



Aetna OfficeLink Updates™

Northeast Region



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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

Aetna's secure provider website: Transaction enhancements to help you

With your feedback in mind, we redesigned the precertification, eligibility and claim status screens to simplify your experience.

Check out these new transaction enhancements on [our secure provider website](#):

Precertification

- Comments section to submit clinical data
- Ability to indicate a level of service (urgent, emergency, and elective)

Eligibility & Benefits

- Redesigned screen for easier use
- Simplified search options
- Benefit type saved

Claim Status

- Claim received date included in response details
- Total patient responsibility displays



Agreements with out-of-network labs violate your Aetna contract

We understand that certain provider offices have been asked by LabCorp to sign laboratory services agreements. LabCorp is not contracted with Aetna.

Your physician agreement with Aetna requires you to refer your Aetna patients to in-network providers*. Therefore, signing a laboratory services agreement with LabCorp for your Aetna members to use LabCorp violates your Aetna agreement.

If you have been requested to sign, or have signed, a laboratory services agreement with LabCorp,

we ask you to contact us at [**nationalancillarycontracting@aetna.com**](mailto:nationalancillarycontracting@aetna.com).

Out of network costs more

Your Aetna patients will almost always pay more out of pocket when they access care from nonparticipating providers. You can help them save money by referring them to in-network providers.

To find participating providers and facilities, visit our [**DocFind**](#)® online provider directory.

*Limited exceptions may apply



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
Clinical Policy Bulletin #0530 – Transvaginal Ultrasonography for Ovarian and Endometrial Cancer Screening and Other Selected Indications	3/1/2012	We are revising CPB #0530 to state that transvaginal ultrasonography (CPT 76830) is considered experimental and investigational for confirmation of placement of an intra-uterine device following insertion.
A9279 – Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified	3/1/2012	A9279 will be considered incidental to all monitoring systems. Separate reimbursement will not be allowed.
Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder), partial; complete – 21248/21249	9/18/2011 – all other states 3/1/2012 – Texas	Per day limits will apply to the following codes, effective 3/1/2012 for Texas providers. All other states took effect 9/18/2011: 21248 and 21249 will be allowed 2 times per date of service. Multiple surgery concurrency reductions will continue to apply.
Orthotic and prosthetic equipment/supplies – L2780, L2840, L5685	3/1/2012	Per day limits will apply to the following codes, effective 3/1/2012: L2780, L2840 and L5685 will be allowed 6 times per date of service.
Orthotic and prosthetic devices	3/1/2012	Additional components or features for prefabricated or custom knee orthoses will be denied. Modifier 59 will not override these edits.
92586 – Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited	3/1/2012	Newborn hearing screening that is billed to a provider other than a contracted inpatient facility will be denied as incidental. This service is included in the facility's case rate and will not be paid separately.
Bilateral noninvasive physiologic studies of upper or lower extremity arteries	Delayed	The following policy change was communicated in the June 2011 issue of <i>Aetna OfficeLink Updates</i> . This policy change has been delayed until further notice. <i>Procedure codes 93922 and 93923 will be considered incidental when billed with either G0166 (external counterpulsation) or 92971 (Cardioassist).</i>

Clarification for facilities: Change to stop-loss calculation

We previously informed you that we changed how we calculate reimbursement under stop-loss provisions for participating facilities. This change will apply to cases in which inpatient days are denied as “length of stay not necessary.”

We want to clarify that this change applies to reimbursement under stop-loss provisions for participating facilities for all Aetna plans, with the exception of the Traditional Choice® plan. We made this change so that the stop-loss calculation will be more consistent for Aetna plans.

See the **June 2011** issue of *Aetna OfficeLink Updates* for more information.

Aetna will use new data sources for drug payment rates

First DataBank stopped publishing Average Wholesale Price (AWP) information effective September 28, 2011.

This data was used to determine our payments for drugs. This action results from First Data Bank's class action lawsuit settlement of March 30, 2009.

Our payment rate updates published on or after January 15, 2012, will be based on prices from the sources listed below. Once we select an appropriate source for each code we will not change a designated source for a code unless the designated

source stops publishing an amount for the code or we first notify you. This change will not impact our current update schedules.

