Updates to our National Precertification List

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

Annual precertification updates effective January 1, 2017

Note the following change to dialysis precertification:

- We’ll only require precertification when a participating provider requests dialysis services at a nonparticipating facility. Dialysis at a participating facility will no longer require precertification.

We’ll still require precertification for cochlear device and ventricular assist device (VAD) services. However:

- Replacement items for use with the cochlear implant won’t require precertification. This includes replacement headset/headpieces, microphones, coils, cables, external speech processors and external controller components. Quantity limits may still apply. For more information, see Clinical Policy Bulletin #0013 - Cochlear Implants and Auditory Brainstem Implants.

- Miscellaneous VAD replacement supplies and accessories won’t require precertification. For more information, see Clinical Policy Bulletin #0654 - Ventricular Assist Devices.

Ophthalmic medical injectables will require precertification. This includes Eylea (aflibercept), Macugen (pegaptanib) and Lucentis (ranibizumab).

continued on page 2

This is our last issue

This issue of Coventry Provider News (CPN) is last one for this newsletter.

With the Aetna-Coventry integration now mostly complete, Aetna will go back to producing one newsletter for all participating providers — Aetna OfficeLink Updates (OLU). You’ll get the same information in OLU that you’ve been receiving in CPN.

If you haven’t yet signed up to receive OLU by email, you can do so by registering at our secure provider website. If you already get OLU by email you don’t need to do anything.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health and Life Insurance Company, and their affiliates (Aetna).
The following drugs/medical injectables won’t require precertification:

- Aloxi IV (palonosetron HCl)
- Anzemet IV (dolasetron mesylate)
- Aredia (pamidronate)
- Boniva (ibandronate)
- Jevtana (cabazitaxel)
- Reclast (zoledronic acid)
- Zometa (zoledronic acid)

Reminders and updates

The following new-to-market drugs require precertification:

- Afstyla (antihemophilic factor [recombinant], single chain) and Viekira Pak XR (ombitasvir, paritaprevir, ritonavir, dasabuvir) — precertification required effective August 2, 2016
- Epclusa (sofosbuvir and velpatasvir) — precertification required effective September 1, 2016
- Tecentriq (atezolizumab) — precertification required effective September 2, 2016
- Zinbryta (daclizumab) — precertification required effective September 3, 2016

More information about precertification is available 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. Our standard payment policies identify services that may be incidental to other services and, therefore, ineligible for payment. 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>Placement of permanent, hysteroscopically placed tubal implant devices intended for female sterilization on the same date of service as an endometrial ablation</td>
<td>October 15, 2016</td>
<td>The U.S. Food and Drug Administration and American College of Obstetricians and Gynecologists advise against placement of permanent, hysteroscopically placed tubal implant devices intended for female sterilization on the same day as an endometrial ablation.</td>
</tr>
<tr>
<td>Modifier 53 — discontinued procedure</td>
<td>October 15, 2016</td>
<td>In April 2016, we told you we were going to change how we pay nonparticipating Medicare claims. We decided not to change our policy. We will continue to allow 100% of the fee schedule for nonparticipating Medicare claims.</td>
</tr>
<tr>
<td>Noninvasive prenatal testing</td>
<td>January 15, 2017</td>
<td>Noninvasive prenatal testing codes are used to detect chromosomal abnormalities. There are currently an additional 35 lab codes that test for chromosomal abnormalities aside from the noninvasive prenatal testing codes. We will no longer pay for the 35 lab codes when billed in conjunction with noninvasive prenatal testing codes as these procedures differ in technique or approach but lead to the same outcome. Modifier 59 will be restricted from overriding these edits.</td>
</tr>
<tr>
<td>Modifier SU — denotes use of facility equipment</td>
<td>January 15, 2017</td>
<td>Services performed in any place of service and billed with modifier SU are not payable unless contracted.</td>
</tr>
<tr>
<td>ER level of care</td>
<td>January 15, 2017</td>
<td>CPT Code 99285 is used to indicate medical conditions that are of high severity, are potentially life threatening, and require the immediate attention of a physician. Services for constipation, earaches and colds, for example, should not be billed using CPT code 99285. When a hospital or physician bills a level 5 emergency room service (CPT 99285) with a designated minor diagnosis code, we’ll down code 99285 to a level 4 emergency room service (CPT 99284).</td>
</tr>
<tr>
<td>Pelvic and transvaginal ultrasounds</td>
<td>January 15, 2017</td>
<td>We will deny pelvic ultrasound (76856) as incidental when billed with a transvaginal ultrasound (76830) on facility claims. Specialist claims are currently subject to this edit.</td>
</tr>
</tbody>
</table>
Note these upcoming service code changes

