



Aetna OfficeLink Updates™

Mid-Atlantic Region

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Options to reach us

- Go to www.aetna.com
- Select "for Health Care Professionals"
- Select "Medical"
- Select "Log In" or "Register Now!"

Or call our Provider Service Center:

- For indemnity and PPO-based benefits plans call 1-888-MDAetna (1-888-632-3862)
- 1-800-624-0756 for calls related to HMO-based benefits plans and WA Primary Choice plan

Get paid faster, reduce paper with ERA and EFT

Improve your cash flow. More conveniently manage your finances. Reduce paper in your office. These are just some benefits of using electronic remittance advice (ERA) and electronic funds transfer (EFT).

ERA is an electronic statement, detailing your claims payment and denials history. It is available for all Aetna benefits plans.

EFT lets you receive your payments electronically.

Use ERA and EFT together

We do not offer EFT alone, but you can get ERA without EFT. However, by using both ERA and EFT together, you can:

- Get paid faster than with paper Explanation of Benefits (EOB) statements and checks.

- Access online EOBs and automated posting capabilities.
- Receive fast, confidential and secure claims payments deposited directly into your designated bank account(s).
- Improve your cash flow by eliminating mail delays, check holds, and fees for depositing paper checks or lockbox processing.
- Eliminate paper EOBs and checks.

It's easy to get started

To learn more and to enroll, go to: http://www.aetna.com/provider/medical/service_med/electronic_med/era.html.

Heads up: Many claims are not NPI compliant

We're finding that many provider offices submitting claims to us are not fully complying with the HIPAA National Provider Identifier (NPI) regulation. That's because an overwhelming number of providers are still submitting electronic claims with both NPIs and a secondary identification number.

Tax ID and NPI are all we need

We want to re-emphasize that Aetna does not use legacy (secondary) identifiers to pay claims. We have always used the billing

provider's tax identification number and name and address information to identify the provider to be paid. Now we can use the NPI to identify a provider, as well.

Please note that to correctly process your electronic claims, the only identifying numbers we need are your tax ID and your NPI. Removing legacy identifiers before submitting your claims will help ensure you are in compliance with the federal regulation, and it won't impact your cash flow.

How to avoid transaction rejection

If you submit electronic transactions using computer software, contact your computer system vendor support area to make sure your claims are compliant.

If you are not appropriately using your NPI in electronic transactions, you need to start doing so immediately as we begin to move toward rejecting noncompliant HIPAA transactions.

Eligibility transaction gives your office a wealth of member benefits information

Our electronic eligibility transaction can be a welcome aid when you need to check eligibility quickly. It offers convenient searches by member ID or by member name and date of birth.

Find copay information and more

This real-time tool returns a wide variety of benefits information when you submit an inquiry through our secure provider website via NaviNet®, or through a participating vendor/clearinghouse website:

- Member ID, group number, plan sponsor name or plan number/plan name.
- Active coverage, original date of coverage or termination date.
- Insurance/product type and plan name.
- Detailed financial information, including deductible, copayment and coinsurance for individual and family levels.
- Aetna HealthFund® information.
- Lifetime and annual maximums and remaining dollar amounts.
- Exclusions, limitations and accumulation information.

- Coordination of benefits (COB) information, when applicable.

You can submit benefits inquiries for up to 18 months prior to the current date. The tool is available 24 hours a day, 7 days a week for all Aetna benefits plans.

Look at what's available

To learn more about the eligibility transaction, view the marketing sheet at http://www.aetna.com/provider/medical/service_med/electronic_med/transactions.html.

Office managers: Take advantage of these online options

We're continually finding ways to pay claims more quickly and accurately, and to make working with us easier. Consider these options for your office:

Electronic claims payment – If your office isn't using electronic Explanation of Benefits (eEOB) and you want to start, sign up today on our secure provider website via NaviNet®. Through eEOB, you can use electronic funds transfer (EFT). It's a fast, easy, secure way to get claims paid.

Online account management – Our secure provider website via NaviNet also offers

Account Management Tools to help you manage your patient accounts. These tools let you view claims status, produce reports, audit internal records and much more. Tools include the Claim History Report and online Claim Reconsideration.

We're #1 in claims payment

In 2008, Aetna ranked #1 overall in athenahealth's 2008 PayerView Ranking. The results show Aetna pays providers faster and denies claims less often than other health plans that were measured. We also earned high scores for the percent of claims resolved on first submission.

