



Aetna OfficeLink Updates™

West 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)
- For HMO-based benefits plans call 1-800-624-0756

Physician clinical alerts available through the NaviNet® provider website

Our enhanced secure provider website via NaviNet boasts many new features and improved functionality. One of the new features, Care Considerations, is aimed at enhancing care and improving health outcomes.

With the launch of the new website, by mid-April, provider offices can retrieve and respond to Care Considerations online. Care Considerations are clinical alerts sent to physicians based on a member's claims history. They identify potential wellness opportunities or safety risks that may call for further attention by the physician.

Electronic Care Considerations allow you to promptly act on the information to benefit your patients. Only your practice's NaviNet security officer will have access to Care Considerations initially. That individual must give others within the practice access to this information.

Where to find Care Considerations on NaviNet

Once you are registered with NaviNet and have permission to access Care Considerations, you can find them in your NaviNet "Action Items." An alert will be displayed if you have new Action Items. (The Action Items symbol is the orange flag on the NaviNet toolbar in the upper right part of the NaviNet screen.)

In addition, staff with permission to perform web-based eligibility transactions and to view Care Considerations may receive an "alert" when eligibility details on a patient are returned. The alert will indicate that a Care Consideration is available for the patient. The Care Consideration can be opened directly from the alert screen immediately or at a later time.

How to register with NaviNet

To register with NaviNet, visit www.aetna.com. Select "for Health Care Professionals," "Medical" and "Register Now!" from the "Provider Secure Website" box on the right.

Coming soon: Online access to Personal Health Records

With the recent introduction of NaviNet, provider offices will soon be able to access their Aetna patients' Personal Health Record (PHR)s, with the patient's permission.

We expect that providers will be able to view their patients' PHRs in the coming months. Please note, however, that only providers who have registered for NaviNet

will be able to view patient PHRs, and only after their patients have given their physicians access to the records.

Watch for more details in future issues of *Aetna OfficeLink Updates*.

Benefits of access to a PHR

The PHR provides a comprehensive view of patients' health care treatment and health

history. It contains up to 24 months of health information based on Aetna claims data, as well as information patients have entered regarding their health status and history. Having this information at your fingertips could help reduce medical errors and improve patient safety.

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 |
|--------------------------------|---|---|---------------------|
| (93000-93010) (93040-93042) | ECG codes billed with ambulance transport | Electrocardiogram (93000 - 93010) and Rhythm ECG Codes (93040-93042) will be denied as incidental when billed with primary ambulance codes (A0225/A0426/A0427/A0428/A0429/A0430/A0431/A0433/A0434). | September 15, 2008 |
| 90772 | Evaluation & Management (E&M) Codes billed with 90772 | E&M Codes (preventative, new and established), with the exception of 99211, will not require a modifier 25 when billed with 90772. 99211 will require a modifier 25 to be appended in order to be paid. | September 15, 2008 |

Aetna earns NCQA accreditation for all PPO plans

Our PPO plans have received Full Accreditation from the National Committee for Quality Assurance (NCQA). This recognition makes us the first national insurer to hold NCQA accreditation for all its PPO plans.

We also received Full Accreditation for all 12 Medicare Advantage PPO plans that were submitted for review. For the review, we presented information to NCQA about all facets of our health plan operations, such as:

- Health plan programs, clinical policies, network accessibility and member satisfaction.
- How we help members through clinical programs, pharmacy management, and support and referrals associated with behavioral health issues.

- Our network credentialing process and ongoing quality reviews to help demonstrate our members are receiving high-quality, evidence-based care.
- Member rights, complaint and appeal handling, and privacy and confidentiality.
- Our online consumer health tools including our Personal Health Record, health risk appraisals, claims and pharmacy information, and other web-based consumer tools.

Billing for nerve conduction velocity tests

As a reminder, we will deny claims for nerve conduction velocity (NCV) tests if they are billed without an electromyographic (EMG) test on the same date of service. This is consistent with our current Clinical Policy Bulletin #502.

