



Aetna OfficeLink Updates™

Mid-Atlantic Region

Inside This Issue

Policy and Practice Updates . . .2-6
Aetna's Education Site for
Health Care Professionals 7
Prescription Medications &
Pharmacy Management8-9
Striving for Quality
Excellence 10
Mid-Atlantic News 11

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 all other benefits plans and WA Primary Choice plan

Our new policy on professional charges for "Never Events"

Because we are committed to improving patient safety and promoting quality efforts, we are implementing a new reimbursement policy for professional charges concerning "Never Events."

Specifically, as of August 15, 2009, we will not pay provider claims for Never Events. Under our policy, Never Events are defined as:

- Surgical procedures performed on the wrong person,
- Surgical procedures performed on the wrong side or body part, or
- The wrong surgical service or other invasive procedure is rendered to the patient.

In addition, any health care provider in attendance during the erroneous surgery or service will not be permitted to seek payment from the patient for these services. This policy is based on our support of the National Quality Forum

(NQF), the Leapfrog Group, the National Business Coalition on Health and the National Business Group on Health.

Contact us about any Never Event

To notify us of a Never Event, call our Provider Service Center. The service center will refer the event for further review. In addition, for Never Events, you should bill us your regular charges, although you should not expect payment for services directly related to these events.

With Never Events, you will continue to have access to all applicable appeals available under your contract with us.

Note: We recently notified participating facilities about our Never Events and Serious Reportable Events (SREs) reimbursement policy. Specifically, Aetna will not pay for charges related to Never Events or for charges directly and solely related to eight SREs.

How you can get our communications by email

Many of you have told us that you'd rather get communications from us electronically instead of through the mail. But to do so, we need to have your most current email address.

Even though we have a lot of email addresses in our files, too many of them are either outdated or no longer in service. If you've changed your address

but haven't yet informed us, we urge you to do so as soon as possible.

Email communications are timely, environment friendly and easy to share. Give us your new or updated email address by visiting

<https://aetna.providerpreference.com>.



Policy and Practice Updates

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 accompanying chart outlines coding and policy changes:

Procedure	Implementation Date	What's changed
Proper billing of parenteral infusion pumps	8/15/2009	Equipment used in conjunction with a medical and/or surgical procedure, is considered incidental to the primary procedure, and no additional payment will be made to physicians.
Dialysis training	8/15/2009	Aetna allows one complete course of dialysis training per year. 90989 should be used to report the completed course. If only a portion of the course is completed, code 90993 is reported for each session provided. A maximum of six will be allowed. Reporting both of these codes is not appropriate, since the course will have been either completed or not completed at the end of the training sessions.
Extended ophthalmoscopy	8/15/2009	Extended ophthalmoscopy refers to the meticulous evaluation of the interior of the eye, and includes a drawing of the retina observed through a dilated pupil and a written interpretive report. Aetna considers extended ophthalmoscopy medically necessary for evaluation of a range of posterior segment pathology, when the level of examination requires a complete view of the posterior segment, where documentation is greater than that required for a routine ophthalmoscopy. Medically necessary indications include glaucoma; intraocular neoplasms; ocular trauma; certain abnormalities of the retina or choroid; and certain vitreous disorders.
Fracture care	8/17/2009	Comprehensive fracture treatment should only be billed by the provider who provides the global fracture treatment service. Physicians providing less than comprehensive fracture care should bill using the CPT codes reflecting the specific services rendered. We will pay one fracture treatment service and related services for the same fracture during the 90 day global period. The fracture treatment codes include the actual fracture care and related follow-up visits.
Nerve conduction velocity	8/17/2009	Nerve conduction velocity studies are considered experimental and investigational if performed without a concurrent or prior needle electromyography study (excluding carpal tunnel syndrome and Lambert-Eaton Myasthenic Syndrome diagnoses). Refer to Clinical Policy Bulletin #0502 for additional information.
Arthroscopy	11/16/2009	Modifier 59 will no longer override these codes as 29875 is considered integral to the successful completion of 29877 and 29881.
Cytogenetics	11/16/2009	88291 is currently mutually exclusive when billed with codes 82013, 82106, 83890-83892, 83894-83898, 83901-83906, 83912, 84443, 85300-85306, 85730, 86701-86703, and 88182-88189. Effective with this change, Modifier 59 will not override these codes if these lab tests are not part of the cytogenetics studies.
Multiple/duplicate component billing	11/16/2009	For procedures eligible to be billed with a component modifier, Aetna will allow payment for one professional and one technical component of a laboratory or diagnostic test. Additional professional interpretations or technical components by the same or different provider are considered duplicative, and are not eligible for separate reimbursement unless it is a repeat test/ procedure.
Chemotherapy administration and non-chemotherapy drug infusion	11/16/2009	Modifier 25 will no longer override the denial of CPT code 99211 when billed with a chemotherapy administration code or non chemotherapy drug infusion code.

