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Aetna OfficeLink Updates™

West Region

Inside This Issue

Policy and Practice Updates . . . 2
Office Wise 3-4
Prescription Medications & Pharmacy Management 5
Medicare 6-7
Aetna's Education Site for Health Care Professionals 8
Striving for Quality Excellence . 9
West News 10-11

Options to reach us

- Go to **www.aetna.com**
- Select "Health Care Professionals"
- Select "Medical Professionals Log In"

Or call our Provider Service Center:

- 1-800-624-0756 for HMO-based benefits plans, Medicare Advantage plans and WA Primary Choice plan
- 1-888-MDAetna (1-888-632-3862) or all other plans

Aetna's policy on H1N1 flu vaccine administration

Aetna will cover administration of the H1N1 flu vaccine for all fully insured medical plan members and self-funded plan members unless the plan sponsor decides otherwise. We are offering this coverage even in instances where members' plan does not include coverage for preventive care or has limits on such coverage.

- Claims for vaccine administration should be submitted with CPT code 90470 or HCPCS code G9141.

Aetna Administration will not pay for the cost of the vaccine, which is being made available at no cost.

- Aetna will pay for the administration of one or two doses of H1N1 flu vaccine, based on recommendations from the Centers for Disease Control and Prevention (CDC).
- Co-pays, co-insurance and deductible will not apply for the administration of the vaccine.

Help keep patient costs down – refer to network providers

Aetna is beginning to move away from out-of-network plan benefits that are currently based on "reasonable" or "prevailing" charges, which are typically paid based upon Ingenix databases.

Our new default approach will be based in most states on Aetna's standard rates that are used as the basis for contracting with providers who participate in our network, known as the Aetna Market Fee Schedule. When the payments pertain to out-of-network benefits, the schedule will be known as Aetna Out-of-Network Rates (AONR). (This schedule does not apply to emergency services or other benefits considered at the in-network benefits level of a member's plan.)

As a result, members will likely be responsible for a larger out-of-pocket amount when they seek services from nonparticipating providers. To minimize these costs, remember to refer patients to in-network providers. For a complete list, visit **www.aetna.com/docfind.**

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Policy and Practice 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 accompanying chart outlines coding and policy changes:

Procedure	Implementation date	What's changed
Arthroscopy	3/1/2010	29822 (arthroscopy, shoulder, surgical; debridement, limited) will be allowed when billed with 29826 (arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release).
Dosimetry	3/1/2010	When basic dosimetry is billed, ten (10) units of 77300 per date of service and 20 units per course of therapy will be allowed.
Anesthesia/pain management	3/1/2010	Aetna currently denies an anesthesia service when billed with a pain management service; modifier 59 will not override this edit.
Vertebroplasty	3/1/2010	Vertebroplasty, kyphoplasty and vesselplasty (e.g., Vessel-X) will be considered experimental and investigational as noted in Clinical Policy Bulletin #0016 (Back Pain – Invasive Procedures).
Allergen specific IgG quantitative or semi-quantitative (86001)	3/1/2010	As noted in Clinical Policy Bulletin #0038 (Allergy Testing and Allergy Immunotherapy), IgG RAST/ELISA testing is considered experimental and investigational.
Post procedure period for radiation therapy procedures	3/1/2010	In addition to following CMS 90-day post procedure logic for E&M services billed with radiation therapy treatment, E&M services will also be denied when billed 90 days following radiation therapy procedures 77401-77416, 77418, 77422-77423, 77520-77525, 77600-77620, 77785-77789.
Anesthesia services	5/14/2010	Aetna allows payment of anesthesia services (ASA codes) only when billed by an anesthesiologist or an oral surgeon. Anesthesia represents an area of medicine that requires unique training and only physicians having the unique training and skills to provide safe and qualified anesthesia services should bill an anesthesia service.
Facet joint injections	5/14/2010	Aetna allows two (2) sets of facet joint injections per region once every three (3) years (two (2) cervical or thoracic and two (2) lumbar or sacral). A set is considered six (6) injections. Refer to CPB #0016 (Back Pain – Invasive Procedures).
Procedure codes requiring precert	Annual reminder	Claims submitted with procedure codes listed on the National Par Provider Precert List (NPL) are reviewed to verify the provider's participation status and to determine if a precert is required for the specific code billed. Failure to contact Aetna for precertification will relieve Aetna or plan sponsors and members from any financial liability for the applicable services. For a list of procedure codes requiring precert, refer to **http://www.aetna.com/provider/medical/resource_med/coverage_med/precertification_policy_att_a12-12.html**
Claim auditing logic using date of service	Informational purposes only	Aetna's coding and payment policies are applied based on the specific date of service of the claim.

