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Aetna OfficeLink Updates™

Mid-America Region

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Options to reach us

- Select **Health Care Professionals**
- Select "Medical Professionals Log In"

If you have more questions after viewing the information online, call us:

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

We're changing the way we pay providers

Aetna is moving to electronic funds transfer (EFT) as our exclusive payment method. If you're still receiving paper checks from us, we urge you to enroll in EFT if you haven't done so already.

EFT is a secure transaction where we transmit payments directly from our bank account to yours. It works in the same way as the direct deposit of paychecks and income tax refunds.

How this change affects you

We'll be rolling out EFT enrollment in stages. You might get a letter from us soon asking you to enroll.

After you enroll, we'll stop sending your paper Aetna Explanation of Benefits (EOBs) statements. Instead, you can access them on our secure provider website on NaviNet®. **Register** for the site or **log in**, and you'll be able to download EOBs to your computer, print and save them.

How to enroll

You can enroll using the **EFT Enrollment utility** from the Council for Affordable Quality Healthcare® (CAQH). Even if you currently use CAQH for credentialing you'll still need to register separately for the tool using the "Register Now" button.

Benefits of EFT:

- You'll get paid up to a week faster than paper checks
- Your office will have less paper to track

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Updates to our National Precertification List

The following changes to Aetna's National Precertification List (NPL) are effective as noted below.

Reminders

- Effective March 3, 2014, oral appliances don't require precertification.
- Effective May 9, 2014, Precertification for Vimizim™, a new-to-market enzyme replacement drug, is required.

View more information about **precertification** on the 2014 Participating Provider Precertification List ("General information").

Policy and Coding Updates

Clinical payment, coding and policy changes

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

Procedure	Implementation date	What's changed
DME and places of service	9/1/2014	DMEPOS items are only covered when billed in a covered place of service as listed in the CMS DME Supplier Manual. DME rented for use in a facility place of service will not be paid.
DME delivery, setup and dispensing (A9901)	Reminder	DME delivery is considered part of the total payment rate and won't be covered when billed separately.
Drug testing and drug assay frequency	Reminder	There are daily and annual frequency limits on qualitative drug screens and quantitative drug assays. Refer to the "Frequency Limits – Drug Testing & Therapeutic Drug Assays" payment policy on our **secure provider website** under the Claim Payment and Coding Policies section for more information.
Once per lifetime procedures and tests	Reminder	Certain procedures and tests can only be performed once per lifetime.
Teriparatide (Forteo) – HCPCS J3110	Reminder	The effects of long-term treatment with teriparatide are not known at this time. Therapy for more than two years is considered experimental and investigational. Refer to **Clinical Policy Bulletin** (CPB) #0666 – Teriparatide (Forteo) for more information.

Updated clinical policy: osteoarthritis of the knee

We've updated our clinical policy for Osteoarthritis of the Knee – Selected Treatments. The new policy states that we consider arthroscopic partial meniscectomy experimental and investigational for degenerative meniscal tears.

When to use this policy

Refer to this updated policy to:

- Determine if these procedures are medically appropriate for our members.
- Verify that a member meets medical necessity criteria before you perform the procedure.

Read the full **Clinical Policy Bulletin** (CPB) #0673.

We're changing the way we pay providers Cont. from page 1

- You'll no longer need to track down lost paper checks
- Direct deposits to your account eliminate trips to the bank
- Peace of mind knowing you'll get paid even in the case of inclement weather or natural disasters, which can affect regular mail delivery

Don't use CAQH? Print an **EFT enrollment form** and then fax the completed form to us with your bank account information.

Questions?

E-mail us using the **Contact Us** link on our website.

Check out our new, easier to use website

You may have noticed that we made some big changes to the **Health Care Professionals** (HCP) section of our **aetna.com** website.

Although the site looks different, everything you need is still there. And it's easier than ever to find whatever information you're looking for.

Now with just one click, you can view information that you've come to rely on – such as our precertification lists, clinical policy bulletins and medication formularies. The changes are part of a full redesign of Aetna's website that began last year.

New sections

We built the navigation of the HCP hub on what you said is most important to your day-to-day work. Using that feedback, we created new sections that combine similar materials in one location, including:

- **Manuals** – This section contains our Office Manual for Health Care Professionals (formerly called the Health Care Professional Toolkit). You no longer have to log into our secure site to access the Office Manual. Same goes for our Aetna Benefits Product guide, and our Behavioral Health and Women's Health manuals.
- **Forms** – We put all forms – including those relating to Medicare, injectable medications and claims – in one place.
- **Insurance regulations by state** – Certain regulations or requirements specific to your state are available through a state-by-state pull-down menu.
- **Newsletters** – You can read current and past issues of *Aetna OfficeLink Updates* and *Behavioral Health Insights*.

