Updates to our National Precertification List

These changes to our National Precertification List (NPL) will take effect as noted below.

A new drug class, injectable respiratory drugs, will require precertification starting July 1, 2016. This class includes Nucala (mepolizumab) and Xolair (omalizumab) which currently require precertification.

Reminders and updates

Effective January 14, 2016, the following changes applied to precertification:

These new to market drugs require precertification:
- Coagedex (coagulation factor X [Human])
- Adynovate (antihemophilic factor [recombinant], PEGylated)
- Strensiq (asfotase alfa)
- Nucala (mepolizumab)
- Kanuma (sebelipase alfa)

Amevive (alefacept) and Iplex (mecasermin rinfabate) no longer require precertification.

Effective February 12, 2016, the following new to market drugs require precertification:
- Imlygic (talimogene laherparepvec)
- Vorvendi (von Willebrand factor, recombinant)
- Zepatier (elbasvir and grazoprevir)
- Empliciti (elotuzumab)

Effective March 1, 2016, the following new to market drugs require precertification:
- Uptavi (selexipag)
- Darzalex (daratumumab)

You can find more information about precertification under the “General information” section of the NPL.
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 advises us on issues of importance to physicians. The chart below outlines coding and policy changes:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Effective date</th>
<th>What's changed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presumptive and definitive drug testing</td>
<td>January 1, 2016</td>
<td>We follow the 2016 CMS coding recommendations for definitive and presumptive drug testing. The frequency limit for each (definitive and presumptive) is 8 times per 365 days, from the time the service is first rendered.</td>
</tr>
<tr>
<td>Changes for observation stays over 24 hours</td>
<td>July 15, 2016</td>
<td>Observation stays over 24 hours require notification effective April 1, 2016 (For Florida, this took effect January 1, 2016). Notification is required by 5 p.m. local time on the business day following when the patient is in observation for more than 24 hours.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Effective July 15, 2016:</strong> An observation stay over 24 hours will be subject to the late notification penalty of up to $4,000 if we're not notified timely as noted above. Failure to notify us at all will result in denial of the observation stay.</td>
</tr>
<tr>
<td>Multiple surgical procedures</td>
<td>July 15, 2016</td>
<td>Effective July 15, 2016, for commercial and participating Medicare claims, when a provider performs more than one eligible procedure on the same patient during the same operative session, we calculate the allowable benefit as follows:</td>
</tr>
</tbody>
</table>
|                                                 |                | • 100 percent for the first procedure with the highest RVU  
• 50 percent for the second procedure with the second highest RVU  
• 25 percent for each subsequent procedure                                                                 |
<p>| Modifier 53—discontinued procedure             | July 15, 2016  | We will pay 20 percent of the fee schedule for commercial and participating Medicare Advantage claims. We will pay 50 percent of the fee schedule for non-participating Medicare claims.                                                                                           |
| Modifier 59—distinct procedural service        | July 15, 2016  | Effective July 15, 2016, our Modifier 59 policy will apply to facility claims. When a procedure or service is billed with Modifier 59 on the same date of service as another procedure, we may consider both codes as eligible for payment. Refer to the “Modifier 59—Distinct Procedural Service” payment policy and exceptions on our <a href="#">secure provider website</a> under Claim Payment and Coding Policies for more information. |</p>
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<td>Modifier 74 – discontinued outpatient hospital/ ambulatory surgery center (ASC) procedure after the administration of anesthesia</td>
<td>July 15, 2016</td>
<td>We will reduce payments to 50 percent for commercial and participating Medicare Advantage claims.</td>
</tr>
<tr>
<td>Physical performance tests and measurements</td>
<td>July 15, 2016</td>
<td>Assessments of the progress or status of a condition, including physical performance tests and measurements (CPT 97750) are considered integral to the overall care of the patient. We will not allow additional payment for these services.</td>
</tr>
</tbody>
</table>
Stay informed on the web

Visit us online to get a copy of your Provider Manual and information on the following items:

- How our Quality management program can help you and your patients. We integrate quality management and metrics into all that we do. You can find details on the program goals and the progress toward those goals online.
- How we work with members in our chronic disease management programs and how to enroll a member in a disease management program.
- Our complex case management program and learn how to refer members.
- Member Rights and Responsibilities.
- What utilization management is and how decisions are made, including our policy against financial compensation.
- Clinical Practice Guidelines and Preventive Services Guidelines.
- Pharmacy information (see related article).

You can access these materials by following the prompts below:

- **Commercial** – Choose “Quick Links”. Select your state under “Regional Health Plan”. Select “Providers”. Select “Document Library”.
- **Medicare** – Choose “Quick Links”. Select “Medicare”. Scroll to “Provider Resources”. Select “Document Library” and then select your state.
- **Medicaid** – Choose “Quick Links”. Select “Medicaid. Select your state’s plan. Select “For Providers”. Select “Document Library”.

If you don’t have internet access, call our Provider Service Center for a paper copy.

How we determine coverage

Our utilization management program helps our members get medically necessary health care services in the most cost-effective setting available under their benefit plan. We work with members and providers to evaluate services for medical appropriateness, timeliness and cost.

- We use nationally recognized guidelines and resources to make our coverage decisions.
- We base our decisions entirely on if the care or service is appropriate for the member and if it’s covered under the member’s plan.
- We don’t pay or reward providers, our employees or other individuals to deny coverage or care.
- We don’t encourage our employees to deny coverage. In fact, we train our employees to focus on the risk to members if they don’t use certain services.
- We don’t encourage decisions that result in our members underutilizing services.

Providers can discuss coverage denials with a Coventry medical director during the decision-making process. We can also share the criteria the medical director used to make their coverage decision. Just call the customer service phone number in your Coventry Provider Manual.