Individual service codes will be reassigned within contract Service Groupings. Changes to an individual provider’s compensation will depend upon the presence or absence of specific service groupings within their contract.

Unless otherwise indicated, these updates will be effective March 1, 2017. The changes are outlined below:

<table>
<thead>
<tr>
<th>Codes</th>
<th>Provider types affected</th>
<th>What’s changing</th>
</tr>
</thead>
<tbody>
<tr>
<td>93312 – 93318</td>
<td>Facilities including acute short-term hospitals and ambulatory surgery centers</td>
<td>Will be <strong>removed</strong> from Coventry Enhanced Grouper: Grouper 10.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If listed as a carve-out service, the rate will be applied.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If not listed above, then the undefined procedure rate will be applied.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If the contract contains <strong>none</strong> of the above provisions, the relevant terms of the contract will rule.</td>
</tr>
<tr>
<td>78808</td>
<td>Facilities including acute short-term hospitals and ambulatory surgery centers</td>
<td>Will be <strong>removed</strong> from Coventry Enhanced Grouper: Grouper 10.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If listed as a carve-out service, the rate will be applied.</td>
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<td></td>
<td>• If the contract contains <strong>none</strong> of the above provisions, the relevant terms of the contract will rule.</td>
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</tbody>
</table>
How to update data about your office

To update your office’s demographic information, go to our secure provider website and sign in. You should notify us whenever the following information changes:

- New email and mailing addresses
- New phone or fax numbers
- Name changes due to marriage or another life event
- Hospital, group and independent practice association affiliation(s)
- Ethnicity, languages spoken and specialty information

We also have a flyer that has more information on how to make changes.

If you’ve been calling our Provider Service Center to make these changes, you should use the secure site instead. It prevents unauthorized individuals from submitting wrong information about your office or facility.

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage plans and Qualified Health Plans (QHPs) to maintain accurate directories. Having your most up-to-date information lets us do that.

Electronic transactions

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

NaviNet Security Officers have 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 register.

This issue of Coventry Provider News is not applicable to any workers’ compensation and/or auto networks you may participate in.
Resources for patients at risk for heart disease and stroke

Current heart disease and stroke prevention guidelines focus on:

- Assessment of risk
- Statin therapy
- Treating obesity as a disease
- Lifestyle management

These guidelines advise matching a patient’s risk level with the intensity of treatment. They also encourage a heart healthy diet with moderate to vigorous activity 3 – 4 times a week. For overweight and obese patients, these guidelines recommend using behavioral strategies to help patients achieve goals.

They also recommend statin therapy for these groups:

- Patients who are 40 to 75 years old without heart disease, but who have a 7.5 percent or higher risk for heart attack or stroke within 10 years
- Patients with a history of heart attack, stroke, angina, peripheral artery disease, transient ischemic attack, or coronary or other arterial revascularization
- Patients who are ages 21 and older with a very high LDL level
- Patients who are 40 to 75 years old with type 1 or type 2 diabetes

You can get a full set of guidelines by downloading them to your smartphone or tablet.

