



Aetna OfficeLink Updates™

West Region

Inside This Issue

Policy and Practice Updates . . .2-4
 Office Wise 5
 Striving for
 Quality Excellence 6
 Aetna's Education Site for
 Health Care Professionals 7
 Medicare8-9
 West News10-11

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) for all other plans

Online precertification: cost savings and convenience

Submitting and inquiring about your medical precertification requests electronically is a simple, efficient way to save your office both time and money.

You could grow your savings by submitting *all* of your medical precertification requests electronically. Sending as few as 10 electronic precerts a month could save you nearly \$1,045* annually.

We offer electronic precertification transactions and tools on our secure provider website featuring:

- Availability for all Aetna benefits plans 24 hours a day, Monday – Saturday
- Minimal wait time for initial responses (one minute or less)
- Secure data transmission
- Ability to search diagnosis and procedure codes by description

- Option to create a personalized list of "favorite" providers/facilities that you normally include on your precert requests

Many of our vendor partners also offer the ability to submit and inquire on precertifications.

Start now

- Contact your software vendor/clearinghouse and verify their ability to submit real-time precertification transactions to Aetna.
- Log in or register to our secure provider website via NaviNet® and access our online precertification transactions from the Aetna Plan Central home page.

To learn more, log in to www.AetnaEducation.com and launch the 15-minute Precertification Recorded Webinar.

*Savings amount obtained by using the Milliman Study option of our [EDI Savings Calculator](#).

Where to find information on health care reform

To help you succeed in the new health care environment, we have created a website that contains information about the health care reform legislation.

Go to www.aetna.com and then click on the Health Care Reform link under "About Us" on the bottom of the page. This site has links to questions and answers about various topics contained in the legislation.

More information is available on the Department of Health and Human Services website at <http://www.healthcare.gov>.

Aetna will continue to work toward improving the quality of health outcomes, and providing better value for each dollar spent on care.



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
Surgical pathology	October 17, 2010	As of October 17, 2010, 88346 (immunofluorescent study, each antibody; direct method) is allowed five times per date of service.
Multiple procedure reductions for CT scans, MRIs or ultrasounds	February 1, 2011	For dates of service on or after February 1, 2011, the policy for multiple procedure reductions for certain diagnostic imaging services will change. The initial CT scan, MRI or ultrasound will be allowed at 100 percent and subsequent scans performed on the same day will be allowed at 50 percent. The reduction will apply to: <ul style="list-style-type: none"> scans performed on contiguous body areas, and technical and global charges
Prosthetic socks	February 1, 2011	Effective February 1, 2011, L8400 - L8499 will be allowed twelve (12) times per prosthesis per date of service.
Surgical repair of vestibular stenosis	February 1, 2011	Effective February 1, 2011, 30930 (fracture nasal inferior turbinate(s) therapeutic) will be allowed when billed with 30520 (septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft).
Surgical repair of vestibular stenosis	March 1, 2011	Effective March 1, 2011, 30930 (fracture nasal inferior turbinate(s) therapeutic) will be allowed once per date of service.
Modifier 81 – minimum assistant surgeon	March 1, 2011	When Modifier 81 is billed and the procedure is considered eligible for use of an assistant surgeon, Modifier 81 will be paid at 12 percent of the recognized charge/surgical fee allowance or the negotiated rate.
Impression casting of a foot when billed with an orthotic procedure	March 1, 2011	S0395 will be denied when billed with an orthotic procedure code (L0100 - L9999) within a 90-day timeframe.
Modifier 59 exceptions	March 1, 2011	Effective March 1, 2011, Modifier 59 will not override the following incidental edits/code combinations: <ul style="list-style-type: none"> 92502 when billed with 30000 - 31615 (nose, accessory sinuses, larynx, trachea) 92502 when billed with 40490 - 42972 (lips, vestibule of mouth, tongue and floor of mouth, dentoalveolar structures, palate and uvula, salivary gland and ducts, and pharynx, adenoids, and tonsils) 92502 when billed with 69000 - 69979 (auditory system) 45990 when billed with 45000 - 45999 (rectum) and 46000 - 46999 (anal) 57410 when billed with 56405 - 58999 (female genital system) 94150 - Vital capacity, total 94250 - Expired gas collection, quantitative, single procedure 94690 - Oxygen uptake, expired gas analysis; rest, indirect 94760 - Noninvasive ear or pulse oximetry for oxygen saturation; single determination 94761 - Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations

HEALTH CARE REFORM

Use the right billing codes for preventive services

Under the Patient Protection Affordable Care Act (PPACA), health plans must now cover in-network preventive care services without cost sharing (copayments, coinsurance, deductibles, etc.)