These accomplishments tie into Aetna's guiding principles, which includes resolving as many claims as possible on initial submission to lower the number of resubmitted items.

How to find out more

Check out helpful claims tools today:

- Log in to our secure provider website.
- Select "Claim EOB Tool" to find out more about eEOB and EFT, or
- Select "Account Management Tools."

Changes to 2009 precertification list

The following removals and additions to the Aetna Participating Provider Precertification List will take effect January 1, 2009:

Removal:

- Clinitron and electric beds

Additions:

- Xolair (Omalizumab): Must be precertified through Aetna Specialty Pharmacy® at 1-866-503-0857 or by fax to 1-888-267-3277.

- *Oncotype DX* (breast cancer related multi-gene assay): Must be precertified through Aetna Pre-Cert Department.

Precertification approvals are valid for six months from the date of issue, unless stated otherwise at the time. Precertification requirements apply to all Aetna plans, except for Traditional Choice® and the Aetna Medicare OpenSM Plan, our Medicare Private Fee-for-Service plan. We will update the precertification list online before January 1, 2009.

You can always use our Precertification Code Search Tool to find out if a specific code needs precertification. Simply enter a valid five-digit CPT code and get precertification requirements specific to that procedure. You'll find the tool on the Aetna website; choose "for Health Care Professionals," "Medical" then "Precertification List" from the list of Shortcuts on the left.

What's new on our secure provider website

We're continually refreshing our secure provider website to give you access to the latest tools and resources for doing business with us. Highlights of recent site content updates include:

Aetna Plan Central

- Added link to Aetna's Guiding Principles for Physician Relations press release

Education

- See the feature article in this issue for updates to our Education Site for Health Care Professionals

AETNA SUPPORT CENTER UPDATES:

Doing Business With Aetna

- Added *Aetna OfficeLink Updates*™ – August 2008 issue
- Added *Aetna Behavioral Health Insights*™ – September 2008 issue
- Added Select List mailings
- Updated Health Care Professional Toolkit
- Updated Aetna Medicare OpenSM Plan (PFFS) Online Tools and References to add *Bad Debt Reference Guide*
- Added new information about Aetna Individual Medicare Supplement PlanSM
- Updated AMA/CMS Reimbursement Code Updates to add ICD-9 Diagnosis Codes Exempt from POA Reporting, Effective October 1, 2007

- Added *Behavioral Health Facility Follow-Up Care Within 7 Days of Discharge* flyer to Behavioral Health page

- Replaced Clinical Practice Guidelines for:
 - Helping Patients Who Drink Too Much
 - Treating Patients With Bipolar Disorder
 - Treating Patients With Major Depressive Disorder

Clinical Resources

- Replaced Clinical Practice Guidelines for:
 - Diabetes
 - Hypertension
 - Hypercholesterolemia

Pharmacy

- Added new link for HCNN online drug safety alerts

Forms Library

- Updated Diabetes Three-Year Checklist
- Updated ERA/EFT Enrollment Form
- Added Laboratory Selection forms for DE, PA, NJ, VA, MD and DC
- Under Pharmacy Forms, added:
 - Medical Exception/Precertification Request for Prescription Medications (Non-Medicare Commercial Plans) Form
 - Medical Exception/Precertification Request for Prescription Medications (Medicare Plan Participants Only) Form

Review claims and resolve payment issues online

Our easy-to-use Account Management Tool helps you resolve your payment and accounts receivable issues and search your Aetna claims history with just a few clicks of a mouse. You can also:

- Search and view Explanation of Benefits (EOB) statements and claims details.
- Submit claims directly to us for reconsideration one at a time. Or, resubmit multiple claims within one request.
- Request a customized, downloadable report of your claims history details.

Account Management tools

The Account Management Tool is actually a suite of tools on the "Aetna Plan Central" home page of our secure provider website via NaviNet[®]. It includes:

- **Claim History Report** – Request and download a claims history spreadsheet to reconcile your accounts and analyze processed claims. The report is normally available the next morning and can be downloaded for 7 days.
- **Multiple Claim Reconsideration** – Request reconsideration of 10 or more claims believed to have been incorrectly reimbursed.

- **Claim Reconsideration** – From your searched claims, easily identify, review and, if necessary, submit individual claims for reconsideration.

Resources to help you

Step-by-step help documents are available on each tool form by clicking the "Tool Help" icon at the top of the forms.