Procedure	Implementation Date	What's changed
Concurrency of multiple Evaluation & Management services (same day)	8/15/2009	We will apply concurrency rules (100/50) when two E&M services are billed and allowed with Modifier 25. The preventive medicine visit will be considered the primary service and payable at 100% of allowed and the eligible office, or problem-focused, E&M will be considered the secondary service payable at 50% of allowed.
Obesity surgery and hiatal hernia repair	11/16/2009	39502, 39520, 43280, 43324, 43499, and 43659 will deny as incidental when billed with obesity surgery code ranges 43770-43774 and 43842-43848. Modifier 59 will not override these codes as hiatal hernia repair (39502, 39520, 43280, 43324, 43499, and 43659) is considered an integral part of obesity surgery.
Multiple surgery reductions	N/A	Multiple surgery reductions apply to codes that meet Aetna's definition of surgery. *An effective date was incorrectly noted in the February 2009 issue of OfficeLinks Updates. This is a general policy clarification.
Antepartum care	N/A	CPT codes 59425 and 59426 represent antepartum or prenatal care services and will be treated the same as any other E/M service. These services are not recommended for separate reimbursement when a global maternity service is also reported. If a global maternity service is reported separately, in addition to an antepartum or prenatal care service either by the same or different provider, Aetna will request a corrected bill on the global maternity service to more accurately reflect the services actually rendered. If a global maternity service has already been reported, the antepartum or prenatal care services will be denied as included in the global maternity reimbursement.
Billing of multiple units	N/A	When multiple units of a service are billed on a single line, Aetna will apply the same frequency limits and concurrency rules that currently apply to the service when it is billed on multiple lines.
<u>Correction:</u> Problem-focused Evaluation and Management (E&M) and consultation codes	11/16/2009	Problem-focused E&M and E&M consultation codes will not be allowed when billed with codes 92506, 97001, 97002, 97003, 97004, or 92610, unless Modifier 25 or 59 is appended to the claim.

Does your office have an immunization registry?

We encourage your office to consider using an immunization registry.

Immunization registries are confidential databases used to maintain immunization records on a statewide basis. They can help your office by:

- Providing a reliable patient immunization history. This may help eliminate duplicate immunizations for patients who previously saw other providers.
- Improving office efficiency by consolidating immunization information.

- Simplifying completion of proof-of-immunization paperwork for your patients' school, camp and daycare admission requirements.
- Generating appointment reminders for immunizations that are due or overdue.
- Recording vaccine manufacturer and lot number automatically for each patient, which can help identify patients for revaccination if vaccine lots are recalled.
- Reducing your office's need to obtain documentation during Healthcare

Effectiveness Data and Information Set (HEDIS®) data collection.

- Providing safe storage of data.
- Helping determine what proportion of children in your practice is adequately immunized.

For more information, visit <http://www.cdc.gov/vaccines/programs/iis/providers.htm>.

*HEDIS is a registered trademark of the National Committee for Quality Assurance.

Policy and Practice Updates

You may be eligible for Bridges to Excellence® bonus payments

Through our national licensing agreement with Bridges to Excellence (BTE), Aetna-participating physicians may be eligible for bonus payments for performance in one or more BTE programs.

BTE is a nonprofit company committed to creating significant leaps in the quality of health care. BTE does this by recognizing physicians and other health care providers who demonstrate that they are following recognized standards of patient care and promoting enhanced payments to them.

We also post BTE recognition next to physicians' names in DocFind®, our online provider directory.