When you submit claims for preventive services, it is important to use the correct preventive care HCPC, CPT and/or ICD-9 billing code(s). This will help ensure that you are paid your contracted rate by Aetna.

The right preventive care billing code should be the primary code on the submitted claim when the main purpose of the member's visit was for preventive care.

Find codes on NaviNet

You can access these preventive care codes online through our secure provider website via NaviNet. Go to "Aetna Plan Central," then "Aetna Support Center," then "Claims," then "Benefit Guidance Statements." Then, scroll down to "016 – Routine Preventive Visits."

If you don't have access to NaviNet, you can register by going to www.aetna.com. Click on "Health Care Professionals" at the top of the page, then "Medical Professionals Log In." Offices without internet access or a computer can call our Provider Service Center for more information about the preventive services codes.

Check member eligibility

To determine if a patient's plan covers preventive care at 100 percent, check member eligibility and plan features at the time of the visit. Services designated as preventive care include periodic well visits, routine immunizations and routine screenings for symptom-free or disease-free individuals.

Note that while the law is in effect now, it doesn't mean all members immediately have this coverage. Plans must cover preventive care 100 percent when they renew on or after September 23, 2010. Also, certain "grandfathered" plans may be exempt from this requirement.

Updates to HCPCS claims reimbursement

Effective December 20, 2010*, we are enhancing our medical claims system to validate the dosing frequency and submitted charges of certain specialty or injectable medications administered in the physician's office. This affects all Aetna benefits plans.

A dosing algorithm will screen these claims to identify possible billing errors that exceed standard dosing frequency for the drug. This frequency threshold is safety driven. It is based upon dosing frequency in the product labeling; Food and Drug Administration dosing guidelines; and peer-reviewed, published medical literature for each drug.

This policy applies to many office-administered medications billed with Healthcare Common Procedure Coding System (HCPCS) codes. Visit our secure provider website via NaviNet. Once logged in, select "Aetna Support Center" then "Claims" and "CPT/HCPCS Coding Tools."

*In Texas and Ohio, the effective date is March 20, 2011.



Experimental, investigational lab tests are not covered

At times, we hear from members who unexpectedly had to pay for lab tests they thought were covered services. Although these tests were ordered by their physicians, these procedures are experimental or investigational based upon evidence-based standards. As a result, they are not covered under the terms of the member's health plan.

Reminder: Aetna plans do not cover laboratory tests that are considered experimental or investigational, even when these studies are ordered by a participating physician. The chart below lists some of the most commonly ordered experimental or investigational lab tests.

Lab test	Aetna Clinical Policy Bulletin (CPB)
Homocysteine cardiovascular test (83090)	0381, 0562
Lipoprotein (A) (83695)	0381
Immunoassay for tumor antigen, quantitative CA 19-9 (86301)	0352
Infectious agent detection by nucleic acid (DNA or RNA); Papillomavirus, human, amplified probe technique (87621)	0443
PCR test for Lyme disease (87476)	0215, 0650
VAP cholesterol test (83701)	0381

Because these tests are not covered, we will reject claims submitted for them. Your patient will be financially responsible for these services.

Your Aetna patients should be aware of our position and understand they will be responsible for payment. If you have questions about these procedures, refer to the corresponding Aetna CPB for a review of the medical evidence on which our position is based.

Verify coverage

We offer an online reference tool listing laboratory tests that are excluded from coverage, or that may be conditionally covered. Go to our secure provider website via NaviNet by selecting "Claims" from the Aetna Plan Central home page then "Clinical & Payment Policy Code Lookup," and then "Select a code by Category" drop-down menu.

Facilities: determine patient responsibility charges for in-patient services

We've added a new feature to Aetna's Payment Estimator tool that allows you to request an estimate for commonly-utilized inpatient services.