This policy is supported by the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM). According to the AANEM, standardized nerve conduction studies performed independent of needle EMG studies may miss data essential for an accurate diagnosis.

Find out quickly if you need a precertification

You can now find out in mere seconds if a medical procedure requires precertification by using our online Precertification Code Search Tool.

You'll find the tool on the home page of our enhanced secure provider website via NaviNet. The self-service tool is available at the top of the "Aetna National Participating Provider Precertification List" page in a blue box entitled "Is a precert required by Aetna?"

How to use the code search tool

Simply enter a valid five-digit CPT or HCPCS code. You'll know immediately if precertification is required, and if precertification is required through a delegated organization (MedSolutions, National Imaging Associates, CareCore) and not through Aetna.

The tool searches procedure codes associated with services outlined on our National Participating Provider Precertification List. If a procedure code is not on the Precertification List, it does not necessarily mean the service is covered. Check the patient's eligibility, benefits and plan coverage limits using one of our self-service options:

- From our secure provider website via NaviNet – <https://navinet.navimedix.com/Main.asp>. After signing in, select "Aetna Health Plan" under "Plan Central." From the home page, select "Eligibility" from the left navigation area and "Eligibility and Benefits Inquiry."
- Via our automated telephone voice response system, Aetna Voice Advantage®.



Join those already using the tool

Year-end 2007 results indicated daily usage by more than 700 unique users who checked on at least 7 codes during a website visit. Check out the tool today.

Self-service tools help manage accounts and access claims data

Are you interested in more easily managing your patient accounts? Do you have a question about a claim reimbursement? Instead of calling or writing Aetna, just go online and use these self-service functions to:

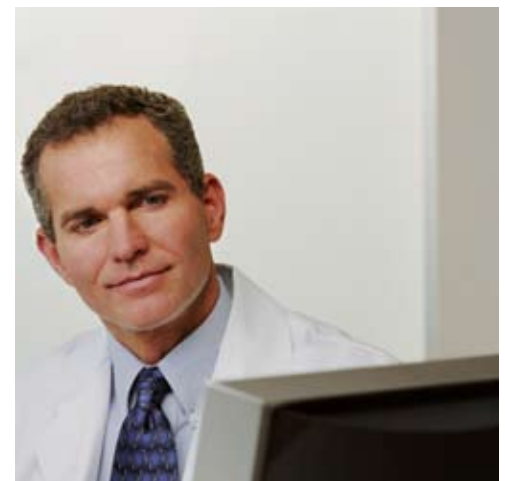
- Help reconcile accounts.
- Identify claims that may not have been paid accurately and submit requests for reconsideration.
- View processed claims results/claims status.
- Review and update patient records.
- Produce administrative, managerial and other reports.
- Audit internal records.

To access these functions, visit our secure provider website via NaviNet and select the "Account Management Tool" link, where you will find:

- **Claim History Report** – Request and receive a customized report* of your claims processed within the last 12 months, with over 50 fields of expense line-level detail.
- **Multiple Claim Reconsideration** – Request reconsideration of 10 or more claims that you believe may have been reimbursed inaccurately for the same systemic reason. You can use this function in conjunction with the Claim History Report to identify the Aetna claim IDs to be reviewed.
- **Claim Reconsideration** – Submit requests for single claim reconsiderations via the eEOB Claim List View, after reviewing recently processed claims online. (Use this function for one-time issues.)

We've also revised our Claim History Report to deliver more information faster and to allow you to limit your request by TIN, PIN, procedure codes, revenue codes, claim status, and service date.

* The report request will normally be processed overnight and is available the next day for download from the website for seven days.



Aetna Voice Advantage adds precert self-service option

You asked and we listened. We've added medical precertification functionality to our automated telephone system, Aetna Voice Advantage (AVA).

The AVA system provides the information you need, when you need it. It's available 24/7 by calling one of our toll-free numbers. Check out these new precertification self-service features:

- *Automated precertification inquiry* – Determine by CPT or HCPCS code if precertification is required. You can check multiple CPT or HCPCS codes during the same call.
- *Documented reference numbers* – An AVA reference number is given when no precertification is required to document your call.
- *Precertification fax-back option* – You can request to receive a fax – including

your AVA reference number – when no precertification is required.

