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Aetna OfficeLink Updates™

Mid-America Region

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Options to reach us

Select **Health Care Professionals**, then "Log In/Register."

If you have questions after viewing the information online, call us:

- **1-800-624-0756** for HMO-based and Medicare Advantage plans
- **1-888-MDAetna (1-888-632-3862)** for all other benefits plans

80.22.803.1-Dec (12/16)

Updates to our National Precertification List

These changes to the **National Participating Provider Precertification List (NPL)** will take effect as noted below.

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 effective August 2, 2016
- Epclusa (sofosbuvir and velpatasvir) — precertification effective September 1, 2016
- Tecentriq (atezolizumab) — precertification effective September 2, 2016
- Zinbryta (daclizumab) — precertification effective September 13, 2016
- Zomacton [somatropin (rDNA origin)] — precertification effective November 1, 2016
- Cuvitru (Immune Globulin SC, human) — precertification effective November 11, 2016
- Exondys 51 (eteplirsen) — precertification effective November 15, 2016

Sermorelin Acetate will not require precertification effective November 1, 2016.

You can find more information about precertification under the "General information" section of the **NPL**.

Our policy on testing for the Zika virus

Aetna considers Zika testing medically necessary per **Centers for Disease Control and Prevention (CDC) recommendations**.

The U.S. Food and Drug Administration has approved the use of two Zika virus tests under an Emergency Use Authorization. The CDC Trioplex rRT-PCR and Zika MAC-ELISA (testing for anti-Zika IgM) are available at qualified labs in the United States.

Continued on page 2

Our policy on testing for the Zika virus (continued from page 1)

Zika testing can be performed by the CDC, some state health departments, local/county health departments, and by certain CDC-approved commercial labs.

Quest Diagnostics® is an Aetna preferred in-network drug testing services laboratory and can **perform the full range of Zika tests**. We cover the following testing:

- 87798 – Zika PCR assay
- 86790 – Zika IgM serology test

Zika virus is usually found in serum for about 7 days (or longer in pregnant women) and in urine for about 14 days after the onset of symptoms. For patients who are 2 – 12 weeks after onset of symptoms, serologic testing (IgM) should be considered to test for Zika infection.

For more information, see **Clinical Policy Bulletin (CPB) 0650: Polymerase Chain Reaction Testing: Selected Indications**.

Changes to the provider appeal process

We've streamlined the provider appeal policy for members enrolled in commercial plans by:

- Eliminating level 2 appeals for practitioners
- Requiring the use a specific form when submitting appeal requests

Providers who want to appeal a claim should submit it in writing using the **Practitioner and Provider Complaint and Appeal Request form**. Providers will also need to ensure that they provide all supporting documentation. They will only have **one** opportunity to appeal.

We'll require use of the form effective **March 1, 2017**, but we encourage you to start using it now.

These changes will help ensure that we have the information we need to get the request to the appropriate area and to do a full review of the request. These changes affect participating and nonparticipating providers.

Learn more

Read our **FAQ** for an overview of the appeals process

Note: Any regulatory requirements supersede these guidelines.

Policy and coding updates

Clinical payment, coding and policy changes

We regularly adjust our clinical, payment and coding policy positions as part of our ongoing policy review processes. 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.

Procedure	Effective date	What's changed
Screening for high blood pressure in adults	October 31, 2016	The United States Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation *before* starting treatment. Members with an asymptomatic elevated blood pressure/white coat hypertension in-office reading may rent an ambulatory blood pressure monitor (ABPM) from their provider to obtain a confirmatory blood pressure reading. The ABPM rental will be allowed on an annual basis when billed with ICD-10 R03.0 (elevated blood pressure reading, without diagnosis of hypertension). When ABPM is unavailable, elevated office measurements confirmed through home blood pressure monitoring may be acceptable. We will provide a home blood pressure monitor when prescribed (1 per member). For more information, refer to **Clinical Policy Bulletin #0025 — Automated Ambulatory Blood Pressure Monitoring**. Our participating suppliers are available to assist members with obtaining a home blood pressure monitor: • Medline: **1-866-356-4997** • McKesson: **1-888-220-5010**
Assistant surgeon	March 1, 2017	We are updating our assistant surgeon list effective March 1, 2017. For more information about this policy and to view our current list, visit our **secure provider website**.
We no longer pay for FluMist	August 30, 2016	Due to concerns over its effectiveness, we no longer cover the FluMist vaccine, also known as the nasal spray. This coverage change began with the 2016-17 influenza season. For more information, refer to **Clinical Policy Bulletin #0035 — Influenza Vaccine**.
Surgical procedures	March 1, 2017	We will allow 50% of the contracted rate for services billed with modifier 74.