To learn more, go to Aetna's Education Site and take these short courses: "Online Claim History Report" and "Electronic EOBs & Claim Reconsideration."

Prescription Medications & Pharmacy Management

Updates to Aetna's formulary (Commercial and Medicare)

DRUG	COMMERCIAL HMO and PPO				MEDICARE Part D			
	Coverage Update	Precertification (PR)	Step-Therapy (ST)	Quantity Limits (QL)	Coverage Update	PR	ST	QL
FORMULARY ADDITIONS								
Avinza (morphine sr)	Preferred (P)				*	*	*	*
Azilect (rasagiline)	P				*	*	*	*
Bystolic (nebivolol)	P				*	*	*	*
cetirizine syrup	*	*	*	*	Covered (C)	X		X
cefuroxime inj	*	*	*	*	C			
Dronabinol	*	*	*	*	C	X		
Evamist (estradiol transdermal spray)	*	*	*	*	C			
Folbecal and Vitaphil tab aide	*	*	*	*	C			
Risperidone	P			X	C			
Ramipril	P			X	C			
Novoseven RT (coagulation factor VIIa (Recomb) for inj)	Preferred Pharmacy Managed Self-Injectable (P-PMSI)	X			*	*	*	*
Ocella (drospironone-ethinyl estradiol 3-0.03 mg)	*	*	*	*	C			
paroxetine cr	*	*	*	*	C			X
Pentacel, Kinrix	*	*	*	*	C			X
Perforomist Neb (formoterol fumarate soln neb)	P		X		*	*	*	*
Simcor (simvastatin/niacin sr)	P			X	*	*	*	*
Voltaren Gel (diclofenac topical)	P		X		*	*	*	*
FORMULARY REMOVALS								
Altace (ramipril)	*	*	*	*	Not Covered (NC)		X	X
Risperdal (risperidone)	Formulary Excluded (FE)		X	X	*	*	*	*
NEW DRUGS – Nonpreferred (NP) or FE								
Liquadd (dextramphetamine oral soln)	FE		X	X	NC	X	X	X
Neotic (antipyrine-benocaine-zinc acetate)	FE				*	*	*	*
Primalev (oxycodone/APAP)	*	*	*	*	NC		X	
Requip XL (ropinirole sr 24 hr)	FE		X		NC		X	X
Rotarix	*	*	*	*	NC			
Xolegel kit Corepak (ketoconazole gel/hydrocortisone kit)	FE				*	*	*	*
Xyntha inj (antihemophilic factor recombinant PAF)	NP-PMSI	X			*	*	*	*

The Preferred Drug, Precertification, Step-Therapy and Quantity Limits lists are subject to change.

Visit www.aetna.com/formulary for current information. Many medications on the Aetna commercial and Medicare Preferred Drug Lists are subject to manufacturer rebate arrangements between Aetna and the manufacturer of those medications. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Some programs, such as Step-Therapy, Precertification and Quantity Limits, are not available in all service areas. Precertification programs do not apply to commercial members in Indiana. Step-therapy does not apply to fully insured commercial members in Indiana and New Jersey.

Commercial California members: In accordance with state law, California HMO members who are receiving coverage for medications added to the Formulary Exclusions, Precertification or Step-Therapy lists will continue to have those medications covered, for as long as the treating physician continues prescribing them, provided the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition.

Commercial Texas members: In accordance with state law, full-risk members in Texas who are receiving coverage for medications that are removed from the Preferred Drug Lists during the plan year will continue to have those medications covered at the same benefits level until their plan's renewal date. The term "precertification" does not mean a reliable representation of payment of care or services to fully insured HMO and PPO members.

This material is provided for informational purposes only and is not intended to direct your treatment decisions. You should exercise your own clinical judgment regarding the appropriate treatment of any individual patient.

Aetna's Education Site for Health Care Professionals

Learning Opportunities From Aetna...Developed With You In Mind

New courses for physicians, nurses and office staff:

Office Administration: Electronic EOBs & Claim Reconsideration

Recorded Events: Electronic EOB Tool recorded webinar

We also offer Aetna in-service, face-to-face sessions and live webinars. For upcoming events, see our online calendar on the Education Site. To get started, visit our secure provider website via NaviNet® and click on the Education link from the Aetna Plan Central home page.