Correction – pharmacy precertification

In the September 2009 issue, we incorrectly included information about precertification for the drugs listed below. Precertification will not apply to these drugs on January 1, 2010:

- OXYCONTIN/*oxycodone* SR
- DURAGESIC/*fentanyl patch*
- COMBUNOX/*oxycodone-ibuprofen*
- *butorphanol*/STADOL NS

Existing quantity limits will be extended to all commercial pharmacy plans effective January 1, 2010.

Get your claims paid faster with EFT

We know you want to get paid quickly for the services you deliver. That's why Electronic Funds Transfer (EFT) may be the answer for you.

Instead of sending paper checks, we'll send payments to you via EFT – a secure, free, online capability.

In a recent survey, providers told us they like EFT because they:

- Receive prompt electronic payments directly to their bank account(s) up to one week faster than with paper checks.
- Eliminate the need for trips to the bank, as well as reduce handling time by staff.
- Save paper and manage their business more effectively with a convenient audit trail.

Enroll today by following these steps:

- Fill out the EFT enrollment form at **www.aetna.com/provider/data/ERA_EFT_Enrollment_Form.pdf** and attach a voided check or letter from your banking institution.
- Fax the completed form to our secure enrollment desk at 860-754-9122. You'll begin receiving EFT payments directly to your bank account within 10-15 days after enrollment is completed.

Check out our improved self-service account management tools

Recently, we enhanced the online Claim History Report available on our secure provider website via NaviNet.® The report now includes additional Medicare data to help your office with claims reviews and managing your accounts receivable. You can securely download your reports through NaviNet.

The online Claim Reconsideration tool allows you to easily select and submit claims for payment reconsideration. This convenient function sends your claims directly to Aetna for prompt handling.

If you have 10 or more claims requiring payment reconsideration for the same reason, the Multiple Claim Reconsideration function lets you to send them together in one request to the appropriate area at Aetna.

Access these tools through the 'Account Management Tools' menu on the Aetna Plan Central page of NaviNet. To learn more about the tools, visit the "Aetna's Online Account Management Tool (AMT)" course on Aetna's Education Site at **www.AetnaEducation.com**.

Quest Diagnostics® tools assist with lab results

Quest Diagnostics offers tools to help physicians and staff order, track, trend, provide results and remind patients of laboratory testing, including "Care360" and "TestMinder™."

Care360 Physician Portal

Providers can order or review lab results, prescribe medications, and access patient histories from any location.

TestMinder

With TestMinder, an automatic email reminder is sent to patients who have standing orders. The goal is to increase patient compliance for recurrent lab testing.

The e-mail reminders will help prompt them to schedule appointments by using the online appointment scheduler each time they are due for a test. This service is especially useful for patients with chronic illness and for patients requiring frequent drug monitoring.

Refer to participating labs

As a reminder, refer your Aetna patients to a participating lab, such as Quest Diagnostics. Doing so may significantly decrease their out of pocket expenses.

For more information on the tools Quest Diagnostics offers, go to **www.questdiagnostics.com** or contact your local Quest Diagnostics sales representative.

Office Wise

Compassionate Care Program enhances hospice benefit

Aetna's Compassionate Care Program (ACCP) provides a full spectrum of benefits for support and services to terminally ill members and their families, including nurse case management support, online tools and information.

As of September 1, 2009, we began offering the following enhanced hospice benefit to most employer groups:

- The option for a member to continue curative care while in hospice
- The ability to enroll in a hospice program with a 12-month terminal prognosis
- Elimination of the current hospice day and dollar maximum plan limits, including respite and bereavement services*

Pilot program results

We made these changes as a result of a 2005 pilot program in which we liberalized end-of-life benefits for members and their families. Results showed that hospice utilization increased while the use of acute care and hospital-based services decreased with the enhanced hospice benefit, along with nurse case management, Member and caregiver testimonials also indicated greater satisfaction in the program's value.

