Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

September 2013 • Volume 10, Issue 3

Aetna OfficeLink Updates™

Southeast Region

Inside this issue

Options to reach us

- 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

New solution will improve COB processing

We're working with 11 of the nation's top health plans and trade associations affiliated with the Council for Affordable Quality Healthcare (CAQH®) to streamline and improve the accuracy of Coordination of Benefits (COB) processing.

Through enriched information, this initiative will help health plans and providers "get it right the first time." Our members will benefit from better service, improved accuracy and timeliness.

How you'll benefit

This centralized enrollment and eligibility database will help you streamline processes to improve health care delivery, quality, coordination and efficiency by:

- Efficiently and securely accessing patient COB information
- Confirming primary and secondary coverage to ensure you are sending a claim to the correct health plan in the proper order
- Paying claims more accurately
- Helping assure that patients' coverage is correctly coordinated across health plans

More information

This solution will launch across the country this fall in a state-by-state, phased approach. Visit **CAQH** for more information.

Some member ID cards to change

The display of our product names on ID cards is changing. Medicare ID cards will not change.

Why are they changing?

- To separate the product name from a customer specific image (logo). For consistency, the product name is in the middle of the upper right section of the card.
- To update some of the product names to be more descriptive and better aligned to the Aetna brand names.

There is no impact to member benefits or to providers.

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. 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 chart below outlines coding and policy changes:

Procedure	Implementation date	What's changed
*Therapy Evaluations and Re-evaluations	12/1/2013	Therapy re-evaluations are subject to the following billable timeframes: • Physical and occupational therapy re-evaluations (97002 and 97004) are eligible for payment once every 30 days. • Speech therapy re-evaluations (S9152) are eligible for payment once every 90 days. • Athletic training re-evaluations (97006) are eligible for payment once every 30 days. • Refer to the Therapies – Evaluations/Re-evaluations payment policy on our **secure provider website**.
*Multiple surgical reductions – mid-level practitioners	12/1/2013	Effective 12/1/2013, a system enhancement will allow multiple surgical reductions to apply to mid-level practitioner claims. Currently, mid-level providers (MW, NP, PAS and RNs) are paid at 85 percent across the board for eligible services. Effective with this update, if a mid-level physician performs multiple surgical procedures for the same patient, on the same date of service: • Aetna will pay the primary procedure at 85 percent. • Aetna will pay the secondary at 42.5 percent. • Aetna will pay all subsequent services at 21.25 percent. This update aligns with multiple surgical procedure reductions currently applied to physician claims.
Levonorgestrel-releasing intrauterine system, 13.5 mg (Skyla)	7/1/2013	Effective 7/1/2013, HCPCS code Q0090 replaced J3490 (when billed with a preventive diagnosis) as the appropriate code for Skyla. We will continue processing claims incurred prior to 7/1/2013 for J3490 when billed with a preventive diagnosis as a preventive benefit for up to 120 days after 7/1/2013.
*Special charges and incremental nursing charges	9/1/2013 (Excludes Washington at this time) 12/1/2013 - Maryland	We will no longer roll up special charges (revenue code 221-223) and incremental nursing charges (230-239) into the room and board charges billed on facility-based confinement claims for all products. For all HMO and Traditional plans (excluding Medicare Advantage and fully insured plans subject to Maryland state legislation), we will enforce the existing inpatient private duty nursing payment policy for inpatient private duty nursing services billed in conjunction with a confinement and add special charges to the existing policy.
Lab national coverage determinations (NCDs)	1/1/2013	Effective for dates of service on or after 1/1/13, we will apply the 23 CMS lab NCDs to participating and nonparticipating Medicare Advantage claims. Implementation of the lab NCDs was completed on 6/20/2013. You can view **lab NCDs** at the CMS website.

*Washington state providers: This item is subject to regulatory review and separate notification.

Corrections

Note the following corrections from the June 2013 issue of *Aetna OfficeLink Updates*:

Proper mid-level practitioners billing requirements: The telephone numbers for the Provider Service Center are:
- **1-800-624-0756** for HMO-based plans
- **1-888-632-3862** for all other plans

Precert for Medicare inpatient services: Precertification is required for most Aetna health plans. Exceptions include plans where the ID card indicates Retiree Medical Plan in the name or Medicare Supplement Plan. These plans are secondary to Medicare and do not require Precertification.