CME helps your office prepare for pandemic flu

Our new CME course, "Pandemic Flu: Aware and Prepared," provides information and resources to help you prepare for an outbreak of pandemic flu or similar health crisis. Our one-hour CME can help you:

- Articulate the most appropriate practices for mitigating the impact of a flu outbreak.
- Develop a strategy to prepare your staff and patients for a potential pandemic flu outbreak.
- Access resources to help you determine your office's readiness for a pandemic flu outbreak.

To enroll, select "Continuing Education" from our course catalog.

Accreditation: This activity was planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through a joint sponsorship of Trinity Healthforce Learning and Aetna Incorporated. Trinity Healthforce Learning is accredited by the ACCME to provide continuing medical education for physicians.

Trinity Healthforce Learning designates this education activity for a maximum of one Category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity.



Pandemic flu course for office staff, nurses

Our 30-minute "Pandemic Flu Awareness and Preparedness" course for office staff, office managers and nurses is designed to give you the facts about the threat of a pandemic flu outbreak. The course serves as a reminder of the skills and tools you will need to help protect yourself, your colleagues and your families from infection from pandemic flu, as well as other less serious communicable diseases.

At the end of this course, you will be able to:

- Differentiate the various types of influenza.
- Recognize four critical areas of focus for infection control.
- Identify what Aetna has done to prepare for a pandemic.
- Create a contingency plan for you and your family.

To enroll, select "Office Administration" from our course catalog.

Visit us at the MGMA conference in October

The Medical Group Management Association (MGMA) 2008 Annual Conference takes place at the San Diego Convention Center from October 19-22.

This year, our booth will focus on electronic options for doing business with us. Our secure provider website offers a variety of electronic solutions, along with easier navigation and enhanced features.

To learn more, visit booth #1924 at the MGMA conference. We look forward to seeing you there.

Download our new course catalog

We've made it easier to find courses with our new downloadable, printable course catalog. Explore our wide range of courses at http://aetnaofficelink.providerpreference.com/files/Education_Catalog.pdf.

Policy and Practice Updates

Clinical, payment and coding policy changes

As part of our ongoing policy review process, we regularly adjust our clinical, payment and coding policy positions. 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 accompanying chart outlines coding and policy changes:



CODES IMPACTED	PROCEDURE	WHAT'S CHANGED	IMPLEMENTATION DATE
96110	Developmental testing billed with preventive Evaluation and Management services	96110 will be allowed when billed with preventive E&M codes but will only be allowed 3 times within the first 36 months of life. This change is intended to support the recommendations of the American Academy of Pediatrics for periodic, formal screening for autistic spectrum disorders in the context of preventive health care in the medical home. While developmental surveillance should occur at every well-child visit, reimbursement is intended for use of any of a variety of standardized developmental tools, the results of which should be documented in the medical record.	November 17, 2008
92311, 92312 and 92316	Contact lens fitting	Contact lens fitting is only covered following cataract surgery.	January 1, 2009
93318	Echocardiography billed with Doppler codes	93320, 93321 and 93325 will be denied when billed with 93318.	February 16, 2009
95831, 95832, 95834 and 95851	Muscle testing and motion measurements	95831, 95832, 95834 and 95851 currently deny when billed with an E&M code. A change is being made to no longer override the denial if Modifier 59 is appended to the procedure or Modifier 25 is appended to the E&M code.	February 16, 2009
	Correct Coding Initiative (CCI) edits restricting Modifier 59	Aetna will follow CMS CCI edits that restrict the use of Modifier 59 on the following edits: 33405 when billed with 33863 77315 when billed with 77418 77331 when billed with 77418 85007 when billed with 85025 90471 when billed with 90465 90471 when billed with 90467 90473 when billed with 90465	February 16, 2009

Appropriate indications for color-flow Doppler echocardiography

Aetna considers color-flow Doppler echocardiography in adults medically necessary for certain indications, as listed below. These indications are supported by evidence-based guidelines from the American College of Cardiology, American Heart Association and American Society of Echocardiography.

These guidelines outline the accepted capabilities for Doppler echocardiography

in the adult patient. As a result, Aetna adopted the following indications:

- Evaluating septal defects
- Evaluating the severity of valvular stenosis or regurgitation
- Evaluating the site of left-to-right or right-to-left shunts
- Assessing diseases of the aorta
- Evaluating prosthetic valves

For more details on color-flow Doppler echocardiography and the evidence-based guidelines behind our policy, go to http://www.aetna.com/cpb/medical/data/cpb_num.html and click on Clinical Policy Bulletin (CPB) #0008, *Color-Flow Doppler Echocardiography in Adults*.