After submitting a request for an inpatient service estimate, you will receive reliable estimates for:

- Aetna's payment amount (according to your fee schedule) for non-urgent, female-related inpatient services
- Patient responsibility amount for your facility charges, along with an estimate of responsibility for all those related charges (anesthesia, radiology, etc.)

No more keying

Other than entering basic member information and choosing what type of service you want to estimate, you don't have to key any data. Using historical information, Aetna "builds" your estimate submission based on our determination of services that are commonly billed together, and we include the diagnosis, revenue and procedure codes.

Try it today

Access the new inpatient features by selecting "Payment Estimator" from the Aetna transaction menu on our secure provider website via NaviNet. Learn more about the new inpatient feature by reviewing our [Payment Estimator](#) website.



Physicians: update your hospital privileges in DocFind®

If you maintain hospital privileges, it is important to keep that information current in our DocFind online provider directory.

Aetna's relationship with a hospital can affect the amount of coinsurance a member pays to use that hospital. Therefore, members may use DocFind to choose providers based on their hospital privileges. We encourage you to regularly review your DocFind listing and confirm that your hospital privileges and practice information are current.

Revise your profile

To access your listing, go to www.aetna.com. Select "Health Care Professionals" and then "Medical Professionals Log In." To update address information, affiliations, or demographics select "Update Provider Profile" tab from the left chrome menu in Aetna Plan Central.

You can add a new provider profile to DocFind through the Aetna transaction menu on our secure provider website via NaviNet. Choose "NaviNet

Data Maintenance," then "Provider Maintenance." (Note that this transaction is available to your office's NaviNet security officer only.)

For more information on how to add providers, see the Provider Maintenance User Guide. You can access this guide via NaviNet Customer Support from the Customer Support menu. Then, under User Guides, choose "Aetna."

Be prepared for new radiology accreditation requirements

Beginning January 1, 2012, Aetna will have new radiology accreditation requirements for our commercial business. This policy does not apply to Medicare. Our Medicare policy was communicated in the September 2010 newsletter.

To be eligible for reimbursement for the technical component of advanced diagnostic imaging procedures, the following types of providers must be accredited by the American College of Radiology (ACR) and/or the International Accreditation Commission (IAC):

- Independent diagnostic testing facilities
- Freestanding imaging centers
- Office-based imaging facilities
- Physicians
- Non-physician practitioners

- Suppliers of advanced diagnostic imaging procedures

This accreditation requirement applies to the technical component of advanced diagnostic imaging procedures. For these purposes, advanced diagnostic imaging procedures exclude X-ray, ultrasound, fluoroscopy and mammography. Included are:

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Computed tomography (CT)
- Echocardiograms
- Nuclear medicine imaging, such as positron emission tomography (PET)
- Single photon emission computed tomography (SPECT)

Note the following:

- Providers not accredited by the ACR or IAC by January 1, 2012 will not be eligible for payment for advanced diagnostic imaging services.
- This requirement will not apply to patients who are in the hospital or in hospital emergency departments.
- This policy will not apply to hospitals, unless they own one of the above listed providers.
- The accreditation process can take 9 to 12 months, so we recommend you begin the accreditation process as soon as possible.

Reminder: Update your demographic information

It is essential that our members have accurate information about your practice's participation and location(s). We appreciate your diligence in helping us keep our records up to date.

To update your demographic information, visit our secure provider website via NaviNet. On the Aetna Plan Central home page, choose "Update Aetna Provider Profile."

If, after accessing the website, you have questions about updating your

information, call our Provider Service Center at 1-800-624-0756 for HMO-based and Medicare Advantage plans, or 1-888-MD-Aetna (1-888-632-3862) for all other plans.

Striving for Quality Excellence

Health literacy – avoid medical jargon

A good way to help improve your patients' understanding of what you tell them is to avoid medical jargon. Here is a handy list to help you communicate with your patients who may not understand some medical terms.

Instead of using this word:

benign
chronic
cardiac
edema
fatigue
screening
intake
generic
adverse events

Consider using this instead:

harmless
happens again and again, does not end
heart
swelling, build-up of fluid
tired
test
what you eat or drink
not a brand name
side effects

Take our 10-minute health literacy checkup at www.AetnaEducation.com.