Rate adjustments

Adjustments to payment rates, based on the most current information, will continue to occur quarterly. The rates that are in place for the 4th quarter of 2011 will remain in place until updates are made on or after January 15, 2012. Note: Quarterly changes may result in an increase or decrease to your reimbursement.

Our sources may include:

- Medicare Average Sales Pricing (ASP) (used by most markets as their base schedule for the majority of injectable codes)
- AWP information from ReimbursementCodes.com
- AWP information from Medi-Span®
- Manufacturer direct pricing

Precert required for polysomnography

Effective March 1, 2012, all markets will require precertification for polysomnography (PSG). This precertification will support a comprehensive, end-to-end Obstructive Sleep Apnea (OSA) program.

The program uses evidence-based clinical criteria developed for sleep management. These criteria direct members to the appropriate services and treatments while reducing costs associated with sleep disordered breathing.

Precertification will be required for the following codes:

- 95807
- 95805
- 95810
- 95811

Currently, only the following markets require precertification:

- New York
- Northern New Jersey
- Southern New Jersey

- Delaware
- Maryland
- Pennsylvania
- Virginia (Northern and Richmond)
- Washington, D.C.

To obtain precertification, contact the following vendors:

- CareCore/SMS in NY or NJ
- MedSolutions in DE, MD, NJ, PA, VA and DC

Policy update: Coverage for private rooms

We only provide coverage for private hospital rooms when medically necessary for our members.

If a hospital bills us for a private room when the facility either doesn't have a semi-private room at all or one isn't available, reimbursement is limited to the hospital's

most common semi-private room rate. If the hospital has no semi-private rate, we will determine the most common semi-private room rate.

If an Aetna member chooses a private room, he or she is responsible for the cost

difference between the private room and most common semi-private room.

When submitting claims for inpatient rooms, hospitals should use proper condition, value and revenue codes.

Note these preferred FSH infertility drugs coverage changes

Beginning January 1, 2012, we will allow coverage for these Follicle Stimulating Hormone (FSH) preferred injectable infertility drugs:

- Bravelle (urofollitropin alfa for injection)
- Gonal-F (recombinant follitropin alfa for injection)

- Gonal-F RFF (recombinant follitropin alfa for injection)

In order for members to receive coverage for these drugs, physicians should prescribe one of the preferred drugs listed. This applies to Aetna members in commercial plans. As a reminder, all infertility injectable drugs require precertification.

We will not provide coverage of non-preferred FSH drugs for Aetna commercial members (unless they have a contraindication or intolerance to at least two of the preferred FSH drugs).

Bill accurately for medically covered drugs

We validate the number of units administered and the submitted charges of medications with a dosing algorithm. This algorithm applies to claims for medications billed with Healthcare Common Procedure Coding System (HCPCS) codes, as well as medical drug claims billed with a National Drug Code (NDC).

The algorithm reviews claims to identify possible overbilling errors that exceed standard dosing thresholds. It denies the portion of these claims that exceeds maximum dosing levels based on the product labeling, Food and Drug

Administration (FDA) dosing guidelines, and peer-reviewed, published medical literature for each drug.

Review billing units

We encourage all physicians and health care professionals to review HCPCS and/or NDC units being billed, and the proper conversion of the drug dose that is administered to patients.

For a list of applicable medications, visit [our secure provider website](#). Once logged in, select "Aetna Support Center" then "Claims" and "CPT/HCPCS Coding Tools."




Choose and SaveSM hospitals notified of their status*

Notification letters were sent this fall to all hospitals and facilities that received Choose and Save 2012 designation.

Members in plans with Choose and Save receive the highest benefit, or maximum savings, when receiving care from Choose and Save hospitals and facilities. Choose and Save 2012 designation was based

on certain criteria for clinical quality and efficient use of health care resources. In addition, access and plan sponsor guidance were considered.

Hospitals that received the 2012 Choose and Save designation are identified in Provider Referral DocFind with a blue Choose and Save symbol .