Check member eligibility to verify if your Aetna patients have this benefit.**

* Certain precertification and plan limits apply.

**Aetna's Compassionate Care program is not currently included as a standard feature for Medicare products, Cofinity® plans, Aetna Student Health plans, Aetna Affordable Health Choices®, federal business or conversion business. Plan exclusions and limitations apply.

More choices for hospitals: new accrediting agency

Aetna now recognizes Det Norske Veritas Healthcare, Inc. (DNVHC) as an accrediting agency for hospitals. The Centers for Medicare & Medicaid Services recently approved DNVHC as a national accreditation organization with deeming authority for hospitals.

DNVHC offers a hospital accreditation program called the National Integrated Accreditation for Healthcare Organizations (NIAHO). This program integrates ISO 9001 standards, which are international quality standards that define minimum requirements for a quality management system and the Medicare hospital Conditions of Participation.

NIAHO approval provides hospitals with another accreditation option, in addition to the Joint Commission on Accreditation of Healthcare Organizations and the American Osteopathic Association.

Use Aetna contracted coding for AWCA claims

You can save time and money by properly coding your Aetna Workers' Comp Access® (AWCA) claims according to your Aetna contract.

Coding the claim properly the first time helps avoid your office having to send in the same claim multiple times. Sending a claim with non-contracted codes can also result in processing and payment delays.

Refer to your Aetna contract for the appropriate billing codes. You can also find additional information about claims processing, as well as a list of all AWCA clients/payers, at **awca.aetna.com**.

Prescription Medications & Pharmacy Management

Update: Growth hormone medications

In the September 2009 issue, in an article about the 2010 National Precertification List, we reported on modifications to our growth hormone products that will become effective on January 1, 2010.

Note the following updated information for growth hormone medications:

- Nonpreferred growth hormone products (e.g., Genotropin, Norditropin, Omnitrope) will not be considered medically necessary unless preferred growth hormone products (e.g., Humatrope, Nutropin/AQ, Saizen, Tev-Tropin) do not have the labeled indication.
- Contraindications or intolerance to growth hormone treatment would be consideration for discontinuation of growth hormone.
- Physicians with Aetna patients on nonpreferred products who currently have precertification authorizations and prescription refills extending past January 1, 2010 must prescribe preferred products to these patients in order to avoid disruption in therapy.

For more information, refer to Clinical Policy Bulletin number 0170: Growth Hormone (GH) and Growth Hormone Antagonists. Go to **www.aetna.com** and select "Health Care Professionals" then "Policies & Guidelines."

Precertification is the process of collecting information prior to inpatient admissions and selected ambulatory procedures and services for the purpose of (1) receiving notification of a planned service or supply, or (2) making a coverage determination. Coverage determinations may be based on plan documents and nationally recognized guidelines/criteria. Precertification applies to all procedures and services on the Aetna Participating Provider List and to all benefits plans that include a precertification requirement, with the exception of Traditional Choice® indemnity plans and non-PPO Medicare Open Private Fee-for-Service plans.

Change in source for Average Wholesale Price data

Effective January 1, 2010, we are transitioning from First DataBank to Medispan – another industry standard source – for National Drug Code (NDC) Average Wholesale Price (AWP) data.

We are making this change to facilitate the shut down of a legacy system and maintain consistent payment for administered drugs and injectables. This change should not affect your payments, as there is no significant difference in the NDC AWP data provided by Medispan.

Medicare

Do not collect copays from dual eligible members

Individuals with both Medicare and Medicaid health insurance coverage are called "dual eligibles." Depending on their category of Medicaid coverage, a dual eligible may receive state Medicaid plan assistance to cover their Medicare Part B premium, Medicare Part A and B cost share and certain benefits not covered by Medicare.

Centers for Medicare & Medicaid Services (CMS) guidelines stipulate that dual eligibles who qualify to have their Medicare Parts A and B cost share covered by their state Medicaid plan are not responsible for paying their Medicare Advantage plan cost shares for covered services. Providers may not balance bill for these amounts.

CMS requirements

To comply with this CMS requirement, providers treating dual eligibles enrolled in an Aetna Medicare Advantage plan must do the following for these members:

- Bill Aetna as primary payer and the state Medicaid plan as secondary payer.
- Accept the Medicaid payment as payment in full and not collect any cost share from the member if they participate with their state Medicaid program.
- Prior to providing services, notify the member if they do not accept state Medicaid as payment in full.