RelayHealth® offers online communication, clinical services

RelayHealth, a secure, easy to use web-based service, can assist provider offices to achieve clinical integration. The RelayPlatform can help your practice:

- improve patient satisfaction and office workflow,
- save money, and
- qualify for incentive programs, like American Recovery and Reinvestment Act (ARRA) Meaningful Use.

Online services include:

- An online service offering your patients an alternative to phone calls and office visits. RelayClinical webVisits® are reimbursable, structured online encounters – ideal for non-urgent or chronic medical problems.
- A secure, electronic health record for your patients.
- Connections to hospitals and labs to receive electronic results.

- An easy to use electronic prescribing tool.
- All the components required to help you meet Stage 1 Meaningful Use for Eligible Providers.
- The ability to connect and participate in local and state health information exchanges.

RelayHealth is available to Aetna members in all states where Aetna participating doctors are also enrolled in the RelayHealth service.

To register or learn more:

- Call 1-866-RELAY-ME (1-866-735-2963), Option 2.
- Visit www.relayhealth.com. Click on the “Providers” tab, followed by “Online Services.”
- Visit <http://www.aetna.com/healthcare-professionals/join-aetna-network/online-visits.html>.

AETNA WORKERS' COMP ACCESS

Best practices for requesting prior authorization

An easy way to ensure that your prior authorization request is not met with a “Request for More Information,” “Denial,” or “Split/Modified Decision” notification is to understand which treatment guidelines each utilization review organization (URO) uses to evaluate these requests.

Aetna Workers' Comp Access (AWCA) requires that our network physicians and UROs follow the most current edition of the ACOEM Practice Guidelines (APG) and/or Official Disability Treatment Guidelines (ODG). If the requested service or procedure is not addressed by either one of these guidelines, then supplemental criteria can be used (for example, Milliman & Robertson).

If your treatment request is not substantiated by the evidence-based medicine in these criteria sets, you run the risk of facing a delay or denial.

Access guidelines online

If you treat a large number of workers' compensation patients, consider getting online access to the APG and/or ODG treatment guidelines. Online access can enhance your understanding of how your request is evaluated and keep you current with the rapidly growing body of scientific literature about work-related injuries and illnesses. (Since the guidelines change frequently, paper copies quickly become obsolete.)

How to contact us


Send questions about AWCA treatment and/or disability guidelines to the AWCA Medical Director, Steven Serra, MD, MPH at steven.serra@aetna.com.

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


Medicare Advantage Plans

-  2010 Aetna Medicare Compliance Program (CMS requirement – see course description)
- **Updated** 2010 Medicare Fraud, Waste and Abuse (FWA)

Office Administration

- **Updated** Electronic Connectivity: Aetna's Online Account Management Tool (AMT)

Recorded Events

-  Precertification Recorded Webinar

Reference Tools

- **Updated** Provider Manuals: Women's Health Programs and Policies Manual

Time running out to take required Medicare training

The Centers for Medicare & Medicaid Services (CMS) require Compliance Program training to be completed annually by all Aetna Medicare contracted providers (including staff), downstream and related entities.

So don't delay...log in to the Education Site at www.AetnaEducation.com. Select the Medicare Advantage Plans course catalog then "2010 Aetna Medicare Compliance Program."

Complete a course, and you could win a prize

Make a New Year's resolution to visit us at www.AetnaEducation.com. In our first exciting contest of 2011, you and your office could each win a prize.

The key to this educational opportunity and contest is flexibility – the choice is yours. Just finish any course you've enrolled in but didn't complete, complete a new course altogether, meet the contest requirements and you'll be automatically entered.

Visit www.AetnaEducation.com in January to learn more and view full contest details.

Download our course catalog

Explore our wide range of courses at http://aetnaofficelink.providerpreference.com/files/Education_Catalog.pdf.

Infertility education videos are available for patients and physicians

Reproductive health experts at the Centers for Disease Control and Prevention (CDC) launched three new online videos to provide science-based information for anyone considering assisted reproductive technology (ART). ART services are infertility treatments, including in vitro fertilization (IVF).

