

**Physician Advisory Board
Meeting of December 11, 2009**

The Aetna Advisory Board met on December 11, 2009 in Fort Lauderdale, Florida.

Drs. William Gee, Robert Gunby, H. Robert Harrison, Scott Hayworth, Russell Libby, Leonard Lichtenfeld, Diane Wallis and Michael Workings attended.

Also attending for Aetna were Dr. James Cross, Lynda Goodwyn, William Kramer, Dr. Lonny Reisman, and Amanda St. Amand. Attending for Aetna by phone were Elizabeth Curran, Jay Eisenstock, Elysa Ferrara, Dr. Mark Friedlander, and Steve Kelmar.

Referring to materials distributed in advance of the meeting, Dr. Reisman provided an overview of Aetna clinical initiatives including Aetna's interface with both members and physicians. There was discussion about communications to both members and physicians supporting engagement and clinical decision support. Dr. Reisman described Aetna's efforts to send helpful information to physicians during the appropriate time in the doctor/patient encounter. There was also discussion of health information gaps and the barrier they present to quality and cost containment goals. There was a suggestion for Aetna and other insurers to collaborate on clinical programs in order to provide more consistency for physicians, and Dr. Reisman offered to demonstrate the Active Health Care Engine for Board members.

Referring to materials distributed in advance of the meeting, Mr. Kelmar provided an overview of proposed health care legislation, the current debates, and Aetna's position on various health care reform scenarios. There was discussion of payment reform pilot programs involving incentives and rewards, as well as how health care systems in other countries work. The observation was made that changes to the U.S. system will most likely be evolutionary rather than sudden.

Referring to materials distributed in advance of the meeting, Ms. Ferrara led a discussion on Aetna's performance-based purchasing and transparency initiatives. She highlighted areas of collaboration with providers including high performance provider initiatives, evidence-based reimbursement, performance networks, and health information technology. She shared information on Aetna's involvement with the patient-centered medical home, including sources of funding and approaches to payment. Drs. Harrison and Libby inquired as to the inclusion of pediatrician practices in the medical home initiatives and Ms. Ferrara suggested a detailed conversation off-line to discuss potential activities. There was also discussion on the challenges of coordinating in-patient care and the potential for examining this issue more closely in the context of the patient-centered medical home and the role of the primary care provider.

Referring to materials distributed in advance of the meeting, Mr. Eisenstock shared information on two industry initiatives aimed at reducing administrative burdens on providers. The first, sponsored by America's Health Insurance Plans (AHIP), is a multi-payer portal pilot providing a single channel with patient coverage and claims data from multiple insurance companies. Aetna participates in the pilot in New Jersey and Ohio. The second initiative is supported by the Council for Affordable Quality Healthcare (CAQH) and is managed through the Committee on Operating Rules for Information Exchange (CORE).

CORE's mission is to build consensus among the essential healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between health plans and providers. Essentially, the initiative aims to address inconsistencies and provide seamless transition between information systems and health plans. There was discussion around timing for implementation of the CORE initiative and the affect of ICD-10 on the phased approach. There was also discussion on the benefits of such a system to both insurers and providers.

Referring to materials distributed in advance of the meeting, Mr. Kramer then gave an update on key business and compliance-related activities. He shared that there were no new compliance issues and gave a brief update on the two open disputes. He then discussed the new physician contract addendum he is developing in collaboration with several state medical societies. This addendum is intended to continue many of the terms of the 2005 contract addendum which expired at the end of the Physician Settlement Agreement. He shared that the new addendum will be posted online in the next few months. The physicians supported Aetna's willingness to continue these commitments to the medical community. Mr. Kramer then discussed Aetna's new standard benefit for voluntary out of network use which will generally make reimbursement more consistent and closer to what in-network providers receive. There was discussion on the phased roll-out plan and price transparency, including the "Estimate the Cost of Care" tool available online for members.

Dr. Cross and Dr. Libby then led a discussion on in-office lab procedures including reimbursement for the collection and handling of certain specimens in the office. They discussed the affect on emergency room costs and contracting opportunities related to collection.

Ms. Curran then shared information on Aetna's payment methodologies for ambulatory surgery centers and factors that may influence the negotiated payment methodology, including ownership, service mix and geography.

Referring to materials distributed in advance of the meeting, Dr. Wallis led a discussion on sudden cardiac death in young people and various tests and screening programs. She shared information on Young Hearts for Life, an Illinois-based community screening program initiated by Midwest Heart Foundation which has performed 38,000 ECGs. There was discussion on the potential benefits of these screening and a recommendation for Dr. Wallis to seek endorsement from appropriate medical societies. Dr. Cross indicated that from Aetna's perspective, ECGs are a covered preventive service with no limitations on age.