The website is user-friendly on all devices – PCs, laptops, tablets and smart phones. We hope you'll bookmark the **HCP** section and use it often.

Two changes expected for Aetna Student Health

We want to make you aware of two anticipated changes later in 2014 that may affect your Aetna Student Health (ASH) members.

- **Adoption of Aetna's National Precertification List (NPL)** – This **ASH Information Bulletin** has more details and a list of services that will require precertification for ASH members.
- **Adoption of Aetna's code editing system** – You may notice that payment of certain CPT codes that were paid or denied previously may be affected with this coding change. Visit our **secure provider website** for details on Aetna's claim policies and procedures.

Questions? You can call us at **1-888-632-3862**.

View and update your profile online today

It's important that you keep your office's profile up to date. Members rely on our provider directories for access to current provider information, such as:

- Provider name
- Address
- Phone number
- Languages spoken
- Gender

Members need accurate information to select, contact and visit participating providers. Regulators require health plans to make sure their provider directories are up to date because inaccurate or incorrect information can cost members time and money.

To update your office's profile, use our **secure provider website**. The site is easy to use. It lets you confirm the information you submit and it prevents unauthorized individuals from submitting wrong information about your office or facility.

Electronic transactions

You also can do most electronic transactions through this website. This includes submitting claims, checking patient benefits and eligibility, and requesting precertifications.

Your office's or facility's NaviNet Security Officer has access to Aetna's "Update Provider Profiles" function, through which they can submit demographic changes. They also can authorize other users' access to this feature as appropriate. To use the secure website you must first **register**.

ICD-10 compliance date delayed until 2015

On April 1, 2014, President Obama signed the "Protecting Access to Medicare Act." It addresses a variety of health policy issues. One of those issues is a delay in the transition from ICD–9 to ICD–10 code sets. The law states:

The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)) and section 162.1002 of title 45, Code of Federal Regulations.

Despite this delay, we'll continue working on our ICD-10 projects. This will help ensure that our impacted systems and vendor tools, business processes and policies will be ready for the new compliance date. We will test with targeted providers throughout 2014 and 2015. Watch for information on our testing results later this year.

Finally, we'll follow guidance from the Department of Health and Human Services and Centers for Medicare & Medicaid Services as it becomes available. We'll work closely with the medical community to monitor compliance and manage risk.

Refer patients to in-network dialysis centers

When your patients need dialysis treatments, there is a lot of information to consider. As an in-network provider, keep the following in mind when choosing a dialysis center:

- Your provider contract generally requires you to refer patients to in-network facilities.
- Participating facilities are more affordable and can help members save money.
- If you are currently affiliated with a dialysis center that isn't in our network, let us know. We'll work with you and your patients to find an in-network center.
- If you need help getting a member into a participating facility, call the precertification number on the member's ID card.

Find in-network centers

To see other participating centers:

- Go to our **online provider referral directory**.
- Under "Search for" select "Dialysis."

Medicare

New EOB process may cause payment delays

Aetna Medicare members used to receive a separate Explanation of Benefits (EOB) for each claim. Now they receive a monthly statement that summarizes all the claims we handled for them during the prior month.

This new process may cause a slight delay in these patients paying their share of claims to your practice.

Have questions about Health Care Exchanges? Go to our **Health Reform Connection** website. Don't hesitate to mention this site to your Aetna patients too.

Report all patient safety events to Aetna

We've expanded our Patient Safety Event policy to include two additional adverse events.

For all patient safety events, each facility is responsible for reporting these conditions to Aetna. Call our Provider Service Center to make a report.

What's changed?

Our list of patient safety events now includes:

- Surgical site infection following cardiac implantable electronic device (CIED)
- Iatrogenic pneumothorax with venous catheterization

To view the list, log in to our **secure provider website**. Once logged in, choose Claims → Policy Information (Step 3) → Claim Payment and Coding Policies. Then search by "P" for "Patient Safety."

Why we made this change

We revise our Patient Safety Events policy based on Centers for Medicare & Medicaid Services guidelines and National Quality Forum updates.