This issue of *Aetna OfficeLink Updates* is not applicable to any workers' compensation and/or auto networks you may participate in.

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. These changes are outlined below.

Unless otherwise indicated all updates will be effective March 1, 2017.

Codes	Provider types affected	What's changing
93312 – 93318	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be **removed** from the ambulatory surgery: default rate (DEFAULTSUR). Codes will remain part of the cardiac studies (CARDSTUDIES) outpatient rate. • The contract will no longer apply an ambulatory surgery: default rate. • If the contract contains a cardiac studies (CARDSTUDIES) outpatient rate, then this rate will be applied. • If the contract does not contain a cardiac studies (CARDSTUDIES) outpatient rate, the outpatient default rate will be applied.
78808	Facilities including acute short-term hospitals, ambulatory surgery centers and diagnostic radiology centers	Will be **removed** from the ambulatory surgery: default rate (DEFAULTSUR). Code will remain assigned to DIAGRAD, RAD & RADHCPC (description prints as radiology services for all service groupings listed). • The ambulatory surgery: default rate will no longer be applied to this code. The existing radiology services rate will begin to be applied. • If the contract does not contain any radiology services (DIAGRAD, RAD & RADHCPC) rates, the outpatient rate will be applied.
829 **and** 90945 or 90947	Facilities including acute short-term hospitals	CPT codes 90945 and 90947 will be removed from being linked with revenue code 829 within the hospital outpatient dialysis service grouping (DIALYSISOPH). • The contract will no longer apply the hospital outpatient dialysis rate if these codes are billed together on the claim. The existing all other outpatient rate will begin to apply.
820, 821, 831, 841, 851 **and** 90945 or 90947	Facilities including acute short-term hospitals	CPT codes 90945 and 90947 will be linked to the following revenue code list: 820, 821, 831, 841, 851 within the hospital outpatient dialysis service grouping (DIALYSISOPH). • If the contract contains the following revenue code and CPT code combinations: 820, 821, 831, 841, 851 **and** 90945 or 90947, the hospital outpatient dialysis rate will begin to be applied.

0001M – 0004M, 0006M – 0010M, 0058T, 0111T, 0357T, 0423T, 0443T, 58323, 96902, D0416, D0431, D0475 – D0479, D0481 – D0483, G0027, G0103, G0123, G0124, G0141, G0143 – G0145, G0147 – G0148, G0306 – G0307, G0328, G0416, G0432, G0433, G0435, G0452, G0464, G0472, G0475 – G0483, G9143, H0003, H0049, P2028, P2029, P2031, P2033, P2038, P3000, P3001, P7001, Q0111 – Q0115, S3620, S3630, S3645, S3650, S3652, S3655, S3722, S3840, S3841, S3842, S3844, S3845, S3846, S3849, S3850, S3852, S3853, S3854, S3861, S3865, S3866, S3870	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be **added** to the laboratory services (LAB). • If the contract contains a laboratory services (LAB) rate, then this rate will be applied. If the contract does not contain a laboratory services (LAB) rate, the outpatient default rate will continue to apply.
0001M – 0004M, 0006M – 0010M, 0058T, 0085T, 0111T, 0357T, 0423T, 0443T, 58323, 96902, D0416, D0431, D0475 – D0479, D0481 – D0483, G0027, G0103, G0123, G0124, G0141, G0143 – G0145, G0147 – G0148, G0306 – G0307, G0328, G0416, G0432, G0433, G0435, G0452, G0464, G0472, G0475 – G0483, G9143, H0003, H0049, P2028, P2029, P2031, P2033, P2038, P3000, P3001, P7001, Q0111 – Q0115, S3620, S3630, S3645, S3650, S3652, S3655, S3722, S3840, S3841, S3842, S3844, S3845, S3846, S3849, S3850, S3852, S3853, S3854, S3861, S3865, S3866, S3870	Physicians, specialists, primary care, group physicians	Will be **added** to the laboratory/pathology (LABPRO). • If the contract contains hospital-based physician services for LAB, then the physician claim billed with these codes will be denied. If the contract does not contain hospital-based physician services for LAB, then the physician claim billed with these codes will be allowed, and there will be no change in compensation.
61650	Facilities including acute short-term hospitals and ambulatory surgery centers	Will be **added** to the ambulatory surgery: default rate (DEFAULTSUR). • The ambulatory surgery: default rate will be applied to this code as applicable. • When criteria are met, the ambulatory surgery: default rate may apply. If not, the outpatient default rate will apply.
61650	Facilities including acute short-term hospitals, ambulatory surgery centers	Will be **added** to Coventry Enhanced Grouper: Grouper 10. • If not listed above, then the undefined procedure rate will be applied. • If the contract contains **none** of the above provisions, the relevant terms of the contract will rule.