Consult CPGs and PSGs as you care for patients

We adopt evidence-based Clinical Practice Guidelines (CPGs) and Preventive Services Guidelines (PSGs) from nationally recognized sources. You can access the guidelines on your Coventry plan’s website. Once on the site, go to “Providers” and then to “Document Library.” For help in obtaining a paper copy from the nationally recognized sources, contact your provider relations representative. The following guidelines were adopted March 2016:

<table>
<thead>
<tr>
<th>Clinical Practice Guidelines</th>
<th>Adopted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidelines for the Diagnosis and Management of Asthma</td>
<td>March 2016</td>
</tr>
<tr>
<td>Diagnosis, Evaluation and Treatment of Attention Deficit Hyperactivity Disorder in Children and Adolescents</td>
<td></td>
</tr>
<tr>
<td>Helping Patients Who Drink Too Much</td>
<td></td>
</tr>
<tr>
<td>Treatment of Patients With Major Depressive Disorder</td>
<td></td>
</tr>
<tr>
<td>Standards of Medical Care in Diabetes</td>
<td></td>
</tr>
<tr>
<td>Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventive Service Guidelines</th>
<th>Adopted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grades A and B for Healthy People With Normal Risks</td>
<td>March 2016</td>
</tr>
</tbody>
</table>

Helping patients with a safe transition back home

We want to help make members’ transition to home successful after leaving a facility. Our Readmission Avoidance Program identifies members who are at high risk for readmission, and can help prevent avoidable readmissions.

How the program works

A case manager works with the member in the hospital and for up to 30 days after discharge from a facility. Our case manager will:

- Inform the member that we want to help with a smooth transition to home or to a lower level of care
- Review discharge and medication treatment instructions to facilitate case management
- Consult with the member’s post-discharge treating provider about the treatment plan and follow-up appointments
- Help facilitate follow-up doctor appointments when appropriate, and help schedule visits from a home health care provider if needed
- Continue case management for members with complex needs

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 to use disease management services and how we work with your patients in these programs.
- Our Complex Case Management program, including 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:

- Medicare — Choose “Quick Links.” Select “Medicare.” Scroll to “Provider Resources.” Select “Document Library” and then select your state.

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

Coverage determinations and utilization management

We use evidence-based clinical guidelines from nationally recognized authorities to make utilization management (UM) decisions.

Specifically, we review any request for coverage to determine if members are eligible for benefits, and if the service they request is a covered benefit under their plan. We also determine if the service delivered is consistent with established guidelines. If we deny a coverage request, the member, member’s representative or a provider acting on the member’s behalf may appeal this decision. Members can do this through our complaint and appeal process.

Our UM staff helps members access services covered by their benefits plans. We don’t make employment decisions or reward physicians or individuals who conduct UM reviews for creating barriers to care or for issuing coverage denials.

Our medical directors are available 24 hours a day for specific UM issues. Physicians can contact patient management and precertification staff at the phone number on the member’s ID card. When the card only shows a Member Services number, we’ll direct you through a phone prompt or a Member Services representative.

Where to learn more

More information about our UM criteria, CPBs and Pharmacy Clinical Criteria is on our website. Call our Provider Service Center if you don’t have Internet access and want a paper copy, or need a copy of the criteria upon which we base a specific determination.
**ABNs aren’t valid for Medicare Advantage members**

You 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 CMS prohibits 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. In some instances, it 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 a Medicare Advantage member financially responsible for paying 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 noncovered 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 noncovered 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 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 noncovered service if the member received a preservice OD denial from Aetna and decides to proceed with the service knowing they will be financially liable.

**Balance billing of Qualified Medicare Beneficiary individuals is prohibited**

The Qualified Medicare Beneficiary (QMB) program is a Medicaid program for Medicare beneficiaries that exempts them from being charged for Medicare cost sharing.