These events are potentially avoidable conditions that could reasonably have been prevented through application of evidence-based guidelines. The conditions aren't present when the patient is admitted to a facility. Or they're the sole reason for the admission.

Electronic Transactions

We've updated our online claim form

We've updated our online claim form located on our **secure provider website** to match changes made to the CMS-1500 paper claim form.

You can access the form by clicking on "Claims" then "Claim Submission" from Plan Central. Current form users will find their existing history, patients, etc. carried over to the revised form.

Features of the revised form include:

- **Box 21**: Diagnosis Code – The form now accepts up to 12 diagnosis codes.
- **Box 24E: Diagnosis Pointer** – Although users can send up to 12 diagnosis codes, each claim line can accept a maximum of four (4) diagnosis pointers.
- **Box 30: Reserved for NUCC use** - In the previous form, Box 30 showed the balance due. We removed this box from the new version of the form. The form will automatically calculate the charges based on what users enter in boxes 28 (Total Charge) and 29 (Amount Paid).

Get more help on our updated "Claim Submission Tip Sheet" posted in the Help section on our **secure provider website**.

Note these changes in the paper correspondence you receive

Starting soon a new vendor, Emdeon, will be sending some provider communications to your office or facility. Here's what's changing:

- You'll get paper explanation of benefits (EOB) statements, checks and letters from HealthPayers USA, a service provided by Emdeon*
- They'll be in the same envelope as correspondence from other companies**
- The check color will change from tan to blue
- Packages may include checks immediately followed by corresponding EOBs*

What's not changing

EOBs will look the same.

You don't need to do anything. You'll start to get your EOBs and checks automatically from HealthPayers USA.*

Improve your office's efficiency by enrolling in electronic funds transfer (EFT) and using online EOBs. See our related article about EFT on page1.

*Offices that previously received a letter from us about EFT enrollment or transitioning to electronic EOBs aren't affected by the change to HealthPayers USA.

**At times, you may receive individual packages from us.

Reminder: Send us *all* your Medicare claims electronically

Did you know we can accept *all* Medicare claims electronically? It doesn't matter whether your patient has an Aetna Medicare Advantage or Medicare Supplemental plan.

Send Aetna Medicare Advantage claims directly to us. For patients who have an Aetna Medicare Supplemental plan:

- Start by sending Part B claims directly to Original Medicare for services covered under Medicare.
- Original Medicare will then send us any claims to pay our share.
- Look for "MA18" or "N89" remark codes on your Medicare Electronic Remittance Advice (ERA) or Explanation of Payment (EOP) statement. When you see these codes, the Medicare carrier has automatically sent us your claim.
- You don't need to send us another claim, either electronically or on paper.

Sending duplicate claims can delay claim processing.

Learning Opportunities

Log in or register at **AetnaEducation.com**

New and updated courses for physicians, nurses and office staff

Reference Tools

New – The 2014 Aetna African American History Calendar

New – Claim Electronic Explanation of Benefits Tool Reference Guide

New – Grupo Nacional Provincial reference tool

Updated – Aetna at a Glance (national)

AetnaEducation.com is easier than ever to use

Our new **Education Site** makes searching faster than ever.

Based on your feedback, we completely redesigned the site, starting with an easy-to-use search box on the home page.

This new feature gets you the answers you need so you don't have to log in to search and access most of the content. And, we organized the topics to save you time.

Improvements at **AetnaEducation.com** include:

- A new look and feel that makes it easier to navigate
- A more dynamic "Search" function that gets you to the information you need faster
- A "5-star" rating system, which shows ratings from other users on education they viewed
- "Bite-sized" content for quick education and answers
- Valuable reference tools to make your job easier, and much more

It's easy to find tools and resources

For example, if you want to read a helpful quick reference guide, simply type "at a glance" in the search field. You'll instantly see a wealth of information from our newly updated "Aetna at a Glance," which makes it easier to do business with us. You'll get tips for registering and navigating our secure provider website, as well as national and region-specific information.

CMS-required Compliance Program – complete your Aetna attestation

The Centers for Medicare & Medicaid Services (CMS) requires any Aetna First Tier, Downstream or Related Entity (FDR), such as a provider organization, to complete certain Compliance Program requirements for Aetna. These requirements include:

- General compliance and FWA* training
- Code of Conduct/compliance policies dissemination
- Exclusion list screenings
- Ensure reporting mechanisms for potential FWA and compliance issues
- Offshore protected health information (PHI) operation reporting
- Downstream entity oversight

Access Aetna's Health Care Professional Education site at **www.AetnaEducation.com** for information on these requirements, and to confirm completion of the training through submission of an attestation annually.

