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Aetna OfficeLink Updates™

Mid America Region

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Options to reach us

- Go to **www.aetna.com**
- Select "Health Care Professionals"
- Select "Medical Professionals Log In"

Or call our Provider Service Center:

- **1-800-624-0756** for HMO-based benefits plans, Medicare Advantage plans and WA Primary Choice plan
- **1-888-MDAetna (1-888-632-3862)** for all other plans

One-year delay proposed for ICD-10 compliance

The Department of Health and Human Services (HHS) recently announced a proposed rule that will delay the ICD-10 compliance date for one-year, from October 1, 2013 to October 1, 2014.

This is subject to a 30-day comment period. Based on this announcement, we continue our ICD-10 program work and plan to be ready to process ICD-10 claims by October 1, 2014.

Learn more:

- Read the HHS **announcement**.
- View the **proposed rule**, which is subject to a 30-day comment period.
- Visit **Aetna's website** for current information about our ICD-10 approach.

We encourage you to:

- Continue working toward compliance.
- Use this one-year extension to address any business or system challenges.
- Contact your billing or software vendor to understand their conversion and testing plans.

Facilities: submit procedure code in box 74

When submitting claims, it is important to use valid ICD procedure codes. We will reject claims with invalid ICD procedure codes in box 74 (reason code C34).

This field should be used for inpatient stays with surgery. Otherwise, leave box 74 blank – without any code or date. After the conversion to ICD-10, you can still leave box 74 blank if there is no inpatient stay with surgery.

Help your patients understand their procedure location options

The amount of coinsurance Aetna members are responsible for can vary dramatically depending on where a particular service is performed.

In some cases, there may be a significant difference in out-of-pocket cost between one network facility and another. This is especially true for procedures such as:

- Diagnostic radiology
- Scope procedures
- Outpatient ambulatory surgery

To help your Aetna patients save money, we urge you to discuss their location options with them when sending them for procedures at an outpatient hospital or surgery center. As a reminder, you should refer them to in-network facilities whenever possible.

Policy and Coding Updates

Clinical payment, coding and policy changes

We regularly adjust our clinical, payment and coding policy positions as part of our ongoing policy review processes. In developing our policies, we may consult with external professional organizations, medical societies and the independent Physician Advisory Board, which provides advice to us on issues of importance to physicians. The accompanying chart outlines coding and policy changes:

Procedure	Implementation date	What's changed
Per day limits	3/25/2012	Per day limits apply to the following codes effective 3/25/2012: 4 units per date of service (2 per side – RT, LT) for: • L2430 – addition to knee joint, ratchet lock for active and progressive knee extension, each joint. 6 units per date of service (3 per side – RT, LT) for: • L2850 – addition to lower extremity orthosis, femoral length sock, fracture or equal, each.
Flexible fiber optic endoscopic evaluations	3/25/2012	We will allow the professional component (92613, 92615, or 92617) of a flexible fiberoptic endoscopic evaluation when billed on the same date of service as the technical component (92612, 92614, or 92616).
95900 and 95903 – nerve conduction, amplitude and latency/velocity study, each nerve; motor, with/without F-wave study	3/25/2012	95903 will be allowed when billed with 95900. Modifier 59 will override the edit.
G0269 - placement of occlusive device into either a venous or arterial access site, post-surgical or interventional procedure (e.g. angioseal plug, vascular plug)	9/1/2012	The placement of an occlusive device/collagen plug is considered incidental to the primary procedure and not separately payable.
Arthroscopy	9/1/2012	Modifier 59 will no longer override 29862 and 29863 when billed with 29914, 29915 or 29916.
K0739 – repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes	9/1/2012	K0739 will be allowed 16 times per date of service.
80102 – drug confirmation, each procedure 82145 – amphetamine or methamphetamine	2/26/2012 – all states and DC, except Texas 9/1/2012 – Texas only	The following per day limits apply to the drug screening codes: • 80102 – 4 units per date of service • 82145 – 2 units per date of service
Per day limits	9/1/2012	Per day limits will apply to the following codes effective 9/1/2012: 2 units per date of service (1 per side - RT, LT) for: • L8499 – unlisted procedure for miscellaneous prosthetic services. 6 units per date of service (3 per side - RT, LT) for: • L8417 – prosthetic sheath/sock, including a gel cushion layer, below knee or above knee, each. • A5512 – for diabetics only, multiple density insert, direct formed, prefabricated, each. • A5513 – for diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, includes arch filler and other shaping material, custom fabricated, each.