Changes to January 1, 2014 National Precertification List

The following changes to Aetna's **National Precertification List (NPL)** will take effect on January 1, 2014, unless otherwise noted:

Additions*

- Kadcyla™ (ado-trastuzumab emtansine)**
- Herceptin® (trastuzumab)**
- Perjeta® (pertuzumab)** – see update section below

Modifications

- We'll require precertification for elective cervical and lumbar spinal fusion

Deletions***

- Customized braces
- Canthopexy

Reminders*

- Effective April 30, 2013, precertification for Bivigam™ [Immune Globulin Intravenous (Human), 10% Liquid] is required
- Effective July 1, 2013, precertification for the following is required:

  -Tecfidera™ (dimethyl fumarate)

  -Gattex® (teduglutide [rDNA origin] for injection)

Update – Oncology medications

The Oncology medications listed below will not be added to the NPL on September 1, 2013. This means precertification will not be required:

- Perjeta® (pertuzumab)
- Istodax® (romidepsin)
- Dacogen® (decitabine)
- Temodar® (temozolomide)
- Ixempra™ (ixabepilone)
- Torisel® (temsirolimus)

Effective July 1, 2013, **we now require precertification for Reclast® for Osteoporosis only** (ICD-9 diagnosis codes 733.0 – 733.09).

* You can view the **Clinical Policy Bulletin** (CPB) applicable to any precertification service.

** To precertify these medications, call **1-866-503-0857** or fax the related Medication Request Form to **1-888-267-3277**. Forms are available on our **secure provider website**. Newly approved drugs administered orally, by injection or infusion may be subject to precertification review.

***The removal of a service from the precertification list does not mean that the services will be covered. The services are still subject to review upon submission of the claim for services, and may be denied in accordance with the terms of the member's plan.

General precert information

Precertification and notification means collecting information before elective inpatient admissions and/or selected ambulatory procedures and services are provided. We must receive requests for precertification and notification before rendering services. Failure to contact us before those services are performed relieves us, employers and members from any financial liability.

Precertification applies to all Aetna plans, except for Traditional Choice. The updated precertification list noting these changes will be online before January 1, 2014.

Precertification approvals are valid for 6 months from the date of issue, unless stated otherwise at the time of precertification. Approvals for drugs marked with "†" are valid for 12 months from the date of issue.

Additional information

The term "precertification" does not mean a reliable representation of payment of care or services to fully insured HMO and PPO members.

Precertification programs may not be available in all service areas. For example, precertification programs don't apply to fully insured members in Indiana.

Fully insured California HMO members and fully insured Connecticut PPO members receiving coverage for drugs added to the precertification lists continue to have coverage. Drug coverage continues for such California members as long as the drug is appropriately prescribed and considered safe and effective treatment for the medical condition. Drug coverage continues for such Connecticut members as long as the drug is medically necessary and more medically beneficial than other covered drugs.

Fully insured Texas and Louisiana members shall continue to receive coverage for drugs added to the precertification lists in accordance with their current plan benefit design until their plan renewal date in 2014.

In Texas, the reference to precertification means the utilization review process to determine whether the requested service, procedure, prescription drug, or medical device meets the company's clinical criteria for coverage. Precertification does not mean a reliable representation of payment for care or services to fully insured HMO and PPO members as defined by Texas law.

Notifications are not subject to clinical review. This material is provided for informational purposes only. It's not intended to direct treatment decisions.

Statements of payments and checks may look different

We've made some changes that mean a different look for your statement of payments and checks.

There is no action needed on your end. But you may notice format changes on checks and statements.

If you have questions, call our Provider Service Center.

Note these upcoming service code changes

Aetna will be reassigning the individual service codes listed in the chart below within contract service groupings.

All of these changes will be effective beginning December 1, 2013. Changes to an individual provider's compensation will depend on the presence or absence of specific service groupings within their contract. For the purposes of this information, AEG stands for Aetna Enhanced Groupers.