Visit our new BTE web page

For more details, visit the new BTE page on our secure provider website via NaviNet®. From the Aetna Plan Central home page, select "Aetna Support Center," then "Doing Business With Aetna" and "Bridges to Excellence." The page features information about program availability and recognition, as well as contact information.

Visit www.aetna.com/info/letstalk/contact_us/provider/ to submit an inquiry or suggestion or to request a change or correction related to our BTE program. For more information about the eligibility criteria for BTE enhancements, go to www.bridgestoexcellence.org.

Some patients have \$0 preventive care copay

You may see some patients whose member ID cards list a \$0 copayment amount. This amount relates to preventive care services, such as well-child visits, annual ob/gyn visits and colonoscopy screenings.

ID cards that include \$0 copay

Marriott and Sodexo are two large companies that offer the \$0 copayment to their employees, though there are others, as well. Check each patient's ID card to help you avoid charging the patient when no copayment is applicable.

Verify eligibility, benefits online

You can confirm patient eligibility and benefits information by:

- Visiting our secure provider website via NaviNet, or
- Going to www.aetna.com and visiting the Health Care Professionals page.

If you have additional questions after reviewing the information available online, call our Provider Service Center at:

- 1-800-624-0756 for HMO-based plans
- 1-888-MD Aetna (1-888-632-3862) for all other plans.

Ensure accurate billing for office-administered drugs

Effective August 15, 2009, we will be validating the number of J-code units and submitted charges of medications that are administered in the physician's office.

A dosing algorithm will screen these claims to identify possible billing errors that exceed standard dosing thresholds. This threshold is based upon maximum dosing levels in the product labeling, Food and Drug Administration dosing guidelines, and peer-reviewed, published medical literature for each drug.

We encourage all health care professionals to review J-code billing units and the proper conversion of the drug dose that is administered to your patient(s).

This policy applies to many office-administered medications billed with J-codes. For a complete list, visit our secure provider website via NaviNet. Once logged in, select "Aetna Support Center" then "Pharmacy."



Tax ID changes? Contact us ASAP

If your tax ID number (TIN) changes, contact your Aetna network representative as soon as possible to help ensure our records are up to date.

Policy and Practice Updates

Hospitals: Support patient safety, take The Leapfrog Group survey

We urge all participating hospitals to take part in The Leapfrog Group survey this year. The results give consumers valuable information about how your hospital addresses patient safety and quality.

You can access the Leapfrog Hospital Quality and Safety Survey online.

Go to www.leapfroggroup.org, choose “For Hospitals” then “Leapfrog Hospital Survey.”

We also have a link to The Leapfrog Group website on DocFind, our online provider directory.

2009 changes

The 2009 survey contains these changes:

- Hospitals must have a computerized physician order entry (CPOE) system in at least one inpatient unit and must complete the CPOE Evaluation Tool test to receive credit on this measure.
- The predicated mortality composite measures are being expanded to all seven Evidence-Based Hospital Referral high-risk surgeries.
- The survey has incorporated the National Quality Forum’s Safe Practice for Better Healthcare: 2009 Update.

One new safe practices applies to preventing catheter-related urinary tract infections.

- Four perinatal care measures have been added to the Common Acute Conditions section.

View the survey results

You and your patients can view Leapfrog survey results on DocFind or through the Hospital Comparison Tool on Aetna Navigator®, our secure member website. We refresh this information whenever Leapfrog releases updated survey data.

MEDICARE

Financial incentives now available for e-prescribing

A new Medicare law that took effect in 2009 provides incentives for electronic prescribing (e-prescribing). The law applies to physicians who submit a sufficient number of prescriptions covered under Medicare Part D during the reporting period.

What the incentives are

The incentive amount is 2 percent of Medicare allowed charges for Physician

Fee Schedule-covered professional services reported in 2009 and 2010. This amount will be reduced to 1 percent for 2011 and 2012 and to 0.5 percent in 2013.

Physicians not meeting the e-prescribing standards will see their fee schedule amount for services reduced by 1 percent beginning in 2012, by 1.5 percent in 2013 and by 2 percent after 2013.