Referring to materials distributed in advance of the meeting, Dr. Fried then provided an overview of Aetna's H1N1 flu policy and outreach activities. He shared that Aetna considers the vaccine medically necessary and covers vaccine administration even if a member's plan doesn't include preventive coverage. There was discussion on Aetna's payment for the administration using E&M code 99211 and the fact that Aetna's rate for H1N1 is based on established vaccine administration rates. Dr. Harrison noted that some patients are refusing the H1N1 vaccine and suggested that managed care companies promote its safety.

There was brief discussion of recent US Preventive Task Force guidelines on mammography. Dr. Cross shared that at this time, Aetna does not have plans to change our coverage policy on screening mammography.

Dr. Cross then acknowledged that effective January 1, 2010, the Centers for Medicare & Medicaid Services will remove the "consult" codes from the MPFS (Medicare Provider Fee Schedule). He shared that Since the AMA considers "consult" codes valid, Aetna will continue to accept and price these codes for eligible reimbursement. Consult codes are currently loaded within the Aetna Market Fee Schedule (AMFS) based on the market's conversion factor and RBRVS. Aetna will continue to value these codes within AMFS using RBRVS RVUs and/or other industry guidelines. As AMFS changes are made in 2010, we will evaluate the billing pattern of consult codes and determine the appropriate rate/adjustment based on financial impact.

The group then discussed selected topics that were submitted through the Physician Advisory Board mailbox.

- **Issue:** Concern over some osteopathic physicians trained in family medicine and having worked in dermatology claiming to be dermatologists, despite not having a board certification from the American Board of Dermatology or the American Osteopathic College of Dermatology.
Response: Aetna investigated the dermatology providers in the Philadelphia area. We have credentialed and approved only board certified dermatologists

- **Issue:** Concern about multiple readings of the same EKG when ordered and initially read by the Emergency Room physician. The confirming interpretation by the cardiologist is not paid
Response: Aetna allows payment for one routine interpretation of a laboratory or diagnostic test. Additional interpretations by the same or by a different provider are considered duplicative and not eligible for separate reimbursement. Effective September 15, 2008, Aetna will allow two readings of the same EKG when the provider types are emergency physician and cardiologist. Aetna's payment policy, "Laboratory and Diagnostic Interpretations", has been updated to reflect the exception

- **Issue:** Questioning denial of coverage for Physician Assistant /RNFA when assisting in surgery.
Response When eligibility for an assistant surgeon has been confirmed , the amount of payment will vary depending on the licensure of the provider of service. Services rendered by an eligible non-physician surgical assistant (for example, physician assistant (PA), surgical assistant (SA) or registered nurse) are payable at 12 percent of either the Aetna surgical fee allowance or the contracted rate for the surgeon.
Non-physician eligibility may vary based on state requirements and/or the contracted status of the provider.
Unless mandated, Aetna does not recognize non physicians practicing independently. Aetna reimburses charges made for the services of a health care provider who is not recognized as a legally qualified physician when they are employed and working

under the direct supervision of a recognized physician, they are licensed, the services are covered under the contract and the charges are billed by the employer

- **Issue:** Request for Aetna to cover care plan oversight.
Response: Aetna considers the services encompassed by Care Plan Oversight as integral to, and part of, the total management of the patient and therefore included in the applicable Evaluation and Management service. Aetna also considers charges for physician services when no direct patient contact occurs as an ineligible expense. Aetna's Payment Policy does not apply to Medicare Advantage products.
- **Issue:** Request for review of Aetna's reimbursement policy for the 3D component of saline infusion sonograms.
Response: Aetna does not consider the generation or analysis of automated data as eligible for payment. The use of a computer to manipulate the data previously obtained from the performance of a test or procedure is considered incidental and integral to the test or procedure that was performed and is not separately eligible for reimbursement. Aetna covers the primary procedure but does not pay for the additional software and equipment expenses related to the ultrasound unit employed.
- **Issue:** Request for basis of decision to pay 95251 (Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report) only twice in a calendar year.
Response: Available published evidence regarding the diagnostic use of continuous glucose monitors focuses on the single use, as in documenting nocturnal hypoglycemia in persons with suggestive symptoms. There is a lack of reliable evidence for the frequent repeated diagnostic use of continuous glucose monitors to document changes in trends. The appropriate interval frequency of short-term of continuous glucose monitoring is documented in Clinical Policy Bulletin (CPB) 70, *Diabetes Tests, Programs and Supplies*.

There was brief discussion on the status of the AGHP TRICARE contract. Dr. Cross indicated that the US Government Accountability Office upheld HealthNet's contract award protest. He suggested that the group discuss TRICARE in detail at the next meeting should Aetna be awarded the contract.

Referring to materials distributed in advance of the meeting, Dr. Friedlander then provided information on Aetna's Autism benefit design. He shared an overview of Autism Spectrum Disorders and various intervention options. There was discussion on the potential consequences of federal parity legislation on coverage and benefit design, as well as challenges including overstretched public resources and the variety of diagnosis codes being used by providers in Autism treatment. Autism Speaks and Autism Society of America were recommended as resources.

There being no further business, the meeting adjourned at 3:30 p.m. ET.