Code*	Provider types affected	What's changing
28890	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospitals	Will be removed from the Minor Surgery Service groupings (MINSURDEF, MINSURMED, MINSURMENDO). Code will remain assigned to AEG 4 and DEFAULTSUR. • The Minor Surgery rate will not be applied to this code. If contract contains an AEG 4 rate it will be applied; if the contract does not contain an AEG 4 rate, the Ambulatory Surgery: Default rate will apply.
43281	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospitals	Will be assigned to AEG 5. Code will remain assigned to LAPRO and DEFAULTSUR. • If contract contains a LAPRO rate, no change. If contract does not contain a LAPRO rate, but has an AEG 5 rate, then the AEG 5 rate will be applied; if the contract contains neither a LAPRO or AEG 5 rate, the Ambulatory Surgery: Default rate will apply.
52353	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospitals	Will be assigned to LITHO. Code will remain assigned to AEG 4 and DEFAULTSUR. • If contract contains a LITHO ESWL rate it will be applied; if not, then the AEG 4 rate will apply; if the contract does not contain an AEG 4 rate, the Ambulatory Surgery Default rate will apply
74261	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospitals, and Diagnostic Radiology Centers	Will be assigned to CTSCAN. Code will remain assigned to DIAGRAD, RAD and RADHCPC. • If a CAT scan rate is present in the contract, the CAT scan rate will be applied; if contract does not contain a CAT scan rate, the existing Radiology Services rate will continue to apply.
96570, 96571	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospitals	Will be assigned to ENDO and DEFAULTSUR • If an ENDO rate is present in the contract, the ENDO rate will be applied; if contract does not contain an ENDO rate, the Ambulatory Surgery: Default rate will be applied.
96567	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospitals	Will be assigned to DEFAULTSUR • If an Ambulatory Surgery: Default rate is present in the contract, the Ambulatory Surgery: Default rate will be applied.
0200T, 0201T	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospitals	Will be assigned to DEFAULTSUR • If contract contains an AEG 2 rate it will be applied; if not, then the Ambulatory Surgery: Default rate will be applied.
0213T, 0214T, 0215T, 0249T	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospitals	Will be assigned to DEFAULTSUR • If contract contains an AEG 1 rate it will be applied; if not, then the Ambulatory Surgery: Default rate will be applied.
0238T, 0246T	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospitals	Will be assigned to DEFAULTSUR • If contract contains an AEG 3 rate it will be applied; if not, then the Ambulatory Surgery: Default rate will be applied.
0253T	Facilities including Acute Short Term Hospitals, Ambulatory Surgery Centers, Children's Hospitals	Will be assigned to DEFAULTSUR • If contract contains an AEG 5 rate it will be applied; if not, then the All Other Surgery Default rate will be applied

* Washington state providers: All items listed under the "Code" column were subject to regulatory review and separate notification that was sent on or around July 1, 2013.

Office News

A fast, easy way to collect patient payments

We've teamed up with Citi® to create **Money²SM for Health**. It's an innovative, online patient health care payment solution that makes it easy for your patients to review, understand and pay their bills.

Registered patients click the "Pay Online" option from their Aetna Navigator® secure member website to pay providers who accept the service. Then, funds go directly from their account to yours.

Potential benefits for you

- Improve cash flow and reduce collection costs
- Manage patient payments and refunds with a user-friendly portal
- Improve patient satisfaction
- Get payments from multiple payers as they become connected to the platform

Potential benefits for your patients

- Use one username and password to make multiple provider payments
- Get real-time alerts when payments are due
- Easily reconcile payments to insurance claim details
- Pay from any account – checking, health care accounts (HSA/FSA) or credit

Help patients understand their Accelerated Death Benefit

Many of your patients may have life insurance coverage that offers an Accelerated Death Benefit.

This benefit provides a chance to use life insurance money early. Policies vary, but often 50 to 80 percent of the policy is available. The money can be used for hospital bills, drugs or experimental treatments, living costs or paying off a home.

Who qualifies?

Your patients may have access to money if they're terminally ill with a life expectancy of 6-24 months. They should check with their carrier to see if they qualify.

Sometimes patients may qualify regardless of life expectancy, if they have one of these conditions:

- ALS (Amyotrophic Lateral Sclerosis)
- Artificial life support
- End stage organ failure (non-transplant candidate)

How you can help

Suggest to your patients that they call their life insurance carrier or Human Resources contact for more information. If they have Aetna life insurance coverage, they can:

- Call Care Advocacy at **1-800-276-5120**
- Review our **online resources**

Pharmacies can administer certain vaccines

We expanded the types of immunizations/vaccines that pharmacies can now administer to include:

- Influenza
- Pneumococcal
- HPV
- Shingles (Zostavax)

We expanded this list for our commercial membership effective March 1, 2013, based on increased requests from members, many of whom told us that their primary care physician did not stock these immunizations/vaccines.