The videos provide information about steps patients can take before beginning treatment to improve their chances

of getting pregnant, having healthy pregnancies and healthy babies. Specifically:

- Video one focuses on how to be healthy before, during and after ART treatment
- Video two explains how to evaluate fertility clinics using the CDC's ART Success Rates Report
- Video three provides information about elective single embryo transfer (eSET)

We encourage you to tell your patients about the availability of these videos.

The videos, along with questions might patients ask, are available at www.cdc.gov/art/preparingforart and www.aetnainfertilitycare.com.

Medicare

Aetna Medicare Part D changes could affect your patients

There will be changes to Aetna Medicare Rx[®] (PDP) plans in 2011 that may affect your patients with Aetna Medicare prescription drug coverage.

Some drugs will be removed from the formulary, while others may have stronger clinical controls. As a result of changes in law, some Part D program features have also been revised.

Optimize member benefits

Some drugs may no longer be covered under Aetna Medicare plans with Medicare prescription drug coverage, or will have a utilization management requirement. You can help your Aetna Medicare patients by:

- Prescribing drugs on the Aetna Medicare Preferred Drug List (formulary) at:
>individual plan formulary: http://www.aetnamedicare.com/plan_choices/rx_find_prescriptions.jsp
>group plan formulary: http://www.aetnamedicare.com/group/find_plans.jsp?tab=4

- Switching to an alternative formulary drug, when applicable
- Understanding step-therapy and precertification requirements
- Submitting a medical exception request, when appropriate
- Working with the patient on transition of coverage
- Knowing that the Aetna Medicare formulary differs from the commercial formulary

We will inform you:

- If an Aetna Medicare member has received a temporary fill of a drug that will not be covered under his/her plan in 2011.
- If an Aetna Medicare member is taking a drug in a class protected by the Centers for Medicare & Medicaid Services (CMS) in 2010, and will, therefore, be impacted by a formulary change in 2011. (Please use this information to identify Aetna

Medicare members who could experience disruption in medication therapy, and help them switch to a formulary alternative, when possible.)

Health reform impact

Some Aetna Medicare members may be eligible for lower cost sharing in their plan's Part D coverage gap phase as a result of health care reform legislation. This may occur either through discounts for covered Part D brand drugs from pharmaceutical manufacturers who are participating in the Medicare Coverage Gap Discount Program, or through reduced plan cost sharing for covered Part D generic drugs.

Patients with challenges paying for medications may be eligible for government assistance by calling 1-800-772-1213 to apply for the "Extra Help" program. Visit www.ssa.gov to learn more.

Medicare Advantage changes out-of-pocket limits

Beginning January 1, 2011, our Medicare Advantage (MA) HMO and PPO plans will include a new, mandatory maximum out-of-pocket (MOOP) limit. This limit applies to all covered Medicare Part A and Part B services, as required by the Centers for Medicare & Medicaid Services (CMS).

When an Aetna MA HMO or PPO plan member has met his/her plan's MOOP limit for the plan year, we will send the member a letter stating that the plan MOOP limit has been met. The member is then not required to pay any additional

cost sharing for covered services for the remainder of the plan year.

The letter also instructs the MA member to present the letter in the future to any treating medical providers. That way, the providers will know not to collect any cost sharing for covered services rendered to the member for the remainder of the member's plan year.

A similar letter will also be sent to a member's selected PCP when the member's MOOP limit has been met.

Providers can inquire about a member's benefits limits at any time using our secure provider website via NaviNet, or by calling the Aetna Voice Advantage[®] telephone system.

Providers who have capitation arrangements with Aetna should refer to the separate letter mailed on October 1, 2010, regarding additional requirements so that we can accurately track a member's MOOP expenses.

Patients may be enrolled in hypertension program

Aetna Medicare Advantage members who meet the new hypertension program criteria are being invited to join a year-long program to decrease their blood pressure.

As part of this program, members are asked to collaborate with their physician to set a blood pressure goal and develop

a treatment plan. To promote this collaboration, an introductory letter is sent to the primary care physician or managing physician for each participant explaining the program and noting that the patient has received program information.

Aetna has contracted with Silverlink, a health care communications firm, for phone calls and most of the mailings. Participating members receive a HoMedics Automatic Blood Pressure Monitor to track their blood pressure throughout the program.