Procedure	Implementation date	What's changed
Clarification of multiple therapy procedures concurrency payment rate formula	Policy clarification	The therapy service with the highest practice expense (PE) RVU will be paid at 100 percent. Any subsequent therapy service performed on the same day is paid as follows: {[(Transitioned Non facility Practice Expense RVU x 0.80) + Malpractice RVU + Work RVU] / Total RVU} * contracted rate = payment rate
Epidurals and transforaminal injections for sciatica and radiculopathy	9/1/2012	Epidurals and transforaminal injections will only be allowed for diagnoses of radiculopathy or sciatica. Refer to **Clinical Policy Bulletin #0722 (Selective Nerve Root Blocks) and #0016 (Back Pain - Invasive Procedures)** for more information.
93975 – duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	9/1/2012	We consider uterine artery Doppler studies (CPT code 93975) to be experimental and investigational for the assessment of average-risk or high-risk pregnancies. Therefore, you may see claims denials as a result of this policy. Coverage criteria, including the ineligible diagnosis codes, are in **Clinical Policy Bulletin #0088**.
Medicare Status Code T	9/1/2012	Codes designated with a status code T (injections) on the Medicare Physician Fee Schedule are not payable when billed by the same provider on the same date of service as any other service.
95937 – neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method	9/1/2012	We consider neuromuscular junction testing as experimental and investigational when billed with the following spinal surgery codes: • 22010 – 22855 • 62263 – 63746 • 64470 – 64484 • 64561 • 64581 • 64622 – 64627 • 64772 Refer to **Clinical Policy Bulletin #0697** – Intra-operative Monitoring of Electromyography – for more information.

Correction: CAMBIA not subject to step therapy

The 2012 Aetna Preferred Drug Guide incorrectly listed CAMBIA as requiring step therapy, with a trial of sumatriptan first.

CAMBIA is not subject to step therapy, and physicians do not have to prescribe sumatriptan before Aetna members can try CAMBIA. Visit our **formulary** for up-to-date information.

Integrated Genetics/Integrated Oncology no longer in our network

Integrated Genetics/Integrated Oncology (IG/IO) (formerly known as Genzyme Genetics and Esoterix Genetic Laboratories) became out of network for Aetna members effective April 15, 2012. This was a result of the sale of IG/IO to LabCorp®, an out-of-network provider for Aetna members.

Quest Diagnostics is a preferred in-network laboratory offering genetic services.

As an alternative, Quest Diagnostics offers extensive genetic lab and counseling services that include testing for:

- Common genetic disorders (for example, CF, Fragile X and SMA)
- Rare genetic disorders (for example, Tay-Sachs, Huntington, Familial Dysautonomia)
- Genetic causes of autism and developmental delays
- Down Syndrome and other chromosomal disorders
- Many cancers
- Pharmacogenetics to help guide treatment decisions

Call Quest Diagnostics' provider line at **1-866-GENE-INFO (1-866-436-3463)** to request specific test information or a consultation, or go to **Quest Diagnostics** for more information.

Precertification required for outpatient infusion

Beginning July 1, 2012, we will require precertification for outpatient infusion of the following three drug classes:

- Infusion of Enzyme Replacement drugs – Call **1-866-503-0857**
- Infusion of Immunoglobulin (IVIG) drugs – Call **1-866-503-0857**
- Infusion of (Hemophilia) Blood Clotting Factor drugs – call the number on the member's ID card

More resources

- For infusion of Enzyme Replacement and IVIG, you can find the Precertification Request for Injectable Medication and/or Outpatient Infusion Services form on our **secure provider website** (after June 15, 2012).
- Once logged in, select "Aetna Support Center" then "Forms Library."
- You can also fax the form to **1-888-267-3277**.

If you have questions, call the numbers listed in this article.

Where to see our Medicare and Commercial formularies

We update the Aetna Medicare and Commercial (non-Medicare) Preferred Drug Lists, also known as our formularies, at least annually and from time to time throughout the year.

- View our **Medicare Formulary**.
- View our **Commercial Preferred Drug List**.