Pharmacies contracted to administer these immunizations/vaccines can be identified on our **DocFind**® online provider directory.

Note: PCPs must administer the immunization/vaccine when they are paid by capitation for the service.

Claims processing for Meritain members

Meritain Health members can use doctors and hospitals in the Aetna network. The number of members using Aetna networks through Meritain is growing.

Two easy ways to help you work with Meritain:

- Send claims to the Meritain address on the member's ID card. Meritain will help you with the claims review process.
- Call the Meritain call center with questions about member claims.

Remember that Meritain is no longer an Aetna Signature Administrator (ASA). To identify a member using the Aetna network through Meritain, look for the Meritain logo and network by Aetna. The ID card will also indicate Open Choice PPO or Aetna Choice POS II.

Your office may see Innovation Health members

Aetna and the Inova Health System have established a jointly owned health plan called Innovation Health℠.

The plan is available to select individual customers and employer groups primarily based in Northern Virginia, Maryland and Washington, D.C. As an affiliate of Aetna, Innovation Health members may seek care from Aetna participating providers outside of these markets.

Aetna performs administrative functions for Innovation Health. This means Aetna's policies and procedures will apply to Innovation Health members

- Your Aetna fee schedule applies to these members
- Innovation Health members have their own ID card
- Submit claims using payer ID 40025 and address on the member ID card

Use our **secure provider website** for online transactions and tools for Innovation Health, as well as to access member ID cards. For more information:

- Visit the **Innovation Health website**
- Call the number on the Innovation Health member's ID card

Help your patients achieve healthy pregnancies

Through our Beginning Right® Maternity Program, we'll offer your patients education throughout their pregnancy and access to nurse case management, as needed. Program highlights include:

- Patient educational materials
- A non-nicotine smoking cessation program
- Coordination of home care services arranged during pregnancy
- Authorization for any testing during pregnancy

Encourage enrollment

Some employer groups give a monetary incentive for their employees to participate in the program. To enroll, either you or your patients can call us at **1-800-272-3531**.

You can learn more about the program in our Health Care Professional Toolkit, available on our **secure provider website**.

Determining a member's applicable benefits level

We want to help you apply the appropriate benefits for member plans associated with a **custom** or **narrow network**. Just follow these guidelines:

- **Maximum savings** applies if you as the servicing provider participate in the member's custom or narrow network (i.e., home host, onsite clinic, Choose and Save℠, Savings Plus, Aetna Whole Health℠) or if you're an Aexcel®-designated provider.
- **Standard savings** applies if you as the servicing provider participate with Aetna, but are not part of the custom or narrow network.
- **Out-of-network** applies if you don't participate in the member's network and, for some plans, if you're a non-Aexcel-designated provider.

Get capitation reports on our secure provider website

Just a reminder, you can download and save copies of your monthly HMO capitation reports right from our **secure provider website**. We make new reports available to you the third weekend of each month. Once we run and post the new reports, they overlay the previous month's reports. So it's best to retrieve and save them right away.

Accessing your reports is easy. Once on the secure site, from the Aetna Plan Central home page, under Eligibility choose HMO Rosters/Cap Reports.

Learning Opportunities

Log in or register at **AetnaEducation.com**

New and updated courses for physicians, nurses and office staff

Courses

Changing Health Care Marketplace

New Money$^{2}_{SM}$ for Health – go from unpaid to paid fast

Reference Tools

Updated Products, Programs and Plans: Passport To Healthcare®

No-cost cultural competence CMEs meet state requirements

You can meet special continuing medical education (CME) requirements with our free Quality Interactions® Cultural Competence CMEs. These evidence-based, case-based courses for physicians*, nurses and other health care practitioners educate participants on cross-cultural diversity.

Our courses meet special requirements in these areas:

- Massachusetts: Risk Management
- Nevada: Ethics
- New Jersey: Cultural Competence
- Pennsylvania: Risk Management/Patient Safety
- Texas: Ethics/Professional Responsibility
- Connecticut: Cultural Competence

How to get started

- Log in or register at **AetnaEducation.com**.
- Type cultural in the "Search" field.
- Click "Go."
- Select the course that's right for you.

* This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Tufts University School of Medicine (TUSM) and Quality Interactions, Inc. TUSM is accredited by the ACCME to provide continuing medical education for physicians.

