Updates to our National Precertification List

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

Reminders and updates

Effective April 13, 2016, we added Xeljanz XR to the precertification requirement of Xeljanz. This is a new formulation of a drug that already requires precertification.

Effective May 16, 2016, we modified the name of the drug “Gel-Syn,” which required precertification, to the new brand name “Gelsyn-3.”

Effective June 3, 2016, the following new-to-market drugs require precertification:

- Cinqair (reslizumab)
- Idelvion (antihemophilic factor [recombinant])
- Inflectra (infliximab-dyyb)
- Kovaltry (antihemophilic factor [recombinant])
- Taltz (ixekizumab)

Remember injectable respiratory drugs require precertification starting July 1, 2016. We added Cinqair (reslizumab) to this class as well as Nucala (mepolizumab) and Xolair (omalizumab), which currently require precertification.

Effective September 1, 2016, we will no longer require precertification for the following services:

- Elective (non-emergency) transportation by ground, ambulance or medical van
- Repair of entropion and ectropion

Note: blepharoplasty and canthoplasty procedures still require precertification.

You can now access drug-specific medication precertification forms online and fax them to the number on the form. There’s also a new direct access phone number: 1-800-619-4015. Choose option 1 for commercial plan members and option 2 for Medicare plan members for questions regarding authorizations submitted by fax.

You can find more information about precertification under the “General information” section of the NPL.
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 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>Hemodialysis home visits</td>
<td>October 1, 2016</td>
<td>Hemodialysis home visits are reported with code 99512. Based on the frequency recommendation from the Centers for Medicare &amp; Medicaid Services (CMS), 99512 will be allowed 14 times within a 31-day period.</td>
</tr>
<tr>
<td>Evaluation &amp; Management (E&amp;M) services billed by nonphysicians</td>
<td>October 15, 2016</td>
<td>Currently, we don’t pay E&amp;M codes (99201 – 99499) for certain provider types including audiologists; dietitians; nutritionists; and speech, physical or occupational therapists. We are expanding this list to include additional nonphysician provider types based on CMS’ recommendation. Effective October 15, 2016, we will no longer reimburse E&amp;M services billed by the following specialties: • Licensed practical nurse • Home health/private duty nurse • Visiting nurse • Genetic counselor • Christian Science practitioner • Pharmacist • Behavioral analyst* • Alcohol and drug counselor* • Crisis diversion* • Employee assistance program (EAP) counselor* • Licensed professional counselor* • Substance abuse professional* • Other mental health counselor* • Registered social worker* • Marriage and family social worker* These professionals should review the CPT and Healthcare Common Procedure Coding System (HCPCS) national code sets to select a more accurate code that describes the services they are providing. *We will continue to reimburse for: • 99408: Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes • 99409: Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes</td>
</tr>
</tbody>
</table>

Credentialing change for mental health providers

With Aetna’s acquisition of MHNet/Coventry, we’re consolidating our contracting and credentialing processes.

**MHNet no longer sends out or accepts MHNet credentialing applications.** To apply for participation with MHNet, fill out and submit our [behavioral health provider application](#).

MHNet’s panel is not closed. However, we are working to get all our participating mental health providers onto Aetna’s panel and ready for integration.

If you have questions, call MHNet’s National Provider Relations team at **1-855-995-4086**. Choose option 5 to reach a representative who can help you complete the application.
**Note these upcoming service code changes**

Individual CPT codes were added or reassigned within the Coventry Enhanced Groupings (CEGs). Providers contracted under the CEG methodology will experience changes to their compensation based on the presence or absence of these CPT codes within the contract structure. These changes are outlined below.

All updates are effective October 15, 2016.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Provider types affected</th>
<th>What's changing</th>
</tr>
</thead>
<tbody>
<tr>
<td>38792, 91010, 91020, 91022, 92511,</td>
<td></td>
<td>• If contract contains an Ambulatory Surgery — Coventry Enhanced Grouper: Grouper 1, rate will be applied.</td>
</tr>
<tr>
<td>97597, 97598</td>
<td></td>
<td>• If listed as Ambulatory Surgery Carve Out Surgical Rate, the rate will be applied.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If not listed above, then the Ambulatory Surgery Undefined Procedure Rate will be applied.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If the contract contains none of the above provisions, the relevant terms of the contract will rule.</td>
</tr>
<tr>
<td>31645, 31730, 43220, 46945, 46946</td>
<td></td>
<td>• If contract contains an Ambulatory Surgery — Coventry Enhanced Grouper: Grouper 2, rate will be applied.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If listed as Ambulatory Surgery Carve Out Surgical Rate, the rate will be applied.</td>
</tr>
<tr>
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<td>• If not listed above, then the Ambulatory Surgery Undefined Procedure Rate will be applied.</td>
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<tr>
<td></td>
<td></td>
<td>• If the contract contains none of the above provisions, the relevant terms of the contract will rule.</td>
</tr>
<tr>
<td>31290, 31291, 31634, 31660, 31661</td>
<td>Facilities including acute short-term hospitals and ambulatory surgery centers</td>
<td>Will be assigned to Ambulatory Surgery — Coventry Enhanced Grouper: Grouper 3.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If contract contains an Ambulatory Surgery — Coventry Enhanced Grouper: Grouper 3, rate will be applied.</td>
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<tr>
<td></td>
<td></td>
<td>• If contract contains an Ambulatory Surgery — Coventry Enhanced Grouper: Grouper 4, rate will be applied.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If listed as Ambulatory Surgery Carve Out Surgical Rate, the rate will be applied.</td>
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</table>
Stay informed on the web