For a paper copy of these guides, call **1-800-AetnaRx** (**1-800-238-6279**).

Web browser compatibility issues?

If you are using Internet Explorer 8 and experience any instances of words overlaying each other in your e-mail version of Aetna OfficeLink Updates, there is a simple fix. Go to the "Tools" bar on your browser and click on "compatibility view."

New rules will make electronic transactions easier

The electronic transactions that providers use to receive administrative information from health plans are becoming more standardized.

Under the Administrative Simplification provision of the Affordable Care Act (ACA), all health plans must implement operating rules for the standard electronic transactions required by HIPAA, including:

- Eligibility and claim status transactions (new rules take effect January 1, 2013)
- Electronic funds transfer (EFT) and advice (ERA) (January 1, 2014)
- A unique identifier for each health plan (October 1, 2014)
- Health claims/encounters, enrollment/ disenrollment, referral certification and authorization (January 1, 2016)

Reducing costs

Once all health plans are using the same operating rules, it should be easier for you to get the accurate information you need from us, resulting in lower costs for you.

Aetna intends to fully comply with all parts of the Administrative Simplification requirements. We already offer all of these transactions and, with limited exceptions, also follow the published and anticipated operating rules. We are making adjustments where needed so our transactions are consistent with the new national rules.

For more information on these transactions, go to the **Claims & Administration** section of our website or to our **Health Reform Connection** website.

Use appropriate NDC code for contraceptive claims

When submitting claims for contraceptives, it is important to include the appropriate NDC code.

Under the Affordable Care Act (ACA), most health plans will be required to cover contraceptives with no member cost share when the plan renews or becomes effective on or after August 1, 2012.

The NDC code for all prescriptions helps Aetna identify which claim submissions are for contraceptives. Including the appropriate code will help ensure that we cover the appropriate contraceptives without applying member cost share for a plan that is subject to the woman's preventive requirement of the ACA.

If the NDC code is missing, then Aetna will deny the claim due to missing information (where permitted).

Primary care practices

Take our Integrated Primary Care Behavioral Health Program survey

Through our Integrated Primary Care Behavioral Health Program, you can offer members access to behavioral health services onsite in your primary care practice. A behavioral health clinician provides brief, problem-solution focused intervention.

We invite you to **take a short survey** to share your preferences and/or experiences about offering onsite behavioral health clinician services.

If you'd like to explore making co-located behavioral health services available to patients in your practice, visit our **Integrated Primary Care Behavioral Health** website or **e-mail us**.

Learning Opportunities

Aetna's Education Site for Health Care Professionals
Log in or register at **www.AetnaEducation.com**.

New and updated courses for physicians, nurses and office staff

Patient Education Programs

- Updated Estimate the Cost of Care

Reference Tools

- Updated Health Literacy: More About Health Literacy

Check out these four new and valuable genetics courses

Recent advancements in genetic medicine are helping physicians more effectively diagnose disease, predict risk, and direct and personalize treatment for a range of diseases.

Our new Genetics course catalog is home to four diverse offerings about genetic counseling. They all share a primary goal – to help you learn more about the role that genetic counseling and genetic technologies can play in supporting you and your patients.

Physicians, nurses and other health care professionals can benefit from the education offered in these courses and tools. In Genetics in Clinical Practice: A Team Approach (CME)*, physicians can even earn *12 AMA PRA Category 1 credit(s)*™ toward the AMA Physician's Recognition Award.

Whether it's a brief video or an interactive course, you're sure to learn a lot from these new offerings in our Genetics catalog.

To get started, log in or register at our **Education Site** and select the Genetics Course Catalog.

*Genetics in Clinical Practice: A Team Approach

This educational activity is sponsored by the American Medical Association (AMA). The AMA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing education programs for physicians. This program was planned and produced in the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME).

The AMA designates this continuing education activity for a maximum of 12 *AMA PRA Category 1 credit(s)*™ toward the AMA Physician's Recognition Award. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Consult Clinical Practice Guidelines as you care for patients

The National Committee for Quality Assurance (NCQA) requires health plans to regularly inform providers about the availability of Clinical Practice Guidelines (CPGs).

Our CPGs and Preventive Service Guidelines (PSGs) are based on nationally recognized recommendations and peer-reviewed medical literature. They are located on our **secure provider website** under "Aetna Support Center" then "Clinical Resources."