Our Provider Service Center is ready to serve you

Our Provider Service Center (PSC) is the first point of contact for helping in-network and out-of-network providers and facilities.

If you need help with a claims issue, you should contact the service center directly instead of reaching out to your network account manager.

We want to be your single point of contact for all of your Aetna-related requests. Take a look at the changes we've made to support your PSC experience. We strive to:

- Resolve your call the first time so you don't have to call us repeatedly.
- Provide you with timely, accurate and professional service.
- Make sure you're familiar with our self-service tools and solutions, which are available to you 24/7. These include:
  - NaviNet®, our secure provider website*
  - Our Aetna Voice Advantage® self-service telephone system

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

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

Office news

Tips on requesting electronic referrals

Next year, we'll have new plans that will require referrals. As you see patients in these plans, keep these tips in mind when you request any referrals.

Referrals are:

- Only electronic; there are no paper referral forms
- Requested by the patient's primary care physician (PCP)
- Not required for direct access services, like routine eye care and obstetric/gynecologic (ob/gyn) services
- Not a substitute for services requiring precertification
  - Visit **www.aetnaelectronicprecert.com** to see if a service requires precertification
- Authorized immediately and expire after one year
  - For health maintenance organization (HMO) plans, the first visit must be used within 90 days to keep it active.

For a specific *specialist* using the specialist's National Provider Identifier (NPI) or to a *specialty* using a taxonomy code:

- Use our **provider online referral directory** to find a specialist's NPI
- You can find a list of taxonomy codes on the same website you use for other electronic transactions (Don't use any website? Sign up for our **secure provider website**.)
  - For taxonomy referrals, remind the patient to see a specialist in their network. Patients can find a participating specialist on their secure member website.

Diagnosis and procedure codes are not required. But a referral without a procedure code defaults to a consultation only.

- Use 99499 for consult and treat; it allows the specialist to examine and treat the patient and covers automatic studies.*

For more information on electronic referrals, see our **electronic referral guide** or **Office Manual for Health Care Professionals**.

*Automatic studies by specialty are services performed in a specialist office when patients are seen for visits and evaluations as a result of our direct-access programs or when authorized by a referral from their PCP.

Include ID number when submitting member requests

Every time you send a member request on paper, we'll need the member's ID number to ensure we can direct your request to the correct area.

This helps to verify documents and can reduce the processing time for you and your patients. This may also stop us from returning documents to you or your patient due to lack of sufficient information.

For example, if you're sending patient medical records, include the member's ID number along with the records. It's always helpful to have the Explanation of Benefits (EOB) or copy of the Aetna letter of request.

How you can help this process

Be sure to include the following information when you submit member documents:

- Complete member name
- Complete patient name
- Aetna member ID
- Aetna claim ID if applicable
- Aetna generated documents, such as EPPs, letters, etc.

This provides more information and helps ensure the records and member ID number is given to the correct department in a timely manner.

Make sure to use Institutes of Quality® facilities

Facilities in Aetna's Institutes of Quality network have demonstrated high levels of quality care, efficiency and increased safety practices. If you have surgical privileges, we recommend that you perform them at an Institutes of Quality facility whenever possible.

Quality and efficiency

Institutes of Quality facilities have demonstrated high levels of quality and efficiency performing bariatric, cardiac or orthopedic procedures.