Tufts University School of Medicine designates this educational activity for a maximum of 2.5 *AMA PRA Category 1 Credit(s)™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

View our 2013 HEDIS® results

We annually collect Healthcare Effectiveness Data and Information Set (HEDIS[1]) data from claims, encounters and other administrative data. We also collect data from chart reviews for certain clinical measures. We analyze these results to find opportunities for improvement, and design and implement quality improvement activities.

We submitted our data for 2013 according to National Committee for Quality Assurance (NCQA)[2] reporting requirements.

View our 2013 **HEDIS results**.

[1] *HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

[2] NCQA is the National Committee for Quality Assurance.

Consult Clinical Practice Guidelines as you care for patients

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

Our CPGs and Preventive Service Guidelines (PSGs) are based on nationally recognized recommendations and peer-reviewed medical literature. They are on our **secure provider website**. Look under "Aetna Support Center," then "Clinical Resources."

Preventive Service Guidelines	Adopted 2/12
*USPSTF HIV screening recommendation	Adopted 6/13
*USPSTF Hepatitis C screening recommendation	Adopted 7/13
Behavioral Health	
• Helping Patients Who Drink Too Much	Adopted 2/12
• Treating Patients With Major Depressive Disorder	Adopted 2/12
Diabetes	Adopted 2/13
• Treating Patients With Diabetes	
Heart Disease	Adopted 4/12
• Treating Patients With Coronary Artery Disease	

For a hard copy of PSGs, or a specific CPG, call our Provider Service Center at **1-888-632-3862**.

*U.S. Preventive Services Task Force

Medicare

2014 formulary changes may affect Aetna Medicare patients

In 2014, we're introducing Select Care generics to group and individual Aetna Medicare Advantage plans with Medicare prescription drug benefits (MAPD) and Aetna standalone Prescription Drug (PDP) plans. This change may help your patients save money, which may further encourage them to take their medications as prescribed.

Patient benefits

These Select Care generics are highly-effective drugs that:

- Have lower cost-share options to treat high blood pressure, high cholesterol and diabetes.
- Help lower yearly costs.

We placed some higher-cost generics on brand-name drug tiers for individual and some group plan formularies. For example, these two generic drugs are on the non-preferred brand tier:

- Calcipotriene cream
- Famciclovir tablets

Learn more

Read more about **upcoming formulary changes** after October 1, 2013. We'll also tell our members about these changes.

New ID cards for Aetna Medicare Supplement members

Effective July 1, 2013, we're administering all of our individual Medicare Supplement business at our Senior Supplemental office in Franklin, TN. As a result, individual members whose Medicare supplement policies previously were administered at CHCS will receive new ID cards with updated contact information.

Aetna offers Medicare Supplement insurance coverage through these Aetna companies:

- Aetna Life Insurance Company
- American Continental Insurance Company
- Continental Life Insurance Company of Brentwood, Tennessee
- Aetna Health and Life Insurance Company

To check if a patient has an Aetna Medicare Supplement policy (eligibility verification), go to our **Aetna Senior Products** website.

Submitting claims

Be sure to submit Medicare Supplement claims directly to Medicare. Medicare will process the claims and then send them to us.

CMS to clarify guidance on coverage of skilled services

On January 24, 2013, the U.S. District Court for the District of Vermont approved a settlement agreement in the case of Jimmo v. Sebelius. The settlement agreement is intended to clarify Medicare's existing policy regarding coverage for skilled care services.

The settlement agreement clarifies that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of the potential for improvement or restoration. Coverage depends on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves.

As part of the settlement agreement, the Centers for Medicare & Medicaid Services (CMS) will take all of the following actions:

- Update program manuals to clarify policy
- Conduct educational campaigns for contractors, adjudicators, and providers and suppliers
- Engage in accountability measures, including claims review

CMS will complete the manual revisions and educational campaign by January 23, 2014. For more information, see CMS' **Jimmo v. Sebelius Fact Sheet**.

Where to see our Medicare and Commercial formularies

We update the Aetna Medicare and Commercial (non-Medicare) Preferred Drug Lists at least annually and from time to time throughout the year. These drug lists are also known as our formularies, and can be accessed at:

- **Medicare Preferred Drug Lists**
- **Medication Search** page for the Commercial Preferred Drug Lists

For a paper copy of these lists, call the Aetna Pharmacy Management Provider Help Line at **1-800-AETNA RX (1-800-238-6279)**.