- *Conversational flow* – Your answers to questions posed by AVA flow in the same order as you would provide them to a live representative.
- *Easier navigation* – You can move from precertification self-service to coverage and benefits for the same member or a different member.
- *Smarter call routing* – You receive guidance if precertification is handled by a delegated entity. Or, you will be routed to representatives trained to handle unique situations.

Once you've tried the new precertification self-service option, we'd love to hear your feedback. Send us an email at AVA-Provider@aetna.com.

How to speed up overpayment refund processing

When requesting a refund for overpayment, providing a thorough explanation is one way to avoid delays in the process or having your office do the work twice.

To help ensure credit for a refund is prompt and accurate, please provide the following:

- A copy of our Explanation of Provider Payment (EPP)
- If you don't have a copy of the EPP, send us a copy of the member ID card, the member ID number or claim ID, the patient's name, service date and billed amount
- An explanation of the overpayment
- The billed error
- The charge correction
- The negotiated error fee

- Other insurance carrier payments
- Any duplicate payments received
- Any other information that better explains the refund

If you have questions, please call our Provider Service Center.



Submit facility claims at no charge through Aetna EDI ConnectSM

Did you know you have a free option to submit your hospital and other health care facility claims electronically?

With the Aetna EDI Connect website, you can send all your institutional and professional claims directly to us. The direct-connect site, created specifically for billing systems that submit claims conforming to ASC X12 standards, offers you many advantages:

- No clearinghouse or third-party vendor required.
- No need for data entry on the site.
- No cost to use.

Find out today if Aetna EDI Connect is right for you. View the online tutorial and *Aetna EDI Connect Companion Guide* at www.aetnaedi.com. Or, call 1-877-309-4255.

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

Beginning July 1, 2008, the following drugs will be added to our Pharmacy Management precertification, quantity limit and step-therapy programs:

| DRUG | PROGRAM EDIT |
|-----------------------------|---|
| SUBOXONE | Precertification (for narcotic medications while taking Suboxone) |
| SUBUTEX | Precertification (for narcotic medications while taking Subutex) |
| GLEEVEC | Precertification/Quantity limit (30-day supply per fill) |
| NEXAVAR | Precertification/Quantity limit (30-day supply per fill) |
| REVLIMID | Precertification/Quantity limit (30-day supply per fill) |
| SPRYCEL | Precertification/Quantity limit (30-day supply per fill) |
| SUTENT | Precertification/Quantity limit (30-day supply per fill) |
| TARCEVA | Precertification/Quantity limit (30-day supply per fill) |
| TEMODAR | Precertification/Quantity limit (30-day supply per fill) |
| THALOMID | Precertification/Quantity limit (30-day supply per fill) |
| <i>tretinoin capsules</i> | Precertification/Quantity limit (30-day supply per fill) |
| TYKERB | Precertification/Quantity limit (30-day supply per fill) |
| VESANOID | Precertification/Quantity limit (30-day supply per fill) |
| XELODA | Precertification/Quantity limit (30-day supply per fill) |
| ZOLINZA | Precertification/Quantity limit (30-day supply per fill) |
| MIGRANAL NASAL SPRAY | Quantity limit (1 box [8 doses] every 30 days) |
| PRAVACHOL 40 mg | Quantity limit (1 tablet per day) |
| <i>pravastatin 40 mg</i> | Quantity limit (1 tablet per day) |
| RANEXA 500 mg | Quantity limit (3 tablets per day) |
| TAMIFLU 12 mg/ml suspension | Quantity limit (6 bottles per calendar year) |

UPPERCASE - Brand-name medication
Lowercase *italic* - Generic medication

About these programs

Drugs on the precertification list require prior authorization under benefit plans that include Aetna Pharmacy Management's Precertification program. In cases where you believe it is medically necessary, please submit a medical exception request so Aetna patients may receive coverage for drugs on the step therapy list without trying the prerequisite drug first.