Visit us [online](#) to get a copy of your provider manual and information on:

- 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 to use disease management services and how we work with your patients in these programs.
- How our complex case management program works and how to refer members.
- What utilization management is and how decisions are made, including our policy against financial compensation.

You’ll also find:

- Member Rights and Responsibilities
- 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 paper copies.

We don’t cover concierge or boutique services

Providers can’t charge a fee for any of the following:

- Guaranteed same-day appointments
- Answering phone calls
- Any service that doesn’t have a CPT code
- Any service billed as concierge services, administrative services, etc.

If we determine that an office is charging for any of the services listed above, we will consider the provider to be in violation of their contract. This is grounds for termination from our networks.

Reimbursement for temporary or fill-in providers

Locum tenens physicians fill in temporarily for other physicians. We'll reimburse a locum tenens physician at the same rate as a participating provider. Locum tenens are considered network providers as long as:

- The claim contains the modifier Q6
- The claim has the network provider’s tax identification number (TIN)
- The network provider is billed in box 32
Protect your patients and yourself from cyberattacks

Cyberattacks are one of the greatest risks facing medical practices and the health care industry.

Our Social Security number (SSN) protection, elimination and remediation plan can help you reduce the use of SSNs. You can work with us in this initiative.

Reducing the risk

There are ways you can help reduce cyberattacks. Be sure to refrain from using your SSN as your TIN. One way to stop using your SSN is to get an employer identification number.

Check with your tax adviser and/or the IRS website for more information on this option.

Remember, the only requirement for health care services is the member ID. You don’t need to collect patient SSNs. By not collecting, storing or using the SSN, you’re reducing the risk of identity theft and medical fraud.

We’re here to help

To find out more, email questions to SPEar_Support@aetna.com.

Help improve communication between treating providers

Based on the results of a recent survey, primary care physicians (PCPs) are concerned they don’t get regular reports about their patients’ ongoing evaluation and care from other treating providers.*

This breakdown in communication can pose a threat to quality patient care. We know coordinating care with many physicians, facilities and behavioral health care professionals can be a challenge. And we appreciate your efforts to improve communications.

Use tools to share information

Comprehensive patient care includes communicating with your patients’ other treating health care professionals. To promote collaboration and comprehensive care, it’s critical that PCPs and specialists talk openly with each other.

On directprovider.com, you’ll find tools and resources to help make this process easier. For example, our Eye Care Professional Report for Dilated Retinal Eye Exam, Physician Communication Report and Specialty Consultant Report promote communication during care transitions.

*Each year we survey primary care practices contracted for all Coventry products. The surveys assess the practices’ attitudes and perceptions on key interactions with us. We use the Center for the Studies of Services, a third-party vendor, to administer the surveys. They perform the surveys at a market level accredited by the National Committee for Quality Assurance.
Medicare

We need current data about your office

We’re required by CMS to maintain accurate provider directories for all Medicare Advantage and qualified health plans. This requires you to keep your office information up to date with us. This will help us assist our members in accessing the care that they need.

You should notify us whenever the following information changes:

- Email and mailing addresses
- Phone or fax numbers
- Name changes due to marriage or another life event
- If your office is accepting new patients
- Your hospital and group affiliations

You can update your information by going to directprovider.com. Within the Manage Account > Edit My Profile section of directprovider.com, providers (administrators) can update their provider name, title and email address. Changing your address here will not change your address as it is associated to your TIN in our system.

To change the address related to your TIN, contact Provider Services.

ABNs aren’t valid for Medicare Advantage members

Provider organizations should be aware that an Advanced Beneficiary Notice of Noncoverage (ABN) is not a valid form of denial notification for a Medicare Advantage member.