Pharmacy

2014 changes to Aetna's preferred drug lists

We annually review our preferred drug list (formulary). The list shows many of the drugs covered by your Aetna patients' plans.

We update this list regularly, based on the latest medical findings, information from the Food and Drug Administration (FDA) and drug manufacturers, and cost arrangements (which include manufacturer rebates).

View the 2014 formulary changes

While coverage is not limited to medications on the list, you can help your patients lower their out-of-pocket costs by prescribing drugs on the list, when appropriate. Talk to your patients about treatment options, if any of these changes affect their prescriptions.

Learn more

- View **formulary information**
- Call us at **1-800-238-6279**

Providers in Illinois: We are waiting for approval from the Illinois Department of Insurance, which must approve Aetna's formulary changes. Once we receive it, we will let members and providers in Illinois know about these changes.

Oncology split fill program starting soon

We're changing the way we fill prescriptions and bill for copays for the oncology drugs listed below.

Effective January 1, 2014, we'll implement a "split fill" dispensing provision for certain oral oncology drugs. Split fill means that the member will receive an initial 15-day supply, followed by a second 15-day supply within a 30-day period (one month) for the duration of their therapy. Partial copayment will coincide with each dispense.

Our Specialty Health Care Management nurse team manages these oral oncology drugs, and will support members throughout the course of therapy. Split filling will allow monitoring of the member's response to therapy and any potential reactions or side effects.

The new program includes these drugs:

- Nexavar (sorafenib)
- Votrient (pazopanib)
- Afinitor (everolimus)
- Inlyta (axitinib)
- Jakafi (ruxolitinib)
- Sprycel (dasatinib)
- Tarceva (erlotinib)
- Zelboraf (vemurafinib)
- Sutent (sunitinib)

New generics available in 2013

Generic versions of brand-name drugs that you may routinely prescribe are scheduled for release in the coming months.

Generic drugs can provide a quality, safe and effective alternative to brand-name drugs, while also helping to control costs. They include the same active ingredients as their brand-name counterparts, but often cost far less for your patients.

Generic versions of the following brand-name drugs will be released soon:

- Aciphex
- Advicor
- Bromday
- Cymbalta
- Exalgo
- Lidoderm
- Locoid Lipocream
- Niaspan
- Patanase
- Rilutek
- Vanos
- Vivelle-Dot

Talk to patients about generics

We encourage you to talk about generic drugs with your patients, as appropriate. You can also refer to our **Medication Search Tool**. Use it to understand what types of coverage reviews – such as precertification, step therapy or quantity limits – are required for each drug.

The Aetna Pharmacy Management Provider Help Line is available 24 hours a day, 7 days a week at **1-800-AETNA RX** (**1-800-238-6279**).

Southeast News

Health Care Reform

Get ready for the first open enrollment on public exchanges

The first open enrollment for public health insurance exchanges (also referred to as marketplaces) is set to kick off on October 1. Experts predict that by 2016, more than 24 million people will use public exchanges to buy health insurance.

Your patients may already be asking questions about exchanges and other changes coming as part of the Affordable Care Act in 2014. They may also be looking for information for family members and friends who don't have coverage today.

More information

To help address many of the most common questions about exchanges, Aetna has a **video** that offers a simple, brief and engaging overview of exchanges and how they will work. This could be a great educational tool to share with patients who are asking for help or looking for something to share with family and friends.

The **Exchanges page** on our **Health Reform Connection** website also offers more information for consumers, as well as **what exchanges mean to you**.

We're also working on additional tools and resources to help consumers interested in buying through a public exchange learn more about the Aetna plans that may best suit their needs and find doctors who are participating in their state's exchange. That support will be in place when exchanges go live this fall.

In the coming months, we will also be reaching out to you with more specific information about where Aetna will be participating on public exchanges, and how this may impact you and your practice.

Maryland, D.C., Northern Virginia

New program may prevent avoidable hospital admissions

Through the new Aetna Rx Home Success Program℠, pharmacists and case managers work to reduce avoidable hospital readmissions for 30 days after a patient leaves the hospital or skilled nursing facility. Up to 75 percent of 30-day readmissions may be preventable.[1] This six-month pilot will start in Maryland, District of Columbia and Northern Virginia areas for selected Aetna members.