Preventive Service Guidelines	Adopted 2/12
***USPSTF Cervical Cancer Screening**	Adopted 3/12
Behavioral Health	
• Helping Patients Who Drink Too Much	Adopted 2/12
• Treating Patients With Major Depressive Disorder	Adopted 2/12
Diabetes	
• Treating Patients With Diabetes	Adopted 2/12
Heart Disease	
• Treating Patients With Coronary Artery Disease	Adopted 3/12

*US Preventive Services Task Force

For a hard copy of PSGs, or a specific CPG, call our Provider Service Center.

Download our **course catalog** and explore our wide range of courses.

Mid America News

Preferred vendors for ancillary services can save patients money

We offer many preferred providers that can help you coordinate patient care easily for ancillary services such as:

- Home health
- Infusion
- Hospice
- Skilled Nursing Facilities (SNF)
- Transportation
- Physical, occupational and speech therapy

Contact information

- For home health, infusion or hospice services in Ohio and Michigan, call CSI Network Services at **1-888-873-7888**.
- For SNF services in Ohio, Michigan, Illinois, Indiana, Kentucky, Kansas, Missouri, Texas, Oklahoma, South Dakota, and Wisconsin, call Management and Network Services at **1-800-949-2159**.
- For ground and wheelchair transportation in Ohio, call Cooperative Health Partners at **1-800-547-2642**. Fax referrals can be sent to Cooperative Health Partners at **1-937-325-9522**.
- For physical, occupational or speech therapy in Ohio, call Rehab Provider Network at **1-888-256-2248**.
- For physical, occupational or speech therapy in Kansas (HMO only), – call American Therapy Administrators at **1-888-560-6855**.

Visit DocFind®

Visit our **DocFind** online provider directory to find other participating providers for these, and other ancillary services.

Note: By choosing participating providers, you may save your patients out-of-pocket costs, guarantee services are performed by credentialed providers, and ensure compliance with your Aetna agreement.

Ohio

Individual Medicare HMO plans require referrals

Effective January 1, 2012, your patients residing in the state of Ohio who are enrolled in an individual Aetna Medicare Advantage (MA) HMO plan no longer have an open-access plan.

Therefore, their individual Aetna MA HMO plan now requires them to get a referral from their participating primary care provider (PCP) to see a specialist. Aetna continues to offer some open-access group Aetna MA HMO plans.

What this means to you

You should confirm whether your patient is enrolled in an Aetna MA HMO plan that requires a referral to see a specialist. If a referral is required:

- **PCPs:** When referring your Aetna MA HMO plan patients to see a specialist, you must submit an electronic referral.
- **Specialists:** If your Aetna MA HMO plan patient does not have a referral, immediately contact the patient's PCP and ask that physician to submit an electronic referral.

Notice of Material Amendment to Contract

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

- Clinical payment, coding and policy changes – pages 2-3
- Precertification required for outpatient infusion – page 5
- Individual Medicare HMO plans require referrals – page 7

Ohio, Oklahoma

Savings Plus network now available

The Savings Plus hospital and physician network is now available in Ohio and is targeted for July 1 in Oklahoma. We have notified all designated Savings Plus providers in both states of their status. Aetna members with Savings Plus plans get the highest benefit, reducing out-of-pocket costs when receiving care from Savings Plus providers. The Savings Plus network is available in Ohio and Oklahoma to employers who are looking for plans to better control overall medical costs.

Texas

We update immunization/Rx rates quarterly

Each year, we adjust our immunization/Rx rates. This happens four times a year – January 1, April 1, July 1 and October 1. These rates are based on the Average Sale Price (ASP) and apply to all Aetna plans. You can access these rates on our **secure provider website**. Once logged in, select "Claims" then "Fee Schedules." Or, call our Provider Service Center.

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How to update your demographic information

It's easier than ever to update or correct your office's or facility's phone and fax number(s), mailing addresses and e-mail addresses.

Use our new "**Request Changes to Provider Data**" form. It's located on our DocFind provider directory.

Updating this information will help ensure that you receive important information we distribute – whether it's by e-mail or on paper. It also will provide patients who use DocFind with the most up-to-date and accurate information about where you're located or how to reach you.

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.

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