Help](#) section.

Take our free webinars

Register for one of our [free webinars](#) to learn about these tools and resources. View the upcoming webinar schedules for Doing Business with Aetna, Aetna Claim and Account Management Tools, Electronic Precertification, and Claim and EOB Tool.

Use secure site to update your 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.

Our secure site lets you confirm the information you submit. It 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 patient benefits and eligibility, and requesting precertifications. So, if you’ve been calling our Provider Service Center for demographic changes or with questions about electronic transactions, we ask that you use the secure site instead.

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.
Where to find our Medicare and Commercial formularies

We update the Aetna Medicare and Commercial (non-Medicare) Preferred Drug Lists at least annually and from time to time throughout the year. These drug lists are also known as our formularies, and can be accessed at:

- Medicare Preferred Drug Lists
- Medication Search 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).

It’s easy to calculate body mass index

The U.S. Preventive Services Task Force (USPSTF) recommends screening all adults for obesity. We recommend that you calculate the body mass index (BMI) for all adults. Then, document the value in the patient’s medical record at least every other year.

For patients with a BMI of 30 kg/m or higher, consider referring them for additional help/intervention.

What you can do

- Print a BMI table.
- Post it next to your scale.
- Record the patient’s BMI.
- Use the National Institutes of Health BMI calculator or, download the BMI calculator iPhone app.

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.”

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<tr>
<th>Preventive Service Guidelines</th>
<th>Adopted 2/12</th>
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<td>*USPSTF intimate partner violence screening recommendation</td>
<td>Adopted 3/13</td>
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<tr>
<td>**CDC tdap vaccine for pregnant women</td>
<td>Adopted 3/13</td>
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<table>
<thead>
<tr>
<th>Behavioral Health</th>
<th>Adopted 2/12</th>
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<tbody>
<tr>
<td>*Helping Patients Who Drink Too Much</td>
<td>Adopted 2/12</td>
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<tr>
<td>**Treating Patients With Major Depressive Disorder</td>
<td>Adopted 2/12</td>
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<tr>
<th>Diabetes</th>
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<td>*Treating Patients With Diabetes</td>
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<th>Heart Disease</th>
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<tr>
<td>*Treating Patients With Coronary Artery Disease</td>
<td>Adopted 4/12</td>
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For a hard copy of CPBs, 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
West News

Arizona

Preauthorization required for radiation therapy

Beginning July 1, 2013, we will implement mandatory preauthorization for radiation therapy in Maricopa and Pima counties in Arizona.

How it works

MedSolutions will review authorization requests for medical necessity before services are performed. Board certified radiation oncologists will perform all medical necessity reviews.

To receive payment for services, you must submit authorization requests before rendering services. Services covered by the program are: 2D and 3D conformal, brachytherapy, IMRT, and SRS/SBRT.

This program will help ensure that radiation therapy services provided to our members is consistent with:

• Nationally-recognized clinical and billing guidelines of the American College of Radiology (ACR)
• Other recognized medical societies
• Aetna’s Clinical Policy Bulletins

Note: We sent a letter to impacted markets 90 days in advance of the July 1, 2013 effective date.

California providers: How to access your fee schedule

In accordance with the regulations issued pursuant to the Claims Settlement Practices and Dispute Mechanism Act of 2000 (CA AB1455 for HMO) and pursuant to the expansion of the Health Care Providers Bill of Rights (under CA SB 634 for indemnity and PPO products) we are providing you with information about how to access your fee schedule.

• If you are a provider affiliated with an IPA, contact your IPA for a copy of your fee schedule.

• If you are a provider directly contracted with Aetna, please fax your request along with the desired CPT Codes to 1-859-455-8650. If you have additional questions, please contact the Provider Service Center.

• If your hospital is reimbursed through Medicare Groupers, go to the Medicare website for your fee schedule information.

For more information

Visit the California Department of Managed Care website and select “Existing Regulations.”
Notice of Material Change to Contract

For important information that may affect your payment, compensation or administrative procedures, see the following articles in this newsletter:

• Clinical, coding and policy changes - pages 2-3
• Certain Medicare Advantage plans cover annual physicals – page 5
• Clinical practice guidelines update – page 9
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Under terms of your Aetna contract, you are required to notify us whenever:
- A physician leaves your practice or a new physician joins your practice
- Your office changes its mailing address, phone number and/or fax number
- There is a change to the e-mail address of anyone in your office
- Your office panel status changes (e.g., if you want to re-open your practice to new patients (currently frozen) or if your practice is accepting current patients only)

If we don’t get this information from you, your practice may not receive important information that we send either by e-mail or U.S. mail. Plus, this helps us keep data about your practice current.

Medicare Advantage
If you are contracted for Medicare Advantage (MA), this is also a Centers for Medicare & Medicaid Services (CMS) requirement. Your Aetna agreement requires that you comply with all applicable Medicare laws, rules and regulations and CMS requirements. Per Medicare regulations, CMS requires MA organizations to make a good faith effort to provide MA members with 30 days advance written notice when a provider is terminating from the MA network.

How to contact us
You can give us this information through our secure provider website. On the Aetna Plan Central page, choose “Update Aetna Provider Profile.” If you have questions after going online, call our Provider Service Center.

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