ABNs — sometimes referred to as “waivers” — are used in the Original Medicare program. However, you can’t use them for patients enrolled in Aetna Medicare Advantage plans because the CMS prohibits the use of ABNs.

What is and isn’t covered

Providers who have elected to participate in the Medicare program are expected to understand which services are covered by Original Medicare and which are not.

Aetna Medicare Advantage plans are required to cover everything that Original Medicare covers and, in some instances, may provide coverage that is more generous or otherwise goes beyond what’s covered under Original Medicare.

CMS mandates that providers contracted with a Medicare Advantage plan, such as Aetna, can’t hold an Medicare Advantage member financially responsible for payment of a service not covered under the member’s plan unless that member received a preservice organization determination (OD) notice of denial from Aetna before such services are rendered. If the member doesn’t have a preservice OD notice of denial from Aetna on file, you must hold the member harmless for the non-covered services. This means you can’t charge the member any amount beyond the normal cost-sharing amounts (that is, copayments, coinsurance and/or deductibles).

However, where a service is never covered under Original Medicare or is listed as a clear exclusion in the member’s Evidence of Coverage (EOC) or other similar plan document, a preservice OD isn’t required for you to hold the member financially liable for such non-covered services. Note that services or supplies that are not medically necessary or are otherwise determined to be not covered based on clinical criteria do not constitute “clear exclusions” under the member’s plan, as the member is not likely to be able to ascertain on the face of the EOC that such services will not be covered.

ODs can be initiated either by you or by the member to determine if the requested/ordered service is covered prior to a member receiving it or prior to scheduling a service, such as a lab test, diagnostic test or procedure.

Holding members responsible

Unless a service or supply is never covered under Original Medicare, you’ll only be able to hold an Aetna Medicare member financially responsible for a non-covered service if the member received a preservice OD denial from Aetna and decides to proceed with the service knowing they will be financially liable.
Complete your 2016 Medicare compliance attestation to avoid participation changes

If you are contracted with us to provide health care services for our Medicare Advantage plans, you are considered a “First Tier Entity.” CMS requires that you fulfill specific Medicare compliance program requirements. We describe those requirements in our First Tier Downstream and Related Entities (FDR) Medicare Compliance Program Guide (FDR guide). You should review our FDR guide and make sure you are complying with all the requirements. Then, complete your attestation. You can learn more by visiting www.aetnaeducation.com and searching “attestation.”

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

If you are contracted with Aetna and Coventry, you can complete the attestation on NaviNet®, your secure provider website.* With NaviNet, there are no limitations on attesting for more than 20 TINs. If you have never used NaviNet, we suggest you log in or 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.”

If you are only contracted with Coventry, nothing has changed.

You need to register and take the annual attestation:

- Type “attestation” in the search bar, 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 you can call 1-800-624-0756.

Disregard this notice if you’ve completed your 2016 attestation.

Enroll by August 1 to prescribe Medicare Part D drugs

After February 1, 2017, we can no longer cover claims for Medicare Part D drugs if you don’t have an approved Medicare enrollment or have a valid opt-out affidavit on file.

CMS encourages prescribers to enroll in Medicare or opt out by August 1, 2016. This will help ensure that CMS contractors have enough time to process applications and opt-out affidavits. It will also allow us time to update our systems, so members won’t be impacted.

If you don’t enroll then, we can only provide members with a three-month provisional supply of a medication. We won’t be able to cover additional prescriptions or refills of the same drug after the 90-day period has ended.

How to enroll

Visit the CMS prescriber enrollment site to:

- Enroll immediately
- Check your enrollment status
- Learn more about opting out

Be sure to enroll by August 1, 2016, to ensure your patients have access to Part D drugs.

*NaviNet® is a registered trademark of NaviNet, Inc.
Plan news

Missouri, Illinois

IBEW, Local No. 1, has a new process for specialty drugs

As of May 1, 2016, LDI Integrated Pharmacy Services (LDI) will manage specialty drugs for International Brotherhood of Electrical Workers (IBEW), Local No. 1, Health and Welfare Fund members.

You must purchase certain infusion drugs from LDI’s specialty pharmacy or an LDI-approved specialty pharmacy. You can view a list of these drugs and the approved specialty pharmacies online.

You can continue using existing prior authorizations until August 31, 2016. You’ll need a new prior authorization number from LDI beginning September 1, 2016. Remember, you’ll no longer be reimbursed for infusion drugs given in your office. You must work with LDI directly to obtain these drugs.

If you have questions, call IBEW at 314-752-2330. To start a prior authorization request with LDI, you can call 314-652-4121. Or fax your request to 314-652-4126.