Policy and Practice Updates

Consult Clinical Practice Guidelines for patient care

The National Committee for Quality Assurance requires health plans to inform physicians of the availability of Clinical Practice Guidelines.

Both our Clinical Practice Guidelines and Preventive Service Guidelines are based on the recommendations of governmental and nationally respected professional organizations and based on evidence derived from the peer-reviewed medical literature. You can find them on our secure provider website via NaviNet®. Once logged in, select “Clinical Resources.”

Preventive Service Guidelines	Updated 7/08
Asthma <ul style="list-style-type: none">▪ Treating Patients With Asthma	Adopted 1/08
Behavioral Health <ul style="list-style-type: none">▪ Antidepressant Prescribing Guide for Use in Primary Care▪ Helping Patients Who Drink Too Much▪ Treating Patients With Bipolar Disorder▪ Treating Patients With Major Depressive Disorder	Adopted 1/08 Adopted 4/08 Adopted 4/08 Adopted 4/08
Diabetes <ul style="list-style-type: none">▪ Treating Patients With Diabetes	Adopted 4/08
Heart Disease <ul style="list-style-type: none">▪ Treating Patients With Chronic Heart Failure▪ Treating Patients With Coronary Artery Disease▪ Treating Patients With Hypercholesterolemia▪ Treating Patients With Hypertension	Adopted 1/08 Adopted 11/06 Adopted 4/08 Adopted 4/08

For a hard copy of the Preventive Service Guidelines or a specific Clinical Practice Guideline, please call our Provider Service Center.

CFC-propelled albuterol inhalers to be discontinued

Albuterol inhalers that contain chlorofluorocarbons (CFCs) will not be sold in the United States after December 31, 2008. Albuterol inhalers that contain hydrofluoroalkanes (HFAs) will replace albuterol CFC inhalers.

The Food and Drug Administration (FDA) advises physicians and health care professionals to help patients begin the transition to HFA-propelled albuterol inhalers now.

For more information, visit the FDA website at <http://www.fda.gov/cder/mdi/albuterol.htm>.



Moving the needle: Turning our understanding of health care disparities into solutions

Studies show that people from certain racial and ethnic backgrounds receive lower-quality health care than other patients. A March 2002 Institute of Medicine (IOM) Report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” validated that racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services.

Since 2002, Aetna has focused on improving health care equality for racial and ethnic minorities. Our unique resource – access to huge amounts of data, helps us understand our members’ needs and the cultural differences among targeted populations.

The first stage of our work was based on a recommendation from the IOM report. Aetna began collecting race, ethnicity and language preference from our members on a voluntary self-reported basis. In addition, the company launched several studies, and the Aetna Foundation awarded more than \$20 million in grants for programs that identify and use practical means of reducing or eliminating racial and ethnic disparities in the delivery of health care.

Now we’re using the data we’ve gathered to partner with experts in the field and identify initiatives focused on specific interventions. For example:

- We recently launched a new advisory committee that includes some of the country’s most distinguished medical providers and health benefits professionals. Each has implemented programs in their communities which impact racial and ethnic disparities in health care.
- Since 2003, Aetna has mandated completion of Quality Interactions, a Patient-Based Approach to Cross-Cultural Care®, for our clinical staff. In 2006, we began offering health care providers free access to these online, evidence-based courses. Physicians and nurses completing the courses can earn Continuing Medical Education and Continuing Education Unit credits respectively.
- This year, we are completing several studies. One, identified barriers to mammography for African American and Hispanic/Latina members, and determined if certain outreach strategies could improve screening rates. Another focused on increasing clinically acceptable blood pressure measurements among African American members. We currently are developing recommendations for the integration of learnings from these studies into our prevention and medical management programs.

I am pleased to announce that we recently hired David S. Memel, MD, as head of our health informatics organization. His experience and credentials will strengthen our ability to develop evidence – based solutions. We also are evaluating the racial and ethnic information provided voluntarily by more than 5.5 million members to determine which groups in our diverse population are most at risk for certain diseases. This breakdown will enable us to work with health care professionals to improve quality of care in a much more targeted way.

I’ll continue to share updates with you on this important undertaking.