You also can view this information on [www.directprovider.com](http://www.directprovider.com), our secure provider website.

Learn about our accessibility standards for specialty care

Coventry has established standards for member access to specialty care services. Each specialty care practitioner is required to have appointment availability within the following timeframes:

- **Within 30 calendar days** for routine care
- **Same day or within 24 hours** for urgent complaints

All participating specialty care physicians must have a reliable 24 hours-a-day, 7 days-a-week answering service or paging system. A recorded message or answering service that refers the member to the emergency room is not acceptable.

More stringent state requirements supersede these accessibility standards.

Disease management programs help patients with chronic conditions

Our disease management programs are designed to help your patients effectively manage their ongoing chronic health conditions and improve health outcomes.

Through the programs, we offer our members education and support with an emphasis on preventing complications. We also support the doctor/patient relationship by reinforcing your care plan.

Available disease management programs may include asthma, coronary artery disease and diabetes. To refer a Coventry member, call us at 1-800-579-5755.
Lower cost alternative drug can replace Daraprim®

The price of Daraprim (pyrimethamine) increased from $13.50 per tablet to $750 per tablet in September 2015. This drug is used to treat toxoplasmosis and other parasitic infections.

There is a cost-saving option you can consider for your patients who take Daraprim.

Patients save with compounded version

Your patients can get a compound version of pyrimethamine that also contains leucovorin.

• Members can get this from a compounding pharmacy in our network if they have coverage for compounded medications.
• One of our participating pharmacies, Imprimis Pharmaceuticals, will provide this drug for about $1 per tablet. The actual amount the member will pay depends upon their plan.

If your patient is taking or is going to start treatment with pyrimethamine, you may want to consider if this compound drug is right for them.

Questions?

For questions about compound medicines, or if you want to submit a prescription, visit Imprimis Pharmaceuticals website or call them at 1-866-551-7195.

Changes to our commercial drug lists

On July 1, 2016, our Pharmacy Plan drug lists (formulary) will change. You can view these changes now by following these steps:

1. Visit the Quick Links section of our website
2. Scroll down to “Regional Health Plans” and select your state and plan
3. Select “Health Care Solutions”
4. Choose “Prescription Coverage” and then click on “Formulary”

The changes may affect our:
• Pharmacy Management drug lists
• Precertification program
• Quantity limits program
• Step-therapy program

Options to request a drug precertification:

1. Call 1-877-215-4100
2. Fax your completed prior authorization form to 1-866-738-9682
3. Submit your request through www.directprovider.com, our secure provider website

Where to find important pharmacy information

You can access valuable and important pharmacy information on each individual Coventry Health Care plan website.

The plan websites can be found on our website’s Quick Links section under “Regional Health Plans.” Once on your plan’s website, select “Providers” and then “Prescription Documents” on the right side to find:

• 2016 Formulary changes
• A list of preferred pharmaceuticals, including any restrictions and/or preferences
• Medications which require prior authorization and applicable coverage criteria
• Medications which require step-therapy, including the medications which must be tried/failed prior to coverage
• A list and explanation of medications which have limits or quotas
• Copayment and coinsurance requirements, and the medications or classes to which they apply
• Procedures for step-therapy, prior authorization, generic substitution, preferred-brand interchange and therapeutic interchange
• Information on the use of pharmaceutical management procedures
• Criteria used during the evaluation of new medications for inclusion on the formulary
• A description of the process for requesting a medication coverage exception
Centers for Medicare & Medicaid Services (CMS) compliance changes for 2016

As of January 1, 2016, each first tier, downstream and related entity (FDR) must complete CMS’ training modules to meet general compliance and fraud, waste and abuse (FWA) training requirements.

You can find CMS’ general compliance and FWA training modules on the CMS Medicare Learning Network (MLN). They can be completed, after registration. The general compliance module is titled Medicare Parts C and D General Compliance Training and the FWA course is titled Combating Medicare Parts C and D Fraud, Waste, and Abuse Training. You can also download CMS’ general compliance training and FWA training and incorporate them, unchanged, into your existing trainings/systems.

Complete your attestation by December 31, 2016 to avoid changes in participation status

Through your Coventry and/or Aetna Medicare agreement, FDRs must meet CMS compliance requirements. You can confirm you’ve met them each year by completing an attestation. The new Medicare Attestation is available on NaviNet — Aetna’s secure provider website — for providers contracted with both Aetna and Coventry. Providers who are contracted with Coventry providers will continue to attest through www.aetnaeducation.com.

For Aetna and Coventry (dual contracted) providers: 2016 attestation site changes

In 2016 we have moved the attestation site to NaviNet. With NaviNet, there are no limitations on attesting for more than 20 tax identification numbers.

If you’re contracted with both Aetna and Coventry and have never used NaviNet, we suggest you register today:

- New users: Register for NaviNet and complete your FDR annual attestation
- Existing users: Log in to NaviNet and complete your 2016 FDR annual attestation

Once in Aetna Plan Central, hover over “Compliance Reporting” and then click on “Medicare Attestation.”

For provider contracted with Coventry only, nothing will change

You need to register and take the annual attestation when it is available:

- Visit www.aetnaeducation.com
- Type attestation under “search” and click “GO”
- Click “2016 Aetna Medicare Attestation”

An authorized representative must complete the attestation. One attestation meets Aetna and Coventry annual compliance requirements. Failure to meet FDR compliance requirements may impact your participation status.

We’re here to help

If you need more information, visit www.aetnaeducation.com and search educational content or the list of requirements by typing “FDR” in the search box. Or, call 1-800-624-0756.