State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. However, federal law allows states to limit provider reimbursement for Medicare cost sharing under certain circumstances. Dually eligible individuals may qualify for Medicaid programs that pay Medicare Part A and B premiums, deductibles, coinsurance and copays to the extent provided by the state Medicaid plan.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services to a QMB individual. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions.

**Clarifications about balance billing**

Be aware of these policy clarifications to help ensure compliance with QMB balance billing requirements:

- All Original Medicare and Medicare Advantage providers — not only those that accept Medicaid — must abide by the balance billing prohibitions.
- QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers can’t charge QMB individuals even if the patient’s QMB benefit is provided by a different state than the one where care is rendered.

**More information**

For more information about dually eligible categories and benefits, visit CMS’ Medicare-Medicaid General Information website. For more on the QMB program and other individuals dually eligible for Medicare and Medicaid benefits, see the Medicare Learning Network® publication “Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs.”
Complete your 2016 Medicare compliance attestation

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 you to 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 the guide and make sure you have processes in place to comply with all the requirements. You can then complete your attestation. To learn more, go to www.aetnaeducation.com and search “attestation.”

Avoid changes in participation status

Each year you must confirm you’ve met the Medicare compliance program requirements by completing an attestation. One attestation meets both Aetna and Coventry compliance obligations. Not complying could impact your participation status.

For Aetna and Coventry (dually contracted) providers: You should complete your attestation on NaviNet,* our secure provider website. If you’ve never used NaviNet, log in or register today:

• New users: Register for NaviNet
• Existing users: Log in to NaviNet

Once you log in, go to Aetna Health Plan. Go to “Compliance Reporting” (on the left) and then click “Medicare Attestation.”

For Coventry-only providers: You need to register and take the annual attestation on www.aetnaeducation.com. Type attestation under “search” and click “GO.” Then click “2016 Aetna Medicare Attestation.”

We’re here to help

You can find educational content on www.aetnaeducation.com by typing “FDR” in the search box. Or you can call 1-866-784-4916.

Disregard this notice if you have completed your 2016 attestation.

*NaviNet® is a registered trademark of NaviNet, Inc.
Changes to our commercial drug lists begin on January 1, 2017

On January 1, 2017, our pharmacy plan drug lists (formulary) will change. Starting October 1, 2016, you can view these changes by following these steps:

1. Visit our Quick Links web page.
2. Scroll to “Regional Health Plans” and select your state and plan.
3. Select “Health Care Solutions.”
4. Select “Prescription Coverage,” then “Formulary.”

The changes may affect:
- All 2017 Pharmacy Management drug lists
- Precertification program
- Quantity limits program
- Step-therapy program

Three ways to request a drug precertification:

2. Fax your completed prior authorization form to 1-866-738-9682.

Questions?
For more information call us at 1-877-215-4100.
Utah network changes effective January 1, 2017

We’re changing how we identify Aetna’s networks in Utah. Beginning January 1, 2017, the “Altius Network” will be called the “Aetna Standard Network” and will no longer include the Altius logo:

Also on January 1, 2017, the current Aetna standard network will be called the “Utah Connected Network” with a logo:

What you need to know about this network change

- There’s no change to your contracted rates.
- Many of your patients will have a new ID card. Be sure to update your records with a copy of the patient’s current ID card.
- You may still see patients with old ID cards. You should always verify eligibility and network participation before seeing a member.
- Don’t turn away members who present with an old ID card. Just verify their eligibility and participation.
- You can verify your network and refer patients inside their network by searching our provider online referral directory. Or visit our secure provider website to use the NaviNet provider online tool for eligibility and benefits. To register for NaviNet, click here. Then select “Sign Up” under “Getting Started with NaviNet.”
- For members in Aetna plans, use NaviNet to check status and submit claims, and to check eligibility and precert.
- Check out our quick reference tool How Utah’s network realignment affects you on our provider education site. This tool offers details about ID cards, networks and plans.

If you have questions, call Customer Service at 1-800-377-4161 or 801-323-6200.