Sincerely,



Troyen A. Brennan, M.D.
Senior Vice President and Chief Medical Officer

A message from
Troyen A. Brennan, M.D.,
Aetna Chief Medical Officer



Plan Facts and Features

Plan update: Aetna Health Network OnlySM and Aetna Health Network OptionSM

Introduced in July 2007, Aetna Health Network Only and Aetna Health Network Option plans are being purchased by more and more employers. As a result, you may see more patients with these plans and should be aware of some basic plan features.

Open access plan administration

Aetna Health Network Only and Aetna Health Network Option are HMO-based, open-access plans. PCP selection is strongly encouraged, but not required, and referrals are not required for members to access care from participating specialists. The Aetna Health Network Only plan has no out-of-network coverage. The Aetna Health Network Option plan has both in-network and out-of-network coverage.

When administering these plans, you should follow the same administrative processes you use for our other HMO-based plans. The amount you are reimbursed for services is the same as for our other HMO-based plans. Also, the Explanation of Benefits you receive for all products includes these HMO-based, open-access plans.

Check member ID card

The member ID card shows the plans as either “Health Network Only” or “Health Network Option” and indicates that PCP selection and referrals are not required.

- The term “Health” identifies members as HMO members and represents the Aetna network from which they can choose doctors and hospitals.

- “Network Only” indicates the member has coverage for in-network care only, with no out-of-network coverage.
- “Network Option” signifies that the plan has both an in-network benefit and the option to go outside the Aetna network for care from licensed providers.

These plans are offered to new employers and a limited number of renewing employers in all states where we currently offer HMO-based plans, except California and Washington.

Avoid duplicate submissions of Medicare claims

Follow these steps to avoid submitting duplicate Medicare Part B claims when we are the secondary payer. You'll save your office money and avoid time and effort your staff spends reconciling denials for duplicate claims:

1. **Don't send a bill to us** – Medicare pays their share of Part B claims first. Then, in most instances, they *automatically forward* the claim information noting any remaining balance to us.
2. **Look for the “MA18” code on your Medicare Explanation of Payment** – This code means your claim was automatically forwarded to the secondary payer.
3. **Use our online Claim Status Inquiry transaction** – It helps you determine if we already received your claim from Medicare (for ways to access this transaction, see #5 next column).

4. **Confirm that Aetna is reviewing your claim.** Your office should then:

- Wait 30 days before billing us. Medicare carriers send secondary claims every 7 days, and we pay clean claims promptly.
- If your practice management system cannot suppress billing, create a paper claim but do not mail it to us.

5. **Follow up with us in 30 days, if your claim isn't processed** – Check on your claim using:

- Our secure provider website via NaviNet[®].
- Our self-service telephone system, Aetna Voice Advantage[®].
- Your current electronic data interchange (EDI) vendor.

Aetna's depression screening program

The Aetna Depression Management Program provides resources for primary care physicians (PCPs) to help diagnose and treat patients with depression. We also offer PCP offices participating in the program additional compensation for positive depression screenings for Aetna members.

To learn more, or to participate, call 1-888-812-3862 or email us at depression@aetna.com. You can go to www.aetnadepressionmanagement.com to register for the program, tour program highlights and find printable office tools.

Check our Medicare formulary for updates

The Aetna Medicare Preferred Drug List, also known as our formulary, is updated from time to time and may change during the calendar year.

For the most up-to-date Medicare formulary information, please visit: www.aetna.com/members/individuals/medicare/member_assistance/changes.html.

Medical record audit results meet most targets

The Mid-Atlantic Region met or exceeded the performance goal of 85 percent in most categories for medical record audits. We've targeted two areas for improvement that fell below the 85 percent compliance goal:

- Documentation of age-appropriate immunizations
- Documentation of advance directives for patients >18 years of age

Medical record audit criteria and charting resources

Every two years, we conduct an audit to assess how health care professionals are complying with our medical record documentation criteria. You'll find the documentation criteria in our Health Care Professional Toolkit, located on our secure provider website via NaviNet®. Tools to assist with improving medical record documentation are also available on our provider website:

- **Adult Health Maintenance Form** – includes a field to document allergies, a problem list for medical and psychological illnesses, and space to note discussion of advance directives.
- **Pediatric Health and Immunization Summary Forms** – to document allergy and immunization information.
- **Medical History Form** – includes fields to document allergies, immunization history and living will information.

Advance directive criteria and resources

You should document in your patients' charts whether a member has prepared an advance directive. Aetna Participating Practitioner Medical Record Criteria require that documentation about advance directives (whether executed or not) is in a prominent place in the patient's record (except for patients under age 18). For

Medicare patients, such documentation is also a requirement of the Centers for Medicare & Medicaid Services for which we must monitor participating physician compliance.