The program's goal is to reduce inpatient days and emergency room visits, while encouraging greater follow up with primary care (PCP) and specialist physicians.

How patients will benefit

After discharge, patients in the program will get:

- A thorough medication review.
- A personalized care plan, including a medication schedule.
- 30-day care management support.
- Education about chronic illness and warning signs of disease progression.
- A home safety assessment.
- Advance care planning.
- Help with scheduling physician follow-up visits.
- Level of care assessment–with appropriate referral to available case management programs.

The program team will work with physicians to support their patients. Pharmacists will give medication charts and encounter details to the patient's PCP. They'll tell physicians if there are any potential medication-related problems. This includes duplications or gaps in medication therapy, as well as the use of any unsafe prescription or non-prescription medications.

Learn more

If you have questions or need more information, call **1-855-422-8083**.

[1]Medicare Payment Advisory Commission (MedPAC), Report to Congress: Promoting Greater Efficiency in Medicare, June 2007, Chapter 5.

Introducing HomeSTAR®– a CareCentrix®Program*

HomeSTAR is a home-based, hands-on program. Its goal is to lower hospital readmissions. HomeSTAR helps your patient transition from a hospital to a home setting.

How it works – five key interventions

Through education, support and coaching, HomeSTAR offers home health nursing and therapy services.

Patients chosen for the program have services coordinated by a HomeSTAR Nurse Coach. At the heart of the program, Home STAR:

- Supports patient's move from hospital to home
- Assists with home health orders
- Reduces homebound patients and hospital readmissions
- Helps with referral of at-risk patients
- Improves self-management

Referrals and questions

- Call the HomeSTAR team at **1-888-571-6012**

*CareCentrix®, a provider of home health benefits management services, helps manage the home health network for all our members, including Medicare Advantage, in Florida.

Record information about auto accidents, workers' comp

If an Aetna member involved in a motor vehicle accident or workers' compensation injury visits your office, you should

- Record the name of the member's automobile insurance company and/or their workers' compensation carrier
- Verify the member's eligibility through Aetna
- Submit any claims to Aetna

Following these steps will help us expedite processing and help ensure that the claim paid accurately.

Once the claims are submitted, Aetna works with The Rawlings Group, a third-party subrogation vendor, to determine if the member's automobile insurer or the workers' compensation carrier is responsible for paying the claims*. Aetna will reimburse you directly per the terms in your participating provider agreement for any covered services that are billed.

You should also note that members injured in these situations should not have to pay for medical services at the time of the visit, other than the applicable copayment, coinsurance or deductible amount for covered services.

*This process may vary depending on the provider's contract or the member's benefit plan"

aetna®

Contact us at: OfficeLinkUpdates@aetna.com

Route this publication to:

- ○ Office Manager
- ○ Referral and Precertification Staff
- ○ Business Staff
- ○ Front Desk Staff
- ○ Medical Records/Medical Assistants
- ○ Primary Care Physicians
- ○ Specialists
- ○ Physician Assistants/Clinical Nurse Specialists
- ○ Nurses

Help improve communication between treating physicians

Primary care physicians (PCPs) continue to be concerned they don't regularly receive reports about their patients' ongoing evaluation and care from other practitioners and facilities, according to the results of a recent physician survey.*

The failure to communicate poses a threat to quality patient care. We recognize the challenges faced by providers to coordinate care with many types of physicians and facilities, and appreciate your efforts to improve communications.

It's important to share information

Comprehensive patient care includes communication with your patients' other treating physicians and health care professionals. To promote collaboration and comprehensive patient care, it's critical that PCPs and specialists talk openly.

To help you, the following forms are available on the **Documents and Forms** page of our website:

- Behavioral Health/Medical Provider Communication Form
- Eye Examination Report Form
- Physician Communication Form
- Physician Communication Post-Fragility Fracture Care Form
- Specialist Consultation Report

* Aetna annually conducts physician practice surveys to assess primary care practices' attitudes and perceptions on key interactions with us. The surveys, which are administered by a third-party vendor (Center for the Study of Services), are performed at the National Committee for Quality Assurance (NCQA) accredited market level for practices contracted for all Aetna products. Surveys are conducted at the regional level for practices participating in Aetna PPO-based plans only.

www.aetna.com

48.22.808.1-Q3-SE (9/13)

aetna®