An authorized representative of your provider organization must access the 2014 Medicare Compliance Attestation and complete it.

Your organization must ensure that specific actions (e.g., training, code of conduct reviews, etc.) are taken by your employees (e.g., providers, administrative staff, etc.), and any downstream subcontractors that you use for Aetna's Medicare products. Also, specific processes must be in place within your organization (e.g., monthly sanction screening, etc.). Once your organization completes these actions, you'll need to submit an attestation to Aetna as confirmation of completion.

Submitting the attestation

Within the Aetna Provider Education Portal, an authorized representative of your organization must access and complete the attestation each year.

To access it:

1. Go to **www.AetnaEducation.com**
2. Type Attestation in the Search field and click Go.
3. Select the *2014 Aetna Medicare Attestation* (log-in will be required)

Aetna Medicare Compliance

We take Medicare compliance seriously. For questions about our Medicare Advantage and/or Prescription Drug Plans, contact our Provider Service Center at **1-800-624-0756**.

*FDRs who have met the FWA certification requirements through enrollment in Parts A or B of the Medicare program, or through accreditation as a supplier of point-of-sale Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS), are deemed to have met the FWA training requirements. However, they are not deemed from any of the other Medicare Compliance Program requirements, and must still complete Aetna's attestation.

Collect patient payments using Money^2 SM for Health

We've teamed up with Citi® to create **Money² for Health**. It's an online patient health care payment solution that makes it easy for your patients to review, understand and pay their bills.

Registered patients click the "Pay Online" option from their Aetna Navigator® secure member website to pay providers who accept the service. Then, funds go directly from their account to yours.

Money2 for Health benefits for you may include:

- Increased patient loyalty and satisfaction
- Lower administrative costs
- Improved accounts receivable
- Reduced cost of collections
- No set-up fees*
- Easy, self-service tools, along with training materials and support
- Fewer patient billing questions

Register now for Money2 for Health. If you want more information or have questions contact us at **855-803-5819** or at **money2forhealth@aetna.com**. Learn more about our **Terms and Conditions**.

*A small fee is charged only when you receive payments

Where to find our Medicare and Commercial formularies

At least annually, and from time to time throughout the year, we update the Aetna Medicare and Commercial (non-Medicare) Preferred Drug Lists. These drug lists are also known as our formularies.

To find them:

- View our **Medicare Preferred Drug Lists**
- View our **Medication Search page** for the Commercial Preferred Drug Lists

For a paper copy of these lists, call the Aetna Pharmacy Management Provider Help Line at **1-800-AETNA RX (1-800-238-6279)**.

Ohio

Use MedSolutions for Medicare Advantage member preauthorizations

Effective June 16, 2014, MedSolutions will review preauthorization requests for certain outpatient services for Aetna Medicare Advantage (MA) members who live in, or chose a primary care physician located in Ohio.

This change affects providers and MA members in areas where the MedSolutions preauthorization process is already in place for Aetna's network-based commercial health benefit plans. Therefore, preauthorization for MA members will be the same as it is for commercial plan members.

Services needing preauthorization

- Elective outpatient stress echocardiography and diagnostic left and right heart catheterization
- Elective outpatient MRI/MRA, PET scans, CT/CTA, and nuclear cardiology
- Facility-based sleep studies
- Elective inpatient and outpatient cardiac rhythm implant devices

Services not needing preauthorization

- Inpatient services*
- Emergency room services
- Observation bed stays

*__NOTE:__ Preauthorization is required for elective cardiac rhythm implant devices being performed as an inpatient service.

Contact MedSolutions for preauthorization

- Phone: **1-888-693-3211**
- Fax: **1-888-693-3210**
- **MedSolutionsOnline.com**

Reminders

- Ordering physicians must get preauthorization.
- Rendering providers should ensure that ordering physicians got preauthorization before scheduling.
- Not preauthorizing may result in non-payment of provider claims.

Contact us at: OfficeLinkUpdates@aetna.com

Route this publication to:
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- Referral and Precertification Staff
- Business Staff
- Front Desk Staff
- Medical Records/Medical Assistants
- Primary Care Physicians
- Specialists
- Physician Assistants/Clinical Nurse Specialists
- Nurses

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