Understanding generic prescription copay differences

Your patients with Aetna Medicare prescription drug benefits may sometimes pay a higher copay for a generic drug, or find out at the pharmacy that a generic drug is not covered under their plan.

The Medicare Modernization Act defines Abbreviated New Drug Applications (ANDA) as generics, and New Drug Applications (NDA) as brand name. The Centers for Medicare & Medicaid Services (CMS) uses this guidance to define coverage of a drug during the Part D coverage gap. Following this guidance, Aetna Medicare plans with Medicare prescription drug coverage adjudicate

prescription drugs at “point of sale” based on their approved application type (ANDA as generic and NDA as brand).

Further, when a manufacturer develops a prescription drug, they are required to seek Food and Drug Administration (FDA) approval before distribution. Brand drug manufacturers submit an NDA to the FDA for approval.

While most generic drug manufacturers will seek FDA approval by submitting an ANDA, some generic drug manufacturers enter into agreements with brand manufacturers and market an “authorized generic” under an NDA,

while other manufacturers don't submit at all. As a result, these drugs (for which manufacturers have not submitted an application for approval and therefore the drugs are not FDA-approved) are not covered under Medicare Part D.

Help patients save

If appropriate, specify ANDA generics when prescribing generic medications, which may help ensure your patients pay the lowest cost-sharing amount for the medication.

Help women prevent falls and fractures

Aetna Medicare Advantage has developed a program to help members understand the importance of bone health and ways to prevent fractures.

MA members who meet the Fall/Fracture Program criteria will be invited to join the program. It is designed to address the gaps in care for individuals who may benefit from receiving information about preventing future falls and related injuries. The program consists of 3 levels of opportunity for intervention:

- **Level 1** - Female members age 65 years or older with a history of a fracture in the previous 6 months will be contacted by Aetna to assess risks for falls. They may be offered a home health visit for home assessment.
- **Level 2** - Female members age 65 years or older with a diagnosis of osteoporosis, no known history of having a fracture and no evidence of pharmacologic management (medications) to treat osteoporosis will get an automated call reminding them to talk with their physician.
- **Level 3** - Female members age 67 years or older with no known diagnosis of osteoporosis and no evidence of bone mineral density testing in the previous 2 years will get an automated call reminding them to talk with their physician.

Aetna has contracted with Silverlink, a health care communications firm, for automated calls and member letters.

Where to review our Medicare and Commercial formularies

We update the Aetna Medicare and Commercial (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:
>individual plan formulary: http://www.aetnamedicare.com/plan_choices/rx_find_prescriptions.jsp

>group plan formulary: http://www.aetnamedicare.com/group/find_plans.jsp?tab=4

- For up-to-date Commercial Preferred Drug List information, visit <http://www.aetna.com/formulary>.

For a paper copy of these formulary guides, please call 1-800-AetnaRx (1-800-238-6279).

Correction: NovoLog® remains “preferred” on drug list

NovoLog insulin products will remain on the 2011 Aetna Commercial Preferred Drug List. Aetna members in commercial plans will be able to continue using these products without disruption in coverage or copay in 2011.

You and/or your patients may have received an earlier communication stating that NovoLog insulin products would be removed from the list for commercial (non-Medicare) plan members. However, we have made a decision to keep these products on the list.

To view the 2011 Aetna Specialty CareRxSM Drug List, visit www.AetnaSpecialtyCareRx.com.

WASHINGTON

Aetna completes withdrawal from certain plans in Washington

Aetna has completed its Health Care Service Contractor (HCSC) license withdrawal in Washington State.

As first mentioned in the December 2008 issue of OfficeLink Updates, Aetna announced its intent to withdraw from the following plans offered under our HCSC license: Primary ChoiceSM (known as “HMO” in other states), Aetna Open Access[®] Primary Choice, QPOS[®] and Aetna Choice[®] POS. Less than one percent of Aetna’s Washington members were impacted by this decision.

Aetna is retaining its disability carrier license in Washington through Aetna Life Insurance Company (ALIC). Throughout 2009 and early 2010, impacted employer groups were offered an alternative ALIC plan.