A medical exception is also necessary if patients are to receive coverage for amounts in excess of the indicated quantity limits for drugs on the quantity limit list. For the complete list of drugs requiring precertification or a medical exception, visit www.aetna.com/formulary.

*Step-therapy does not apply in New Jersey and Indiana.

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. Recent content updates include:

Doing Business with Aetna

- Updated Behavioral Health Prevention Programs
- Added 2008 Physician Advisory Board meeting dates and updated link to current Board members

Medicare

- Updated Medicare overview pages for both Aetna Medicare and Medicare Private Fee-For-Service plans

- Added overview of Medicare Prescription Drug Plans
- Added overview of Network and Non-Network Based Medicare Advantage Plans
- Added information on Aetna Golden Medicare Dual Advantage HMO Special Needs Plan
- Under Aetna Medicare OpenSM Plan page, added link to *What Health Care Providers Need To Know About Private Fee-For-Service Plans* and updated Aetna Medicare Open Plan Individual Counties

Precertification

- Updated Erythropoietin Injectable Medication Precertification Request Form

Claims

- Added 2008 AMA/CMS Reimbursement Code Updates

Pharmacy

- Added information on Aetna Rx Home Delivery[®]

Forms Library

- Updated Pediatric Vaccine Record form
- Removed Synagis Precertification Additional Information Request Form

Aetna's Education Site for Health Care Professionals

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

New online course offerings for physicians, nurses and office staff:

| | |
|----------------------------------|---|
| Changing Health Care Marketplace | Consumer-Directed Health Plans |
| Continuing Education | Pandemic Flu CME |
| Office Administration | NaviNet Basics – Aetna's Secure Website Transactions NaviNet Security Officer Features |
| Recorded Events | Aetna Medicare Advantage Plans Recorded Seminar |

In addition to our online courses, we offer Aetna in-service face-to-face sessions and webinars. For upcoming events near you, reference our online calendar.

Order your free *Navigating Your Health Benefits For Dummies* guide

Understanding health benefits can be a challenge for your patients. *Navigating Your Health Benefits For Dummies* is for everyone who needs a guide to take the guesswork out of what can be a confusing subject.

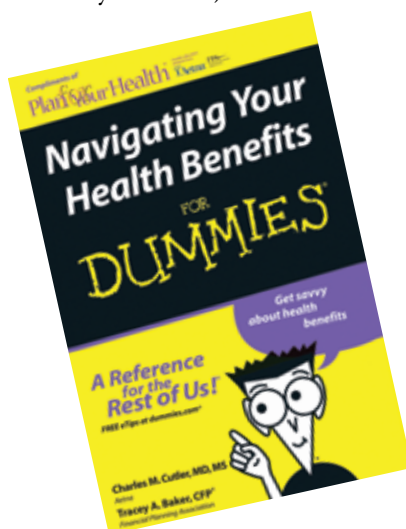
Guide helps patients get savvy about health benefits

We're making copies available at no cost to your office that you can share with patients. The 64-page publication is available in English and/or Spanish and provides easy-to-understand information about health benefits, including:

- Choosing a health plan that fits personal needs.
- Making decisions that match what's happening in one's life.
- Taking advantage of all a plan has to offer.
- Finding a physician or health care professional.
- Appealing a health benefits decision.

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

- Practice name
- Attention
- Street address
- City, state and zip
- Phone number (in case we have a question about your order)
- Quantities
- English and/or Spanish



To access the Education Site and enroll in a course:

- Visit www.aetna.com.
- Log in to our secure provider website. (From the NaviNet® home page, choose "Aetna.")
- Then select the "Education" link.

Physician Focus™

This article, co-authored by Troyen Brennan, M.D., Aetna's chief medical officer, and Donald Liss, M.D., Aetna's Mid-Atlantic regional medical director, is reprinted from Modern Healthcare.

Shared information key to safer health care

Making health care safer is one area where there is vigorous agreement among all constituents: it is critical to improving the quality of life for patients and should reduce medical costs.