* Choose and Save markets: Arizona; California (Central Valley, Los Angeles, No. Calif., San Diego); Connecticut; District of Columbia (Washington, D.C.); Florida (Brevard County, No. FL, South Florida - Palm Beach and Broward County, Tampa); Georgia (Augusta, Savannah); Illinois (Chicago); Indiana (Indianapolis); Kentucky (Louisville); Maine; Massachusetts; Nevada (Las Vegas); New Hampshire (Southern); New Jersey (Northern, Southern); New York (Metro NYC, Upstate); North Carolina (Charlotte, Winston-Salem, Raleigh-Coastal-Greenville); Ohio (Cincinnati, Cleveland, Toledo); Oklahoma (Oklahoma City, Tulsa); Pennsylvania (Central-Harrisburg, Lehigh-Berks, Northeast, South Eastern-Philadelphia); South Carolina; Tennessee (East TN, Nashville); Texas (Austin, Houston, San Antonio); Virginia (Hampton Roads, Richmond, Roanoke); West Virginia; Wisconsin (Southeastern)



Passport to Healthcare – an Aetna International plan

Aetna International has a plan called Passport to Healthcare. Within this plan, we manage covered medical services for our international and expatriate members.

If you participate with the Open Choice PPO plan, these patients are in network. Contact your Aetna representative with questions.

Office Wise

We want to publicize your PIM recognition

We want to help you publicize your Practice Improvement Module® (PIM) accomplishments.

With your permission, we will include this recognition in your listing in our DocFind online provider directory. This will inform potential patients of your PIM accomplishments.

Self-assessment products

This year, the American Board of Internal Medicine (ABIM) increased the number of self-assessment products that ABIM-certified physicians can choose for credit

in its Maintenance of Certification (MOC) program. Once completed, these new ABIM PIMs can be added to our list of accepted PIMs.

ABIM-certified physicians can choose to complete the following PIMs:

- **Clinical Supervision PIM** – for physicians who supervise medical students, residents, or fellows.
- **Cancer Screening PIM** – for physicians who make recommendations to patients concerning screening for common types of cancer.

- **Chronic Obstructive Pulmonary Disease (COPD) PIM** – for recognition, diagnosis, management and treatment of COPD.

- **Chronic Kidney Disease (CKD) PIM** – for the diagnosis and treatment of CKD risk factors as well as the prevention of CKD progression.

- **Preventive Cardiology PIM** – for those who make management decisions regarding the prevention of primary or secondary coronary heart disease.

To grant Aetna third-party permission to retrieve and publicize your PIMs, log in to the [ABIM website](#).

How to get claims info for 1199SEIU insureds

You can now find real-time claims information for members of 1199SEIU United Healthcare Workers East on our secure provider website. Since this information is now at your fingertips, you can make fewer phone calls and save time.

On our secure provider website, you can check claims status and eligibility, view remittance information, update your demographic information and much more.

To get started, visit the [Health Care Professionals](#) section of our website and select “Medical Professionals Log In.”

You can also call **1-888-819-1199** 24 hours a day, 7 days a week to check these patients’ eligibility and claims status.

Radiology accreditation requirements begin in January

As we first communicated in the December 2010 issue of *Aetna OfficeLink Updates*, Aetna will have new radiology accreditation requirements for our commercial business. These requirements will be effective January 1, 2012.

For information on these new requirements, see the [December 2010](#) issue. Note: Echocardiograms were removed from the list of advanced diagnostic imaging procedures.

New fax number for prepay audit claims

A new fax number is available for physicians who receive a medical records request for the prepay audit program coordinated by OrthoNet™ (ONET).

These requests may include operative notes and clinical office records. The new fax number provides quicker turnaround time on medical record reviews. Send requested medical records to **860-754-1550**.

BH PROVIDERS

Identify yourself when calling about rates

When calling to request rates, we ask that you tell us right away what type of practitioner you are.

For instance, if you're a clinical psychologist, licensed professional counselor, psychiatric nurse or any other licensed behavioral health practitioner, let us know that

immediately. Then we can provide you the rates appropriate to your practitioner type.

Other ways to get rates

Non-MD/DOs can also fax fee schedule requests to our Provider Service Center at **1-859-455-8650**. Include the correct PIN and TIN, the desired CPT code(s) and

whether you're a medical or behavioral health practitioner.