- **Bariatric procedures** performed at Institutes of Quality facilities include:
  - Lap bands
  - Bypass
  - Sleeve gastrectomy
- **Cardiac care** procedures performed at Institutes of Quality facilities include:
  - Cardiac rhythm disorders
  - Cardiac medical interventions
  - Cardiac surgery
- **Orthopedic** procedures performed at Institutes of Quality facilities include:
  - Spine decompression (without fusion)
  - Total joint replacement

Your patients can benefit from using Institutes of Quality facilities and possibly receive lower out-of-pocket costs. Patients will also have quality services given before, during and after their procedures.

To view which facilities are in the Institutes of Quality network, visit our **provider online referral directory** and search under "Procedures." Also, check out the **Institutes of Quality facilities fact book**, which has information about the quality and cost efficiency standards we use to evaluate facilities. These standards include:

- Demonstrating low rates of reoperation, acute hospital readmission, medical complications and death
- Meeting specific industry accreditations and certifications
- Providing follow-up care and patient support

To be considered for Institutes of Quality designation, a facility must meet all program requirements. They can be designated in one or more service lines. The service designation is identified under each Institutes of Quality facility.

Learn to better monitor your patients' prescriptions

You can monitor how patients comply with prescribed opioid analgesics and other controlled medications.

Quest Diagnostics is an Aetna preferred in-network drug testing services laboratory. They offer many prescription drug monitoring services including:

- A broad toxicology menu
- Improved medMATCH® results reporting for clear identification of consistent and inconsistent results
- Dedicated toll-free hotline for toxicologist consultation
- On-demand and live learning webinars
- A Quest-sponsored Pain Management Resource Center library of videos, opinion leader interviews, news articles and items on pain management and reducing risks

You can learn more about extended-release/long-acting opioid resources by watching this video: **Abuse-Deterrent Opioid Formulations: What Prescribers Need to Know**.

Helping patients

To help your patients get the most from their benefits plans, you can refer them to Quest Diagnostics or to other national or local participating labs. For the most up-to-date list, visit our **provider online referral directory**. Once there, choose "Labs and Diagnostics Centers" and select "Laboratory (including Quest Diagnostics)."

Call a **Quest Diagnostics** toxicology specialist at **1-877-40 RX TOX (1-877-407-9869)** to request specific test information or a consultation. Or go to the **Quest Diagnostics** website for more information.

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:

- Email and mailing addresses
- 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

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 Demographics" 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**.

Our office manual keeps you informed

Our **Office manual for health care professionals** (manual) is available on our website. For **Innovation Health**, once on the website, select "Health Care Professionals," then "Practice Resources."

Visit us online to view a copy of your provider manual as well as information on the following:

- Our adopted Clinical Practice Guidelines and Preventive Services Guidelines address preventive, acute and chronic medical and behavioral health services. They're located on our **secure provider website**. Select "Clinical Resources" from Aetna Support Center.
- Policies and procedures.
- Patient management and acute care.
- Our complex case management program, including how members can be referred through multiple avenues.
- How to use disease management services and how we work with your patients in the programs.
- Special member programs/resources, including women's health programs, the Aetna Compassionate Care℠ program and others.
- Member rights and responsibilities.
- How utilization management decisions are made and based on coverage and appropriateness of care. It includes our policy against financial compensation for denials of coverage.
- Medical record criteria: A detailed list of elements we require to be documented in a patient's medical record is available in the **manual**.
- Improving medical record keeping: An overview of the 2015 biennial medical record audit results — including our performance goal, overall national compliance score and opportunities for improvement — can be found on page 8 of the March 2016 issue of *Aetna OfficeLink Updates*, which is on our **website**.
- The most up-to-date **Aetna Medicare drug lists**, **commercial (non-Medicare) preferred drug lists** and the **Aetna Leap℠ preferred drug list**. These lists are also known as our formularies.
- 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.

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

Resources for patients at risk for heart disease and stroke

Current heart disease and stroke prevention guidelines[1] 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 three to four 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:

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

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

Helping patients with a safe transition back home

We want to help make a member's transition to home safe and successful after leaving an inpatient 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 for up to 31 days after discharge from a facility. The case manager will:

- Discuss with the member how we can help with a smooth transition to home.
- Review discharge instructions and medications to facilitate case management. This may include referral to an Aetna pharmacist for full medication reconciliation.
- Help facilitate timely follow-up doctor appointments and, if needed, home health care.
- Educate the member on "red flags" or warning signs for when they should seek additional medical care.
- Work with members to help establish a personal health record.
- Continue case management for members with complex needs.