Enhanced compensation possible with new Medicare Advantage program

Through the Aetna Medicare Provider Collaboration Program, medical groups may have the opportunity to enhance their compensation for some Aetna Medicare Advantage members enrolled in their offices.

This new quality-based pay-for-performance program focuses on measures relevant to improved quality of care and outcomes for Medicare beneficiaries with multiple chronic conditions. Program measures include:

- Follow-up care for CHF, COPD and diabetes
- HgbA1c testing for diabetics
- Timely office visits after hospitalization
- Overall reduction in avoidable admissions

Dedicated case management

Aetna may help facilitate success for medical groups in the program through dedicated case management assistance, predictive modeling information and potential quality of care improvement opportunities in the form of Care Considerations.

This program is geared toward primary care physician groups and multi-specialty groups. It is available across our Medicare Advantage HMO/PPO service areas.

For more information, contact your network account manager or Aetna Clinical Project Manager Allyn Webert at 847-359-8546.

Try our risk adjustment data validation tool

We've developed a handy self-assessment tool for reviewing patient records in accordance with risk adjustment guidelines established by the Centers for Medicare & Medicaid Services (CMS). This free tool can help you assess your medical records to determine compliance with CMS specifications.

As a reminder, when treating Aetna Medicare Advantage members you should document all chronic conditions and assessments in the patient's medical record. You also should include all appropriate diagnosis codes to the highest level of specificity when submitting claims to Aetna.

The risk adjustment self-assessment tool is available on Aetna's Education Site for Health Care Professionals at **www.AetnaEducation.com**. After logging in, click "Reference Tools" and then select "Products, Programs and Plans."

Upcoming Aetna Medicare formulary changes

Beginning January 1, 2010, the Aetna Medicare formulary for our individual Medicare Advantage plans with Medicare prescription drug coverage (MA-PD) plans and standalone Medicare prescription drug plans (PDP) will change as follows:

- A subset of Medicare Part D drugs will be covered under our plans rather than all Medicare Part D drugs.
  - Multi-source brand drugs (those with an equivalent generic) will no longer be covered.
  - Single-source brand drugs that have the greatest efficacy and market share were retained, while eliminating some brand drugs that are deemed equally or less effective.
- 90% of all Medicare Part D generic drugs will now be covered in our lowest cost-sharing tier (T1 Preferred Generic).

Members impacted by these changes will likely want to discuss alternative prescription drug options with their physician. We encourage switching to formulary drug alternatives. Medical exception requests can be submitted via the standard precertification process. Members must meet specific clinical criteria to obtain approval for a medical exception request.

Some Aetna MA-PD plans and PDP plans offered to employer groups will also be subject to formulary changes.

Aetna MA-PD and PDP members receive an abridged formulary. Individual MA-PD and PDP members received a formulary change grid containing a summary of changes to our 2010 formulary. Formulary information is available at **www.aetnamedicare.com**.

Note that CMS requires additional changes to MA-PD and PDPs for 2010, including deductible, initial coverage limit, TrOOP threshold and catastrophic coverage cost sharing.

Review our Medicare, non-Medicare formularies

We update the Aetna Medicare and non-Medicare Preferred Drug Lists, also known as our formularies, at least annually and from time to time throughout the year.

- For up-to-date Medicare formulary information, visit **http://www.aetnamedicare.com/plan_choices/rx_find_prescriptions.jsp**.

We recently communicated changes to our commercial Preferred Drug List that will become effective January 1, 2010. This list is updated regularly and shows many of the drugs covered by your Aetna patients' plans. While coverage is not limited to medications on the Preferred Drug List, you can help many of your patients lower their out-of-pocket costs by prescribing drugs on the list, when appropriate. Visit **www.aetna.com/formulary**.

For a paper copy of our Preferred Drug Lists, call 1-800-AetnaRx (1-800-238-6279).