Find advance directive forms for specific states at www.aetnacompassionatecare.com. If the state you practice in is not listed, go to www.uslivingwillregistry.com/forms.shtm for an advance directive form or for additional information.

Medical practices without Internet access can request a paper copy of the toolkit by calling our Provider Service Center.

WEST VIRGINIA

Lab provider joins network

Shenandoah Laboratories, serving the Martinsburg, West Virginia area, has joined the Aetna network as a participating provider and is now available to provide lab services – with or without an appointment:

Shenandoah Laboratories
158 Crimson Circle
Reliance Road Suite
Martinsburg, WV 25403
Phone: 304-262-4757
Fax: 304-262-4759
Email: ShenLab@comcast.net

MARYLAND

New legislation impacts credentialing process

Please be aware that on October 1, 2008, a new law becomes effective in Maryland, SB 595 of 2008.

Under this law, physicians who are joining existing network practices, but whose credentialing is not yet complete, will be paid based on the group's contracted rate. Specifically, these physicians must submit claims listing the group tax ID number as the secondary identifier, including the group name and address. Using only the individual tax ID as the secondary identifier will cause the claim to not be credited to the group.

As a reminder, and in compliance with Health Insurance Portability and Accountability Act (HIPAA), this law does not change the need to use a physician's National Provider Identifier (NPI) as the primary identifier on claims.

For more information about this legislation, visit <http://www.mdinsurance.state.md.us/sa/jsp/Mia.jsp>.

For more information about Aetna's NPI policy, visit www.aetna.com. Select "for Health Care Professionals" then "NPI."

Online pricing information tools coming to select PA markets

This month, we're introducing two new tools in select markets that enable members to better assess health care costs before receiving care. These tools, available on our secure member website, are the medical procedure by facility cost tool and the unit price transparency tool.

Medical procedure by facility cost tool expands to two markets

Our medical procedure by facility cost tool lets members review and compare health care costs for a specific procedure, based on the type of setting in which the procedure is performed. We are introducing the tool in Central and Northeastern Pennsylvania.

With this tool, members can see cost ranges for more than 30 common medical procedures performed at hospitals and ambulatory surgery centers in their area. These procedures include common cardiac

procedures, colonoscopy, hysterectomy and ear tube insertion.

After selecting a procedure, members will see a list of facilities in their area that perform that procedure, along with actual cost ranges. The cost ranges are based on claims data for the past two years.

Cost ranges that will display include all components from admission to discharge and are broken down into two categories: managing physician charges and facility/other charges, which include the facility's charges plus any ancillary charges, such as anesthesia services.

Unit price transparency tool now in Northeastern PA

This month, we're also introducing our unit price transparency tool in Northeastern Pennsylvania.

With this tool, members can view Aetna-contracted rates for participating primary care or specialty physicians for up to 30 of the most common services provided by those physicians. Rate information is also available on other health care professionals, including physical and occupational therapists, speech therapists and pathologists, chiropractors, podiatrists, audiologists, and optometrists.

The rates are specific to the member's health benefits plan. Members can get rate information on office visits; diagnostic tests; and major, minor and other procedures.

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Facilities: Open the door to electronic communications

Are you a participating facility or hospital that would like to say “goodbye” to paper correspondence and clutter? If so, simply visit <https://aetna.providerpreference.com/facilities.php> and register to receive electronic communications from us.

Receiving electronic communications means you can quickly and efficiently have critical information from us at your fingertips – and at your convenience. Don't wait for paper correspondence...sign up today.

Help patients save through our mail-order pharmacy

You can help your Aetna patients get the most out of their prescription plan when they use Aetna Rx Home Delivery®, our mail-order pharmacy service, to obtain their maintenance medications.

Write prescriptions for 90 days
If you write a prescription for a 90-day supply, members may only pay two copays for drugs purchased through Aetna Rx Home Delivery, depending on their benefits plan. They could be paying three copays if they obtained the same quantity at a participating retail pharmacy.

Please note that if you write a prescription for only a 30-day supply with 11 refills, members who get their medications from Aetna Rx Home Delivery may be required to pay two copays under their plan for a 30-day supply of medication. As a result, please write prescriptions to be filled at mail order for a 90-day supply with three refills, when appropriate, so members can maximize their pharmacy benefit.

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