Where to find more information

The National ePrescribing Patient Safety Initiative (NEPSI) makes electronic prescribing software available to physicians at no cost. The software is simple, safe and secure, and requires no download, no new hardware and only minimal training. More information is available at www.nationalerx.com.

Tips for proper medical record documentation

Annually, the Centers for Medicare & Medicaid Services (CMS) conducts risk adjustment data validation audits. During these audits, CMS verifies that diagnosis data submitted by providers to Medicare Advantage (MA) organizations (and by MA organizations to CMS) is accurately supported in the provider’s medical records. These audits help ensure the integrity and accuracy of CMS payments to MA organizations.

If you treat our MA members, your contract requires that you accurately submit claim and encounter data and maintain accurate and complete medical record documentation. In addition, your contract requires that you provide Aetna with any medical record documentation needed to respond to a CMS audit.

To help ensure compliance with CMS requirements, remember that CMS requires that risk adjustment data be

obtained from a face-to-face patient visit, and the resulting medical record must be complete and legible and, at a minimum, include the following:

- The physician’s signature and credentials on each chart entry
- The patient’s name and date of service on each page of the chart
- All diagnoses, at the highest level of specificity, with current health status and treatment plan documented in notes.

Policy and Practice Updates

Enroll in EFT, get prompt payments right to your bank account

If you are concerned about receiving prompt payments for services delivered, then electronic funds transfer (EFT) – a time-tested electronic solution – may be the answer for you.

Instead of paper checks, we'll send payments to you via EFT – a secure, free online capability that allows you to:

- Get claims payments transmitted directly to your bank account(s) *up to one week faster* than with paper checks.
- Reduce mail coming to your office, as well as handling time by your staff.

- Easily verify payments by matching them to submitted claims on an electronic remittance advice (ERA) or electronic Explanation of Benefits (EOB) from our secure provider website via NaviNet.

Follow these steps to enroll

- Complete the EFT enrollment form and attach a voided check or letter from your banking institution. The enrollment form is available at http://www.aetna.com/provider/medical/resource_med/forms_med/forms.html.
- Fax the completed form to our secure enrollment desk listed on the form.

You'll begin receiving EFT payments directly to your bank account within 10-15 days after enrollment is completed. We'll send you confirmation documentation once we begin your setup.

Online EFT resources

- Go to http://www.aetna.com/provider/medical/service_med/electronic_med/era.html for more information about our variety of online services, including EFT.
- Or, use the "Contact Us" link on our website to send us a message.

Put online precertification to work for your office

Submitting and inquiring about your precertification requests electronically is an efficient way to save time and money. The electronic precertification transactions and tools on our secure provider website via NaviNet feature:

- The ability to search diagnosis and procedure codes by description
- Wait time of a minute or less for initial responses
- The option to create a personalized list of "favorite" providers/facilities that you normally include on your precert requests
- Secure data transmission

Use our Precert Code Search Tool

The self-service Precertification Code Search Tool makes it easy to check if a medical procedure needs precertification. The tool also lets you print a record of

your transactions so you can track instances when no precertification is required.

Find the tool at www.aetna.com and choose "Health Care Professionals," then "Medical," "Precertification List" and "The Aetna Participating Provider Precertification List." Enter a valid five-digit CPT or HCPCS code. You'll know immediately if precertification is required, and if precert is required through a delegated organization (MedSolutions, National Imaging Associates, CareCore).

Getting started is easy

Contact your software vendor/clearinghouse to verify it can submit real-time precertification transactions to Aetna. If not, visit www.aetna.com and select "Health Care Professionals," then "Service Solutions."

Or, log in to our secure provider website and access our online precertification transactions from the Aetna Plan Central home page.

What users say about electronic precert

"Everyone in my department uses the Aetna online precertification. It's easy, convenient and time saving. Aetna's electronic precertification is a must that every medical facility should have."

– Arizona medical facility administrator

"Aetna precert has made our lives better. It's user friendly, and fast. We love it."

– Illinois hospital administrator

Submitting claims? Don't include referral attachments

Attaching referrals to your paper claims delays claims processing and subsequent claims payment.


Whether submitted electronically or on paper, claims go through an automated validation process in which we review the member's benefits plan, check if a referral is required and confirm if the referral is on file. If everything is in place, we process the claim quickly. So, there is no need to submit referrals with your claims.