Aetna's Education Site for Health Care Professionals

Learning Opportunities From Aetna...Developed With You In Mind

New and updated courses for physicians, nurses and office staff

Continuing Education

- **Updated** Pandemic Flu: Aware and Prepared CME

Office Administration

- *NEW* Patient Safety: Keep Your Patients Covered: Vaccine Administration for the PCP
- **Updated** ID Cards: Member ID Card Education Tool

Reference Tools

- *NEW* Pandemic Flu Resources: H1N1 reference tool
- *NEW* Patient Safety: Keep Your Patients Covered: Vaccine Administration for the PCP
- *NEW* Products, Programs and Plans: Medicare Risk Adjustment Data Validation Self-Assessment Tool

Don't forget to visit our redesigned Education Site at **www.AetnaEducation.com**. It's full of dynamic features that make it easier than ever to use. Use the available tools to help with administrative tasks, as well as clinical and patient outcomes.

Download our course catalog

It's easy to find courses with our downloadable, printable course catalog. Explore our wide range of courses at **http://aetnaofficelink.providerpreference.com/files/Education_Catalog.pdf**.

Striving for Quality Excellence

Consult Clinical Practice Guidelines as you care for patients

The National Committee for Quality Assurance (NCQA) requires health plans to regularly inform providers about the availability of Clinical Practice Guidelines.

Our Clinical Practice Guidelines and Preventive Service Guidelines are based on nationally recognized recommendations and peer-reviewed medical literature. They are located on our secure provider website via NaviNet under "Aetna Support Center" and then "Clinical Resources."

Guideline	Adopted
Preventive Service Guidelines	Adopted 1/08
Preventive Service Guidelines Updates	
■ Using Aspirin to Prevent Cardiovascular Disease (USPSTF*)	Adopted 5/09
■ Screening Adolescents for Clinical Depression (USPSTF)	Adopted 5/09
■ Folic Acid to Prevent Neural Tube Defects (USPSTF)	Adopted 7/09
Asthma	
■ Treating Patients With Asthma	Adopted 1/08
Behavioral Health	
■ Antidepressant Prescribing Guide for Use in Primary Care	Adopted 1/08
■ Helping Patients Who Drink Too Much	Adopted 4/08
■ Treating Patients With Bipolar Disorder	Adopted 4/08
■ Treating Patients With Major Depressive Disorder	Adopted 4/08
Diabetes	
■ Treating Patients With Diabetes	Adopted 2/09
Heart Disease	
■ Treating Patients With Chronic Heart Failure	Adopted 1/08
■ Treating Patients With Coronary Artery Disease	Adopted 9/08
■ Treating Patients With Hypercholesterolemia	Adopted 4/08
■ Treating Patients With Hypertension	Adopted 4/08

For a hard copy of our Preventive Service Guidelines or a specific Clinical Practice Guideline, call our Provider Service Center.

*U.S. Preventive Services Task Force

Aetna.com has a new look. On September 15, 2009, Aetna launched its redesigned website. The goal of the redesign is to better serve all of Aetna's constituents, with a focus on improving the end user's experience and ability to efficiently complete tasks.

Check out **www.aetna.com** today.

Results of our 2009 medical record review

We conduct a medical record review every two years to assess health care professionals' compliance with Aetna's documentation standards.

The West Region met or exceeded the performance goal of 85 percent in most categories for medical record audits. We have targeted two areas for improvement that fell below the 85 percent compliance goal:

- Documentation of age appropriate immunizations
- Documentation of advance directives for patients >18 years of age

The Health Care Professional Toolkit, located on our secure provider website via NaviNet, includes our documentation standards and tools to help with medical record documentation. These online tools include:

- **Adult Health Maintenance Form:** includes a field for documenting allergies, problem list for medical and psychological illnesses, and space for noting discussion of advance directives with older patients.
- **Medical History Form**: includes fields for documenting allergies, immunizations and living will.
- **Pediatric Health and Immunization Summary Sheet**: includes a field for documenting allergy and immunization information in pediatric patients.

Advance directive criteria

Our Participating Practitioner Medical Record Criteria require that documentation about advance directives (whether executed or not) is in a prominent place in the patient's record (except for patients under age 18). For Medicare patients, such documentation is required by the Centers for Medicare & Medicaid Services, and we must monitor participating physician compliance.

Find advance directive forms for specific states at **www.aetnacompassionatecare.com**. If the state you practice in is not listed, go to **www.uslivingwillregistry.com/forms.shtm** for an advance directive form or for more information.

If you don't have Internet access, you can request a paper copy of the Toolkit by calling our Provider Service Center.