(MD/DOs can view rates on **our secure provider website** under Claims.)

Aetna contracts with Shriners hospitals

Shriners Hospitals for Children® (Shriners) is now in network for Aetna members.

Aetna and Shriners signed a three-year contract that took effect August 1, 2011. The agreement offers our members:

- Expanded access to providers in 16 states

- Ability to receive covered services from 20 Shriners hospitals at in-network rates
- Access to approximately 200 physicians employed by Shriners hospitals, who also joined Aetna's network

Be aware that you should follow standard insurance procedures (precertification, referrals, etc.) when referring patients to Shriners hospitals. To see the Aetna press release about this agreement, which include Shriners hospitals' state locations, **click here**.

HOME INFUSION PROVIDERS

Transition of immune globulin patients

Effective January 1, 2012, home infusion providers whose contracts contain "first dose" language for chronic diseases may need to transition Aetna members who need immune globulin. "First dose" is defined as 56 days for intravenous immune globulin or 28 days for subcutaneous immune globulin.

The effective date of this change in Ohio and Texas only is March 1, 2012.

The transition should be from the home infusion provider to an Aetna network specialty pharmacy, subject to the provisions of the contract. This applies to patients who are new to immune globulin therapy on/or after January 1, 2012.

Member notification

We will contact our members to begin the transition. When the pharmacist contacts the home infusion provider, the member's prescription should be transferred to an

Aetna network specialty pharmacy, after the first dose has been administered by the home infusion provider.

Newest AWCA "eZine" now available

Read the October 2011 issue of the Aetna Workers' Comp Access® (AWCA) virtual magazine – especially for providers who treat injured workers.


The *AWCA Comp Connection eZine* features the critical information you need to know about AWCA to more easily do business with us.

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



Office Administration

-  Products, Programs and Plans: GetNHealthy Nutrition Counseling Videos
- **Updated** ID Cards: Member ID Card Education Tool

Genetics

- **Updated** Genetics in Clinical Practice: A Team Approach (CME)

Reference Tools

-  ID Cards: Standard member ID card, Medicare ID card and Specialized member ID cards
-  New Provider Manuals: Health Care Professional Toolkit – Office Manual
- **Updated** Products, Programs and Plans: Aetna HealthFund® Health Reimbursement Arrangement Overview



Reminder: 2011 Aetna Medicare Compliance Program course available

To access the course:

- Log in or register at www.AetnaEducation.com.
- Click in the "Search" field.
- Type Medicare and click "Go."
- Have your Aetna PIN readily available.

Enhance your cultural competency skills

Quality Interactions® for Health Care Employees is a non-accredited, web-based program. It teaches a cross-cultural, individual-based strategy for communicating effectively with diverse populations. This program is appropriate for health care administrators, office managers, customer service representatives, lab technicians and other non-clinicians.

To access, log in or register at www.AetnaEducation.com and search for Employee.

Download our course catalog

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

Access Aetna's PCP-based behavioral health support programs

Primary care physicians (PCPs) play a key role in diagnosing and treating behavioral health conditions.

To support PCPs, Aetna Behavioral Health offers four clinical programs, with tools and resources to assist physicians in providing members access to needed mental health care:

- Depression in Primary Care
- Alcohol Screening, Brief Intervention, Referral to Treatment
- Pediatric Behavioral Health Management
- Integrated Primary Care Behavioral Health

Learn more about these programs on our [website](#).



Meritain TPA members could visit your office

Aetna recently completed its acquisition of Meritain Health, a subsidiary of Prodigy Health Group. At the time of acquisition, Meritain Health was the nation's largest, independent third-party administrator (TPA) of self-funded health care plans.

As an Aetna-owned company, Meritain members can use physicians and hospitals in our network.



ID card facts

- The ID card issued by the TPA will have the Meritain logo identifying it as an Aetna company.
- The ID card will also contain a logo indicating the network the member is using:
 - > If the ID card has an Aetna logo, we will pay based on the Aetna non-gated fee schedule.

> If the ID card has another network logo, Meritain will pay based on the negotiated rate for the indicated network. **Note:** Meritain is contracted with some companies who may use networks other than the Aetna network for their employees.