Aetna's Education Site for Health Care Professionals


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


New and updated courses for physicians, nurses and office staff


Podcasts


 Electronic Prescribing – A Change in Direction

Office Administration


 Cultural Competency: Reducing Health Care Disparities

 **Updated** Orientation: Getting started with Aetna ... A guided orientation


 **Updated** ID Cards: Member ID Card Education Tool

 **Updated** Products, Programs and Plans: Aetna Medicare OpenSM Plan (PFFS)

Recorded Events

 **Updated** Aetna Medicare Advantage Plans recorded webinar

Reference Tools

 **NEW** Credentialing/Recredentialing: CAQH Reference Guide

We also offer Aetna in-service updates and live, interactive webinars. For upcoming events, see our 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.

Help your patients maximize their health benefits during tough economic times

In the face of today's economic downturn, it is more important than ever that patients are well informed about their health care benefits plans. We are committed to providing you and your patients with tools and resources that help take the guesswork out of what can be a confusing subject.

Aetna's new "Maximize Your Benefits" education campaign is designed to help our members pay attention to their health, learn how to build and maintain a relationship with their physicians, and take advantage of free or low-cost coverage for preventive care.

To support this effort, we are offering *Navigating Your Health Benefits For Dummies*.

Order the "Dummies" guide, share it with your patients

We're making limited quantities of the guide available at no cost for you to give to patients. The 64-page book (English version only) provides information about health benefits, including:

- Choosing a health plan that fits an individual's needs
- Making decisions that support what's happening in one's life
- Taking advantage of all a plan has to offer.

To order copies while supplies last, email the following information to AetnaEducationSite@aetna.com:

- Practice name
- Your first and last names
- Street address
- City, state and zip
- Phone number
- Quantity (25-copy maximum per practice)

To learn more about our Maximize Your Benefits campaign, visit www.aetna.com/healthysavings.

May is Mental Health Month; stay current with our Depression Management CME

With May being National Mental Health Month, there's no better time to take our *Depression Management in the Primary Care Setting* CME.

This recently reaccredited course is designed to educate primary care physicians and nurse practitioners about the Aetna Depression Management Program. We developed the program to help enhance the quality of care and outcomes for patients with depressive disorders.

CiNet Healthcare Learning designates this CME for a maximum of two category 1 credits toward the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity.

To access the CME through our secure provider website, select "Aetna Health Plan," then the Education link. Then, under "CME Courses" on the top menu bar, select "Depression Management in the Primary Care Setting."

Download our new course catalog

It's easier than ever to find courses with our new downloadable, printable course catalog. Explore our wide range of courses at http://aetnaofficialinkprovider.preference.com/filesEducation_Catalog.pdf.

Prescription Medications & Pharmacy Management

Updates to Aetna's formulary (Commercial and Medicare)

We periodically review the Aetna Preferred Drug Lists (formulary) to make sure they meet established criteria for safety, effectiveness and overall value. Recent changes and updates are listed below. To view the complete Aetna Preferred Drug Lists, go to www.aetna.com/formulary.

Changes not applicable are marked with an asterisk (*).