Insurers also have a role to play in improving safety. Access to a broad array of data on the member's health enables us to signal providers and our members about potential gaps in care by leveraging technology, especially through the member's personal health record. But we also contribute by creating incentives as part of the way we pay for care. As a member of The Leapfrog Group, we are encouraging hospitals to adopt those processes proven to reduce errors, to establish a culture which makes patient safety fundamental to the operation of the facility and to report Never Events identified by the National Quality Forum (NQF).

Last month we announced our next step – the development of 'never events' language, based on the NQF list, for our hospital contracts. When we negotiate a new hospital agreement or renegotiate an agreement with a hospital already in our network, we will seek to add this provision. The NQF list is clinically credible and has been vetted through a rigorous review process by multiple health care stakeholders.

The language in our contracts calls for hospitals to report the medical error to at least one of the following agencies within 10 days of becoming aware it has occurred: The Joint Commission, state reporting programs for medical errors, or patient safety organizations. Hospitals also are asked to take action to prevent future events, waive all costs related to a serious reportable event ("never event"), and apologize to the patient and/or family affected by the never event.

While the professional commitment of highly skilled hospital staff and physicians is clearly the most fundamental force promoting patient safety and improvements in care, an unambiguous and real contract provision can only serve to reinforce hospitals' focus on reporting medical errors, consistent with our belief that shared information and transparency are keys to better care.

And we aren't alone. More than 600 hospitals already have demonstrated leadership by voluntarily agreeing to report never events.

The Centers for Medicare and Medicaid Services has of course taken a further step, moving from the NQF list of never events, all of which are clearly errors that should never occur, to refusing to pay for common iatrogenic injuries that are in some cases preventable. We are not persuaded that that this broader approach will have the same effect on encouraging a culture of safety that the focus on never events does.

In summary, no one wants medical errors to happen. We believe it is time for a cultural shift in how safety issues are approached in our health care system. Performance measurement, public reporting and financial incentives are some of the levers that can promote this shift. We hope this strategy will lead to broader adoption of quality measures and reporting and encourage others in health care to support this effort.



More than 600 hospitals already have demonstrated leadership by voluntarily agreeing to report never events.



Plan Facts and Features

How Medicare Part D vaccines are paid

As of January 1, 2008, the cost and the administration fee associated with a vaccine covered under Medicare Part D are now paid under Medicare plans that offer Part D. This is a change from 2007.

This payment policy applies when a member is enrolled in an Aetna Medicare plan that offers Medicare Part D coverage (either a PDP or MA-PD plan) and when the member obtains a Part D vaccine that is included under his/her plan formulary. The cost-sharing responsibility will be based on the member's Part D benefits plan, as well as on where the Part D vaccine is obtained and given.

- When a member receives a Part D vaccine at a participating pharmacy, the member's cost sharing is determined at the point of sale.

- If a member receives the Part D vaccine from a medical provider or from a nonparticipating pharmacy, the member will pay for the Part D vaccine and the associated vaccine administration fee at the point of sale. They will submit a claim to Aetna for reimbursement of both the vaccine and the associated vaccine administration fee.

We've posted more detailed information online, including a chart indicating which vaccines are covered under Medicare Part B versus Part D plan coverage. Please visit the Aetna Medicare section of our secure provider website for more details.

Medication management program supports compliance, promotes patient safety

We participate in a Medicare Medication Therapy Management Program (MTM Program), as required by the Centers for Medicare and Medicaid Services (CMS) for health plans that offer coverage under Medicare Part D. The MTM program:

- Encourages the appropriate use of covered Medicare Part D drugs;
- Promotes optimal therapeutic outcomes and better medication compliance; and
- Helps reduce the risk of adverse events.

We select members for the MTM program based on CMS parameters, and include those who have a chronic disease of high morbidity, high prevalence or management complexity.

Outreach to physicians and members

If we identify potential drug-related issues, we alert the member and all of their prescribing physicians. Outreach may include coordinating pharmacist education,

calling the appropriate physician(s), and/or referral to a social worker or case manager.