[1]Stone NJ, Robinson JG, Lichtenstein AH, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2014 Jun 24; 129 (Suppl 2): S1 – S45.

Medicare

Does your patient have an Aetna Medicare Prime Plan?

You may be seeing patients who have an Aetna Medicare Prime Plan. These plans offer your patients a low or $0 premium and access to a network of local providers.

Here's what you need to know:

- With an **Aetna Medicare Prime Plan (HMO)** your patients must use providers that participate are in our Aetna Medicare Prime Plan network. They can go to any doctor or hospital for emergency or urgently needed care or for kidney dialysis.
- With the **Aetna Medicare Prime Plan (PPO)** they can choose providers both in and out of our Aetna Medicare Prime Plan network. But they'll save money by using a network doctor or hospital.

We've notified all providers who were selected for these networks. We based selection on health system affiliation, geography and services offered.

How to verify if your patient has an Aetna Medicare Prime Plan network:

- For patients with an ID card, look for "Prime" in the plan name under the Aetna logo.
- For patients without an ID card or for more information, call us at **1-888-632-3862**.

Complete your 2016 Medicare compliance attestation

If you're 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**).

Review the guide and make sure you have processes in place to comply with all the requirements. You can then complete your attestation.

Annual requirement

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**.

The attestation is now available on our secure provider website. If you've never used NaviNet, log in or register now:

- **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."

We're here to help

If you need more information, you can find educational content through links within the attestation, or you can call **1-800-624-0756**.

Disregard this notice if you have completed your 2016 attestation.

Pharmacy

Changes coming to our commercial drug lists

Note these upcoming changes to our commercial drug lists:

Reminders:

- **January 1, 2017:** Our pharmacy plan drug lists (formularies) will change. You can view these changes at our **Formularies & Pharmacy Clinical Policy Bulletins** page.
- **April 1, 2017:** Updates will be made to our pharmacy plan drug lists. Starting on January 1, 2017, you can view the list of upcoming changes for April 1, 2017, at our **Formularies & Pharmacy Clinical Policy Bulletins** page.

The changes may affect all 2017 Pharmacy Management drug lists, precertification, quantity limits and step-therapy programs.

Ways to request a drug prior authorization:

1. Call the Aetna Pharmacy Precertification Unit at **1-800-414-2386**.
2. Fax your completed **Prior Authorization Request Form** to **1-877-269-9916**.
3. Submit your completed request form through our **secure provider website**.

Also, our commercial formulary is available through other websites and mobile devices at **www.formularylookup.com**. After "Sort by," choose "Name" and then select "Aetna Inc." for plan information. You can select "Download on the App Store" to access this information on your phone while you're on the go.

For more information, call us at **1-800-238-6279 (1-800-AETNA RX)**.

Fill specialty drugs at network specialty pharmacies only

New pharmacy plan changes for some members will become effective soon. These members will need to fill all specialty drugs through a network specialty pharmacy. Members who don't use a network specialty pharmacy will need to pay the full cost for the drugs.

Sending a prescription to a network pharmacy, such as Aetna Specialty Pharmacy® services, will help ensure that your patients receive full benefits from their prescription coverage.

How to help patients get a new prescription so their drugs will be covered

Choose one of four ways to send in a new prescription:

1. Electronically via **E-prescribe**
2. Phone: **1-866-782-ASRX (1-866-782-2779)**, option 2
3. Fax: **1-866-FAX-ASRX (1-866-329-2779)**
4. Mail: Aetna Specialty Pharmacy, 503 Sunport Lane, Orlando, FL 32809

With Aetna Specialty Pharmacy, your patients get many services, including:

- 24/7 nurse and pharmacist support by phone
- Coordination with your doctor to check that you're getting the right drugs and supplies
- Free, secure delivery within 48 hours of confirming your order
- Helpful information and injection training

Need a precertification?

For specialty drugs on the **NPL** that require precertification, you can submit a request with electronic prior authorization (ePA) services.