Drug	COMMERCIAL HMO and PPO				MEDICARE Part D			
	Coverage Update	Precertification (PR)	Step-Therapy (ST)	Quantity Limits (QL)	Coverage Updates	PR	ST	QL
FORMULARY ADDITIONS								
Astepro (azelastine)	Preferred (P)				*	*	*	*
Bystolic (nebivolol)	*	*	*	*	Covered			
calcitonin salmon nasal spray	P				*	*	*	*
dorzolamide, dorzolamide/ timolol ophthalmic	P				C			
galantamine/sr 24hr	P				C			
Keppra XR (levetiracetam sr)	P				C			X
levetiracetam	P				C			
Progesterone in oil	*	*	*	*	C	X		
Promacta (eltrombopag)	*	*	*	*	Specialty			
Rosaderm kit (sulfacetamide sod-sulf emul kit)	P				*	*	*	*
stavudine	P				C			
sumatriptan	P			X	C			X
tobramycin/dexamethasone ophthalmic	P				C			
Trilipix (fenofibrate)	*	*	*	*	C			
Voltaren gel (diclofenac)	*	*	*	*	C			
Xenazine (tetrabenazine)	P	X			*	*	*	*
FORMULARY REMOVALS								
Depakote, Depakote ER (divalproex)	Formulary Excluded (FE)		X (for Depakote only)		Not Covered (NC)		X	
Depakote Sprinkle (divalproex)	FE				*	*	*	*
Fosamax plus D (alendronate/ vitamin D)	Non-preferred (NP)				*	*	*	*
Metadate CD (methylphenidate once-daily)	NP		X	X	*	*	*	*
NEW DRUGS – Nonpreferred (NP) or FE								
Apriso (mesalamine oral)	FE			X	NC			X
Astepro (azelastine)	*	*	*	*	NC			
Banzel (rufinamide)	FE	X			NC	X		X
Epiduo (adapalene/benzoyl peroxide)	FE				NC			
Ibuprofen Kit Comfort (ibuprofen w/liniment)	FE				*	*	*	*
Moxatag (amoxicillin sr 24h)	FE				NC			
Nucort (hydrocortisone lotion)	FE				*	*	*	*
Prandimet (repaglinide/metformin)	FE				NC			

Continued on next page

Additions to precertification, quantity limits and step-therapy programs*

The drugs listed below will be added to our Pharmacy Management precertification, quantity limits and step-therapy programs effective August 15, 2009. For all drugs requiring precertification, medical exception, step therapy and/or quantity limits, visit www.aetna.com/formulary.

Drug	Program Edit
ARIMIDEX	Precertification
AROMASIN	Precertification
FEMARA	Precertification
RELISTOR	Precertification
LYRICA	Precertification
RELISTOR 12 mg/0.6 ml inj.	Quantity limit (up to 10 injections per 30-day supply)
RELISTOR 12 mg/0.6 ml kit	Quantity limit (up to 7 syringes [1 kit] per 30-day supply)
VOLTAREN GEL 1%	Quantity limit (500 gm [5 tubes] per 30-day supply)
ABILIFY	Step therapy – must try risperidone first
ADOXA	Step therapy – must try doxycycline first
BENICAR	Step therapy – must try Cozaar/Hyzaar AND Diovan/Diovan HCT first
BENICAR HCT	Step therapy – must try Cozaar/Hyzaar AND Diovan/Diovan HCT first
DORYX	Step therapy – must try doxycycline first
GENOTROPIN	Step therapy – must try any two of Humatrope, Nutropin/Nutropin AQ or Tev-Tropin first
GEODON	Step therapy – must try risperidone first
NORDITROPIN	Step therapy – must try any two of Humatrope, Nutropin/Nutropin AQ or Tev-Tropin first

About these programs

In cases where you believe it is medically necessary, patients can obtain coverage for drugs on the step-therapy list without trying the prerequisite drug first, if you submit a medical exception request. Similarly, a medical exception is necessary for patients to receive coverage for amounts in excess of the indicated quantity limits for drugs on the quantity limits list.

In addition, we have updated our system to apply a maximum use quantity limit for the ophthalmic class of medications. This is to promote appropriate use of this drug class.

* Step therapy, Precertification and Quantity Limits may not apply in all service areas. For example, both Precertification and Step-therapy programs do not apply to fully-funded members in Indiana. Step Therapy is also not available for fully-funded groups in New Jersey. However, these programs are available to self-funded plans in New Jersey and Indiana. As with Aetna's Preferred Drug List, Precertification, Step-therapy and Quantity Limits lists are subject to change. Members should refer to their plan documents or call the Member Services number on their ID card for further information. The prescribing provider is not precluded from prescribing another drug covered by the plan that is medically appropriate for the enrollee, nor shall anything in this section be construed to prohibit generic substitution.

Review our Medicare formulary for up-to-date information

We update the Aetna Medicare Preferred Drug List, also known as our formulary, from time to time throughout the year. For up-to-date Medicare formulary information, visit https://www.aetnamedicare.com/plan_choices/drug_list_changes.jsp.