- Send claims to the Meritain address listed on the member's ID card, as Meritain will be processing claims.

If you have questions, call the number on the member's ID card.

New programs can help patients with medication compliance

Beginning January 2012, many of your Aetna patients in commercial (non-Medicare) plans will have access to two new pharmacy programs. These programs can help them improve medication compliance.

- **Therapeutic Optimization:** Patients may be able to switch from multiple doses of a medication daily to just one dose per day, or possibly take one higher-strength pill in

place of multiple, lower-strength pills. We will send letters to prescribing physicians that encourage them to discuss options with their patients.

- **Streamlining Therapy:** Using claims data, we identify patients with asthma who were newly prescribed an inhaler that contains a combination of ingredients. We will send letters to prescribing

physicians that encourage them to follow asthma treatment guidelines. This includes the use of inhaled corticosteroid (ICS) monotherapy prior to combination therapy with long-acting beta-agonists (LABA).

Access our Medicare and Commercial formularies online

We update the Aetna Medicare and Commercial (non-Medicare) Preferred Drug Lists, also known as our formularies, at least annually and throughout the year.

- Go to our [Medicare formulary](#)
- Go to our [Commercial Preferred Drug List](#)

For paper copies of these guides, call **1-800-AetnaRx (1-800-238-6279)**.



Medicare

Note these individual plan changes effective January 1, 2012

Individual Aetna Medicare Rx (PDP) standalone plans will make the following changes effective January 1, 2012:

- A new \$0 generic deductible plan will be available through the Aetna CVS/pharmacy Prescription Drug Plan (PDP) in most states, or through the Aetna Medicare Rx Essentials (PDP).
- In most states, CVS pharmacies will be designated as a preferred pharmacy provider. So, PDP members will have lower cost sharing when filling prescriptions at CVS.

Options for Part D members

These options apply to any member enrolled in an Aetna standalone Medicare prescription drug plan (PDP) or Medicare Advantage plan with Medicare prescription drug coverage (MA-PD):

- Future generic drug launches may help your patients save money if they switch from the brand to the lower cost generic.
- The Aetna Medicare formulary applicable to our Part D benefits will not significantly change in 2012; however, any members impacted by a formulary change are eligible for transition of coverage.
- Aetna Rx Home Delivery® is an option for all members taking maintenance medications.
- Aetna Specialty Pharmacy® can fill prescriptions for medications requiring special handling for members with complex chronic conditions.
- Low-income members may qualify for government subsidies under the Part D program.

Impact to your practice

As a result of the formulary changes, you may:

- Need to help members with Aetna Medicare Part D coverage switch their current prescriptions to a formulary alternative; and
- Encounter more patients requesting transition of coverage help or exception requests.

More information

To learn about our coverage determination and exceptions process, or to contact Aetna if you are helping a member with this process, [click here](#).

2012 Medicare Part D formulary updates could affect your patients

The Aetna Medicare Part D Drug List, also known as our Medicare prescription drug plan formulary (Medicare Part D formulary), will change for 2012.

Visit Aetna's Medicare website using the URLs provided further below to view the 2012 Medicare Part D formulary. The Aetna Medicare website includes the following content:

- The complete Aetna Medicare Part D formulary
- Aetna's Prior Authorization and Step Therapy criteria

The Medicare Part D formulary is updated monthly. The Aetna Medicare website contains current formulary information.

Removal of drugs

Our Medicare Part D formulary may change during the plan year. If we remove a drug from the formulary, add utilization management edits to a drug, or move a drug to a higher cost-sharing tier, we will notify affected members at least 60 days before the effective date of the change. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer takes the drug off the market, we will immediately remove the drug from our formulary and provide retrospective notice to members taking the drug.

Maximize patient benefits

As a result of changes to the formulary, 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 with Medicare prescription drug coverage by:

- Prescribing drugs on the Aetna Medicare Preferred Drug List, which can be found at the Aetna Medicare website:
 - > [Individual plan formulary](#)
 - > [Group plan formulary](#)
- Switching to an alternative formulary drug, when applicable
- Understanding Aetna step-therapy and precertification requirements
- Submitting a medical exception request, when appropriate

Updated CMS guidance clarifies payment for ESRD drugs

Claims for end stage renal disease (ESRD)-related drugs and biologicals that are used by Medicare beneficiaries with ESRD **but are not used to treat an ESRD-related condition** should not be denied for payment under Medicare Part D. This is based on a February 17, 2011 memo issued by the Centers for Medicare and Medicaid Services (CMS memo).