- **NaviNet**: If you're a user of our secure provider website, continue to submit your requests there.
- **CoverMyMeds**: If you don't use NaviNet, you can create a new, free ePA account with CoverMyMeds.

The precertification request forms are also on our **Health Care Professionals Forms** page.

Important pharmacy updates

- **Medicare formularies and Clinical Policy Bulletins:** At least annually we update the Aetna Medicare preferred drug list. View the **Medicare drug list**.
- **Notice of changes to prior authorization requirements — Aetna Commercial drug guides:** Monthly, we add drugs that are new to the market to the **Aetna Commercial Pharmacy drug guides** (formularies). We also update the **Pharmacy Clinical Policy Bulletins** where you'll find our most current prior authorization requirements.

To view the formularies and bulletins visit **Formularies & Clinical Policy Bulletins**. For a paper copy, call the Aetna Pharmacy Management Provider Help Line at **1-800-238-6279 (1-800-AETNA RX)**.

Mid-America news

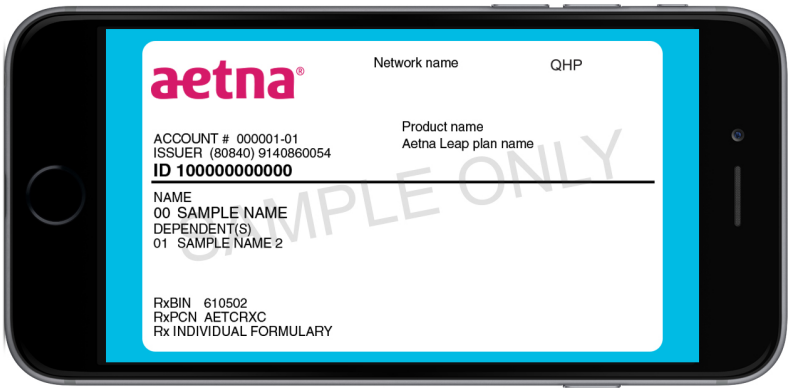
Iowa/Nebraska

New Aetna Leap℠ plans coming in January

On **January 1, 2017**, we'll launch Individual plans, called **Aetna Leap** plans, in new select markets. We won't offer other pre-65 (non-Medicare) Aetna or Coventry Individual products in these markets. Some members will be moving from *CoventryOne* plans to Aetna Leap plans. Members will have a narrow network of pharmacies.

Digital member ID card is key to care

A digital card or paper copy is proof of coverage. To verify eligibility and access digital ID cards, go to our **secure provider website** or **Availity**. Your secure provider website security officer must enable this feature for you to see the cards.



How you can help ensure timely claims processing

- Member IDs always begin with "10." They're 10 digits, plus 2 more digits, based on subscriber or dependents, with no hyphen (***12 digits total***).
  - The subscriber's 2 other digits are always "00."
  - A dependent's 2 other digits will be "01," "02," etc.

  Example: Subscriber ID# 10000013400; Dependent #1 = 10000013401
- Don't add an extra"00," which creates an incorrect, 14-digit ID.
- Use the correct format when sending claims to us.

Note: Aetna Leap plan claims are separate from Aetna claims.

Use the network grid to find key information

View the network grid that is available to our members. It includes information about:

- Where we offer these plans
- PCP and referral requirements
- Out-of-network benefits, which vary by plan (we always cover emergency care, even if out of network)

New Aetna Leap℠ plans coming in January (continued from page 13)

How to see if you're in network

Use our **provider online referral directory** to find out which network(s) you're in. You may accept Aetna, but you may not be in network for all plans. You could be out of network for a specific plan.

Once on the site, select a "**2017 Leap plan**."

No change to the processes you already know

- You can still call us at **1-888-MDAetna (1-888-632-3862)**. When using our self-service phone system, enter the correct member ID, so we can send your call to the right area.
- There's no change in the precertification process, clinical/medical policies and NPL.
- Use our national laboratory, **Quest Diagnostics** or other in-network labs for your patients.

Some members qualify for a grace period

Some consumers who buy insurance on the public health care exchange will qualify for a subsidy to help pay the cost of their coverage. Once the consumer has paid at least one full month's premium during the benefit year, they'll qualify for a three-month grace period. **Learn more** about grace periods for nonpayment.

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