Continued from previous page

Drug	COMMERCIAL HMO and PPO				MEDICARE Part D			
	Coverage Update	Precertification (PR)	Step-Therapy (ST)	Quantity Limits (QL)	Coverage Updates	PR	ST	QL
NEW DRUGS – Nonpreferred (NP) or FE								
Promacta (eltrombopag)	NP				*	*	*	*
Sancuso pad (granisetron transdermal patch)	FE		X	X	NC	X	X	X
Trilipix (fenofibrate)	FE		X		*	*	*	*
Vanoxide HC kit (benzoyl peroxide-hydrocortisone)	FE				*	*	*	*
Venlafaxine ER (venlafaxine sr 24hr)	FE		X	X	NC		X	X
Veripred (prednisolone sod phos oral soln)	FE				*	*	*	*

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 and step therapy programs do not apply to fully-funded commercial members in Indiana. Step therapy does not apply to fully-funded commercial members in New Jersey. These

programs are available to self-funded plans in Indiana and New Jersey. Members should refer to their plan documents or call the Member Services number on their ID card for further information.

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 that 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 List 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.

Striving for Quality Excellence

Keeping you and your patients informed

We want you to be aware of certain policies, resources and programs that can help you and your patients. These include:

Advance directives

The Centers for Medicare & Medicaid Services (CMS) requires you to document in each Medicare patient's chart whether he/she has an advance directive. In addition, Aetna's 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).

Find state-specific advance directive forms at www.aetnacompassionatecare.com. If the state you practice in is not listed, visit www.uslivingwillregistry.com for an advance directive form or for more information.

Enhancing physician-patient communication

Two tools are available to support continuity and coordination of care through better communication.

- The Behavioral Health/Medical Provider Communication Form makes it easier for medical and behavior health providers to share information about a patient's treatment plan. Providers can use the form to pass on detailed information about a patient's diagnosis, medications and risks/concerns. It's located on our secure provider website via NaviNet in the "Forms Library."
- Our "Make the Connection" flyer explains why members should share health information with their medical and behavioral health providers. It outlines the steps members can take to be more active participants in the communication process. The flyer is on our secure provider website under "Aetna Behavioral Health and Employee Assistance Program."

website and go to "Quality Management Program."

Additional resources

- Members' rights and responsibilities: information about access to care and the importance of open communication.
- Case management and disease management programs: information for physicians and members about the various programs we offer and how to access them.

Where to find more

You'll find more information on these topics in our Health Care Professional Toolkit, which is available on our secure provider website via NaviNet. Practices without Internet access can request a paper copy by calling our Provider Service Center.



QM Program information available

We integrate quality management and metrics into all we do. For details on our program, its goals and our progress toward those goals, log into our secure provider

Established guidelines can help guide patient care

Our Clinical Practice Guidelines (CPG) and Preventive Service Guidelines (PSG) are based on nationally recognized recommendations and peer-reviewed medical literature. To the right is a list of the care guidelines we make available to providers at the request of the National Committee for Quality Assurance (NCQA), along with the dates the guidelines were updated and/or adopted.

You can find these guidelines on our secure provider website via NaviNet under "Aetna Support Center," and then "Clinical Resources." For a paper copy of our PSGs or a specific CPG, call our Provider Service Center.

Preventive Service Guidelines	Adopted 1/08
Preventive Service Guideline Updates <ul style="list-style-type: none"> ■ Influenza Vaccine in Children (CDC¹) ■ Newborn Hearing Screening (USPSTF²) ■ Prostate Cancer Screening (USPSTF) ■ Colorectal Cancer Screening (USPSTF) ■ Routine Cholesterol Screening in Adults (USPSTF) 	Adopted 9/08 Adopted 9/08 Adopted 11/08 Adopted 11/08 Adopted 11/08
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 2/09
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 9/08 Adopted 4/08 Adopted 4/08

¹ Centers for Disease Control and Prevention

² U.S. Preventive Services Task Force

Mid-Atlantic News

PENNSYLVANIA

Two transparency tools being introduced in Berks County

In June 2009, we're introducing our medical procedure by facility cost tool and unit price transparency tool in Berks County, PA, to allow members to better assess health care costs before receiving care.

We want you to be aware of the availability of these tools, which can be found on our secure member website.

Medical procedure by facility cost tool

This 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.

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 divided 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

Members can use this tool to 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 other major and minor procedures.