Member access for appointments to primary care physicians

Aetna has established the following standards for members seeking to schedule office visits with their primary care physicians:

Appointment type	Standard
Urgent care appointments	Same day or within 24 hours
Symptomatic care/non-urgent acute complaint	Within 3 days
Routine care	Within 7 days
Preventive routine care	Within 8 weeks

Results from the 2009 Consumer Assessment of Health Plans Survey (CAHPS®) which in part focuses on member satisfaction with obtaining appointments, fell below our established goals. We ask that your office try to meet these standards going forward.

For more information, refer to your provider office manual or the Aetna Health Care Professional Toolkit. The toolkit is available online through our secure provider website via NaviNet.

After-hours access standards

The suggested after-hours access standard is to have a reliable 24-hour, 7-days-a-week answering service or automated system that provides patients with explicit directions. We ask that you review and update your message for appropriate instructions to members.

We recently measured after-hours access to care standards using 2009 CAHPS Health Plan Survey 4.0H and an after-hours survey of physician offices. The offices were evaluated on:

- Providing clear, explicit instructions on what to do in an emergency
- Offering directions on what to do for urgent and non-urgent situations
- Informing callers that a return call by a practitioner should be expected in no more than 30 minutes

Providers who failed to meet the 100 percent performance goal standard were reminded of the importance of proper after-hours communications access. We then resurveyed those offices to determine compliance.

CALIFORNIA

Key parts of our expanded prenatal screening program

We want to remind you of some important components of the California Prenatal Screening Program (PNS), which was expanded earlier this year.

This statewide program for prenatal screening and prenatal diagnosis of major birth defects and genetic disease provides the appropriate standard of care for expectant mothers, with minimum hassle for you and your patients.

About the program

By California law and regulation, prenatal screening with maternal blood markers can now only be performed through the PNS.

The fee for these services is $162. This fee is billed one time only, regardless of the blood tests and services the patient receives in the first trimester, second trimester or both.

If the patient or her prenatal care provider includes her Aetna insurance information when her blood specimen is submitted, Aetna will be billed directly by the PNS.

Test results

The blood specimen is sent to one of seven California state-contracted labs for analysis in the first trimester, second trimester or both. The program's computer system analyzes the results and delivers a screen positive or screen negative result.

Screen negative results are sent to the patient's prenatal care provider, and no additional follow-up services are provided. Screen positive results, indicating higher risk for one or more birth defects, are sent to the patient's prenatal care provider and state regional coordinators for tracking and follow-up.

For more information about the California Prenatal Screening Program, go to **www.cdph.ca.gov/PROGRAMS/pns/Pages/default.aspx**

CALIFORNIA

Aetna Medicare Advantage plan available in new service area

Beginning January 1, 2010, the Aetna Medicare[SM] Plan (HMO) will be available in San Diego, California.

Remember these important points about our Medicare Advantage plans:

- Member ID numbers will start with the letters "ME."
- "Zero copayments" may apply for many covered preventive services.

In addition, providers are required to obtain precertification for certain covered services. Precertification requests can be submitted online.

You can access our Medicare Advantage plan information online through our secure provider website via NaviNet. Once logged in, under "Plan Central," select "Aetna Health Plan," then "Aetna Support Center" (left menu bar), then "Doing Business with Aetna," "Aetna Benefit Products" and "Aetna Medicare."

California providers: How to access your fee schedule

In accordance with the regulations issued pursuant to the Claims Settlement Practices and Dispute Mechanism Act of 2000 (CA AB1455 for HMO) and pursuant to the expansion of the Health Care Providers Bill of Rights (under CA SB 634 for indemnity and PPO products) we are providing you with information about how to access your fee schedule.

- If you are a provider affiliated with an IPA, contact your IPA for a copy of your fee schedule.
- If you are a provider directly contracted with Aetna, fax your request along with the desired CPT Codes to 1-859-455-8650. If you have additional questions, please contact the Provider Service Center.
- If your hospital is reimbursed through Medicare Groupers, visit the Medicare website at **http://www.cms.hhs.gov** for your fee schedule information.

For more information

Visit **www.dmhc.ca.gov/** and select "Providers", then "General Information," "Laws" and "Existing Regulations."

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- ❑ Nurses
- ❑ Referral and Precertification Staff

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