Review these patient safety tips

- Explain drug duplications: When writing a new prescription to replace an existing therapy, indicate which medication the patient should discontinue.
- Encourage medication compliance: Caution patients about the importance of medication compliance and consider their compliance history when making therapy selections.
- Consider drug interactions: Consider the interactions of all medications a patient may be taking. The dynamics of the medication may change with the patient's age or health status.



Changes to guidelines for Aetna Medicare Open Plan

The Aetna Medicare Open Plan is a Private Fee-for-Service (PFFS) plan. Before providing covered services, you should review the most current Aetna Medicare Open Plan Terms and Conditions of Participation and Reimbursement Grid ("Terms and Conditions").

Aetna has established a policy to limit changes to our Terms and Conditions. Except as noted below, if changes are required to the Terms and Conditions, we will generally make these updates at the beginning of each quarter. Any updates will include a brief summary of the information that was changed.

Between quarterly updates, we may be required to make immediate changes to the Terms and Conditions to:

- Ensure compliance with Medicare laws, rules or regulations,
- Follow instructions from the Centers for Medicare & Medicaid Services (CMS), or
- Confirm that our Terms and Conditions are clear and accurate.

We've posted the Terms and Conditions on our secure provider website. If you do not have access to the website, you may request a copy of our Terms and Conditions by calling our Provider Service Center.

Striving for Quality Excellence

HEDIS® 2008 data collection efforts under way

Aetna staff, or our contracted representatives, may contact your office to obtain needed medical record information for our annual Healthcare Effectiveness Data and Information Set (HEDIS) reporting.

What we may need from you

We analyze administrative data, such as medical and pharmacy claims and laboratory data, for the majority of HEDIS reporting. When we can't get information from administrative data – such as a lab test result – we may ask your office to help us obtain the necessary information directly from a patient's medical record.

In collecting this information, we may ask you to fax or mail certain information to us, or our representative may schedule an appointment to visit your office to photocopy medical record information.

Meeting HIPAA guidelines

Providing medical record information for HEDIS data collection is compliant with HIPAA regulations. We handle all information confidentially and use it only in the aggregate. HIPAA Privacy Rules permit the use and disclosure of protected health information without a member's authorization if the use or disclosure falls within the defined scope of payment, treatment or health care operations, including accreditation activities (for example, HEDIS data collection).

Collection of HEDIS information enables us to accurately measure the quality of care our members receive and to identify opportunities for ongoing quality improvement.

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

Tools to enhance physician-patient communication

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

Behavioral Health form

The Behavioral Health/Medical Provider Communication form makes it easier for medical providers to share information about a patient's treatment plan with behavioral health providers, and vice versa. Providers can use the form to pass on detailed information about a patient's diagnosis, medications and risks/concerns. You can find the form on our secure provider website in the Forms Library.

Member flyer promotes information sharing

The "Make the Connection" flyer encourages members to share their health information with their medical and behavioral health providers. It outlines the specific steps members can take to become more active participants in the communication process. The flyer is posted on our secure provider website on the Aetna Behavioral Health page. We encourage you to make copies of this flyer to share with your patients.



Consult Clinical Practice and Preventive Service guidelines as you care for patients

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 nationally recognized recommendations and peer-reviewed medical literature. You can find them on our secure provider website. Once logged in, select “Clinical Resources.”

| | |
|---|---|
| <ul style="list-style-type: none"> Preventive Service Guidelines | Adopted 1/08 |
| ASTHMA <ul style="list-style-type: none"> Treating Patients With Asthma | Updated 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 | Updated 1/08 Adopted 5/06 Adopted 5/06 Adopted 5/06 |
| DIABETES <ul style="list-style-type: none"> Treating Patients With Diabetes | Updated 3/07 |
| 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 Updated 11/06 Adopted 5/06 Last reviewed 5/06 |
| <ul style="list-style-type: none"> Depression Component of Clinical Practice Guideline for Diabetes | Updated 3/07 |

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

Hospitals: Support patient safety through Leapfrog survey

We encourage all of our participating hospitals to participate in The Leapfrog Group survey this year. Completing the survey helps give consumers valuable information about how your hospital addresses patient safety. The survey will be made available to hospitals on April 1, 2008.