View updated rates for injectables, vaccines

We regularly review Aetna Market Fee Schedule (AMFS) rates for injectable drugs and vaccines to make sure they accurately reflect current market pricing, based on the average wholesale price (AWP).

Specifically, we update injectable drug and vaccine rates quarterly, on January 1, April 1, July 1 and October 1. Our basic source for AWP is a nationally recognized vendor for drug pricing. We do not subscribe to the Red Book Pricing Information. From this source, we extract the following information:

- If the code represents a single-source product, we use the applicable AWP for that product to get the rate as defined by the J-code. We then determine the final AMFS rate by multiplying the derived AWP by 85 percent.
- If the code represents a multi-source product, we use the median AWP of the generic form for that product to equate to an average generic price for the J-code. We then determine the final AMFS rate by multiplying the derived AWP by 85 percent.

Clarification: Aexcel Clinical Performance criteria

Use of health information technology criteria was clarified to read:

“At least 75 percent of the group has earned the Physician Office Link designation or, upon reconsideration, informs us of the use of health information technology, which applies National Quality Forum-endorsed measures.”

NEW JERSEY

Where to find our appeal process forms

We have updated the information about internal and external provider appeal processes on our public website.

Go to www.aetna.com, click “Health Care Professionals” then “Medical.” Then, select “Dispute Process” under “Shortcuts.” Then select “Payment Policy” under “Health Coverage Information.”

Use the NJ Health Care Provider Application to Appeal a Claims Determination form when submitting certain claims appeals. You can find this form on our public website by following the links above. Look for “New Jersey” under the “State Specific” heading. If you do not have Internet access, contact our Provider Service Center.



CPE RS51
151 Farmington Ave.
Hartford, CT 06156

Contact us at: OfficeLinkUpdates@aetna.com

Route this publication to:

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits coverage include Aetna Health Inc., Aetna Health Insurance Company, Aetna Life Insurance Company (Aetna) and Strategic Resource Company. (Aetna)

Certain lab tests may be considered experimental or investigational

Select laboratory tests are considered experimental or investigational and are not covered under most Aetna plans. This means your patients may be responsible for the full cost of these tests.

There are several tests Aetna may not cover, but the most common are:

- Lipoprotein cholesterol test (CPBs #0381, 0525)
- Homocysteine cardiovascular test (CPBs #0381, 0562, 0763)

- Lyme disease by PCR (CPB #0215)

You'll find the corresponding Clinical Policy Bulletins (CPBs) at www.aetna.com; choose "Health Care Professionals," then "Medical" and "Clinical Policy Bulletins."

Check to see if a test is covered

We offer an online reference tool listing laboratory tests that are considered experimental and investigational or that may be conditionally covered. Access this tool on our secure provider website

via NaviNet and select "Claims" from the drop-down menu and "Clinical & Payment Policy Code Lookup." Then, pick "Select a code by category."

You can also view our corresponding CPBs, which are posted alongside the CPT code descriptions.

Remind patients at the time a lab test is ordered that they are financially responsible for these tests because they are non-covered services.

Aetna's depression program: a one-stop resource

The Aetna Depression Management Program provides resources for primary care physicians (PCPs) to help diagnose and treat your Aetna patients age 19 years and older with depression.

This program brings together PCPs, mental health professionals and Aetna's care management team. Its focus is on proactive assessment and early intervention – good

news for your patients' quality of life and treatment outcomes.

To refer a member into the program, call our Depression in Primary Care line at 1-888-812-3862. Care planners are available from 9:30 a.m. to 6 p.m. ET. They will respond to your requests within one business day.

Additional compensation available

We offer participating PCP offices additional compensation for positive depression screenings for Aetna members (using billing combination V79.0/99420). To learn more or access our new referral form, visit www.aetnadepressionmanagement.com, or email us at depression@aetna.com.

The information and/or programs described in this newsletter may not necessarily apply to all services in this region. Contact your Aetna network representative to find out what is available in your local network. Application of copayments and/or coinsurance may vary by plan design. This newsletter is provided solely for your information and is not intended as legal advice. If you have any questions concerning the application or interpretation of any law mentioned in this newsletter, please contact your attorney.