Out-of-state patients

HMO members from other states seeking services in Washington may or may not have coverage for out-of-area non-emergency care, depending on their plan’s benefits structure. These individuals could be fully responsible

for non-emergency care claims since the HMO is not offered in Washington.

Of course, in an emergency, when a delay in treatment may endanger a member’s health, we will provide coverage for emergency services at the closest emergency facility, regardless of the facility’s participation status.

If you have questions, contact us at 1-888-632-3862.

OREGON

Single sign-in now available via OneHealthPort™

In cooperation with the Oregon Health Leadership Council and OneHealthPort, Inc., Aetna has arranged to launch OneHealthPort Oregon. This web portal provides free, secure access to multiple payer administrative websites through a single log-in process.

All you need to do is register, create your unique password and log in. To register, visit <http://www.onehealthport.com/register/index.php> and click “Register Now.”

If your organization is already registered with OneHealthPort, you will have access to OneHealthPort Oregon (separate registration is not required). For additional information about OneHealthPort and the registration process, visit OneHealthPort’s online FAQ resource at http://www.onehealthport.com/use_ohp/faq.php.



CALIFORNIA

New timely access rules for providers

Each health plan’s contracted provider network must have enough available licensed health care providers to treat patients within certain timeframes. This is due to new California regulations, effective January 1, 2011.

You can view these timeframes under State-specific Information at: <http://www.aetna.com/healthcare-professionals/policies-guidelines/index.html>.

Note that Aetna does not delegate monitoring and assessment of these standards to any of its contracted provider groups.

Aetna will begin assessing its contracted provider network against these standards in 2011. Assessment will include a survey to determine availability of appointments and a provider satisfaction survey to solicit your concerns and perspectives about the standards.

Member access for appointments to PCPs

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

- Urgent care appointments:
Same day or within 24 hours
- Symptomatic care/non-urgent:
Within 3 days acute complaint

- Routine care:
Within 7 days

- Preventive routine care:
Within 8 weeks

Results from the 2010 Consumer Assessment of Health Plans Survey (CAHPS®), which focuses in part on member satisfaction with obtaining

appointments, fell below our established goals. We ask that your office tries to meet these standards going forward.

For more information, refer to your provider office manual or the Aetna Health Care Professional Toolkit, which 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 around-the-clock answering service or automated system that provides patients with explicit directions for how to access care after office hours. We ask that you review and update your message for appropriate instructions to members.

We recently measured after-hours access-to-care standards using the 2010 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 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, please 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 “Health Care Providers”, then “General Information,” “Laws” and “Existing Regulations.”

COLORADO

Notice of Material Amendment to contract

For important information that may affect your payment, compensation or administrative procedures, see the following articles in this newsletter:

- Clinical payment, coding and policy changes – page 2
 - > Multiple procedure reductions for CT scans, MRIs or ultrasounds
 - > Modifier 81 – minimum assistant surgeon
- Updates to HCPCS claims reimbursement – page 3



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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.”

Preventive Service Guidelines	Adopted 1/10
Preventive Service Guideline Updates <ul style="list-style-type: none"> ■ Screening for Obesity in Children (USPSTF¹) ■ Seasonal Influenza (CDC²) ■ HPV for males ■ Breast Cancer Screening (NCI³) 	Adopted 3/10 Adopted 3/10 Adopted 1/10 Adopted 1/10
Behavioral Health <ul style="list-style-type: none"> ■ Helping Patients Who Drink Too Much ■ Treating Patients With Major Depressive Disorder 	Adopted 3/10 Adopted 3/10
Diabetes <ul style="list-style-type: none"> ■ Treating Patients With Diabetes 	Adopted 3/10
Heart Disease <ul style="list-style-type: none"> ■ Treating Patients With Coronary Artery Disease 	Adopted 10/10

¹U.S. Preventive Services Task Force ²Centers for Disease Control and Prevention ³National Cancer Institute

The information and/or programs described in this newsletter may not necessarily apply to all services in this region. Contact your Aetna network representative to find out what is available in your local network. Application of copayments and/or coinsurance may vary by plan design. This newsletter is provided solely for your information and is not intended as legal advice. If you have any questions concerning the application or interpretation of any law mentioned in this newsletter, please contact your attorney.