2008 Leapfrog survey changes

As you complete the survey, please be aware of these changes to the 2008 survey:

- Hospitals with a Computer Physician Order Entry (CPOE) system will be asked to participate in a simulation test of the system.
- There are revisions/changes to some of the Evidence-Based Hospital Referral (high-risk) procedures.
- The National Quality Forum Safe Practices section focuses on just 13 safe practices (versus 30 previously).
- A new section focusing on two common acute conditions – acute myocardial infarction and pneumonia.
- Another new section focuses on two hospital-acquired conditions – pressure ulcers and injuries occurring during the stay.
- Hospitals are asked to attest their support of the Never Events policy via the survey.

Take the survey online

You can access the Leapfrog Hospital Quality and Safety Survey at www.leapfroggroup.org/for_hospitals. We also have a link to The Leapfrog Group website on DocFind®, our online provider directory.

Leapfrog survey results are available online

You and your Aetna patients can view Leapfrog survey results on DocFind®, our online provider directory, or through the Hospital Comparison Tool available on Aetna Navigator™, our member website. We update this information as Leapfrog releases updated survey data.

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, view your fee schedule online by logging in to our enhanced secure provider website. From the NaviNet home page, select “Claims” from the left navigation bar, and “Fee Schedules” from the drop down menu.

- If your hospital is reimbursed through Medicare Groupers, visit the Medicare website at <http://cms.hhs.gov/default.asp?fromhcfadotgov=true> for your fee schedule information.

If you have additional questions about your fee schedule, please call our Provider Service Center.

For more information

Visit www.dmhc.ca.gov/ and selecting “Providers”, then “General Information,” “Laws” and “Existing Regulations.”



Reminder: After-hours access standards

We recently measured member satisfaction with after-hour access to care (2007 CAHPS® Health Plan Survey 4.0H) and an after hours survey of physician offices. The physician offices contacted were evaluated on the following:

- Providing clear, explicit instructions on what to do in an emergency.
- Providing directions on what to do for urgent and non-urgent situations.
- Informing callers that the time for a return call by a practitioner would be no greater than 30 minutes.

The suggested standard is to have a reliable 24-hour, 7 days-a-week answering service or machine with a beeper or paging system that would provide members with explicit directions.

To help providers try and meet the 100% performance goal standard, we reminded those who did not meet the goal of the importance of proper after-hours messaging. We then resurveyed those offices to determine compliance.

Please take this opportunity to review and update your message for appropriate instructions to members.





CPE RS51
151 Farmington Ave.
Hartford, CT 06156

Contact us at: OfficeLinkUpdates@aetna.com

Please 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 of California Inc., Aetna Life Insurance Company and Corporate Health Insurance Company and Strategic Resource Company.

National Provider Identifier (NPI): Noncompliance may affect your cash flow

NPI is here. NPI is now. Are you using your NPI in electronic transactions?

If you aren't, be prepared for the costly, time-consuming consequences. To comply with the federal regulation, we must reject noncompliant claims and real-time transactions after the impending deadline. Rejected transactions result in more work and aggravation for your office staff and may interrupt your cash flow.

What NPI compliance means

As of May 23, 2008, which is the NPI enforcement date, HIPAA standard electronic transactions must include NPIs and cannot include legacy

identifiers. Transactions that don't have an NPI or that include a legacy provider identifier will be rejected and returned as unprocessable.

Tax IDs are still required on claims.

Share and use your NPI now

If you haven't gotten your NPI already, you're well behind schedule, as the original deadline for obtaining an NPI is long past.

You can use your NPI immediately on Aetna claims. However, we can only accept your NPI in real-time transactions if it has been previously shared with us and entered into our

database. Otherwise, the transaction will fail.

Immediate NPI use will identify any issues, allowing time for resolution prior to the enforcement date.

If you haven't shared your NPI with us, do so immediately. Visit www.aetna.com; choose "for Health Care Professionals," then "NPI."