Prior auth requirements

In accordance with the CMS memo and to confirm that Aetna's Medicare members with ESRD have access to covered drugs at point-of-sale, we will place prior authorization requirements on the five categories of drugs/biologicals always considered renal dialysis drugs when used as specified in the memo.

Questions

To review the CMS memo, visit the [Medicare Drug Coverage Contracting](#) website and select HPMS Guidance History. If you have questions regarding the billing and payment of a drug supplied to an Aetna Medicare member diagnosed with ESRD, contact our Provider Service Center.

Northeast News

NEW YORK

Updated Regulatory Amendment available online

We have posted a Regulatory Amendment to New York provider agreements online. Review this Amendment and keep a copy with your provider agreement.

About the Amendment

This Amendment updates the existing New York Department of Health's Appendix A – the New York State

Department of Health Standard Clauses for Managed Care Provider/IPA Contracts (the "Standard Clauses") that were effective March 1, 2011. The updated Standard Clauses includes Appendix B – Certification Regarding Lobbying (the "Lobbying Certification") as referenced in Section B. 9. g. of the Standard Clauses.

To download a copy, [click here](#). If you don't have Internet access, call our Provider Service Center to request a paper copy.

NEW JERSEY

In-network copays for HMO and PPO plans now lower

To comply with New Jersey regulations, we reviewed three in-network copays for our HMO and PPO plans.

On April 1, 2011, we lowered the in-network copay for chiropractic visits and physical/occupational/speech therapy visits. On September 1, 2011, we lowered the copay for outpatient laboratory services. We are refunding members the extra copay amounts they were charged for these services since the effective date of the change.

Service/maximum copay

- | | |
|----------------------------------|------|
| ▪ Chiropractic visits | \$25 |
| ▪ PT/OT/ST visits | \$20 |
| ▪ Outpatient laboratory services | \$15 |

In-network copays for the services above will not be higher than the amounts shown. Some Aetna plans were not impacted, and some members may have even lower copays than those shown.

DELAWARE, PENNSYLVANIA

Chiropractors: Contract with ASH Networks to remain “in network”

Effective December 1, 2011, ASH Networks is administering certain components of the chiropractic benefits for all Aetna products (including Medicare Advantage), except Traditional Choice®, ASA, AWCA and Aetna Student Health, in PA and DE.

To continue providing chiropractic services to our members at their highest benefits level in these markets, you need to

contract with ASH Networks. If you have not yet received a credentialing package, contact ASH Networks at **1-888-511-2743**.

Once you have signed a participation agreement with ASH Networks, you will continue to be considered an in-network provider for Aetna members through ASH Networks. At that point, your direct contract with Aetna will become dormant.

If you are an existing ASH Networks contracted chiropractor, no action is required. The provisions under your current agreement with ASH Networks will apply for Aetna members.

PCPs: Refer Aetna patients to participating ASH Networks chiropractors

You can help your Aetna patients minimize their out-of-pocket costs by referring them to participating ASH Networks chiropractors. You can find these providers in our DocFind® online provider directory with an ASH Networks designation.

Referral should indicate one visit. ASH Networks provider IDs are:

- PA: PIN # 9198755
- DE: PIN # 9662734

How to inform us about changes in your practice

Under terms of your contract with Aetna, you are required to notify us whenever:

- A provider leaves your practice or a new provider joins your practice
- There is a change of mailing address, phone number, fax number
- There is a change of e-mail address
- You change your office panel status – if you want to re-open your practice to new patients (currently frozen) or if your practice is accepting current patients only

If you don't give us this information, your practice may not receive important information that that Aetna sends either by e-mail or U.S. mail.

Updating information

You can give us this information through our secure provider website. On the Aetna Plan Central Page, choose “Update Aetna Provider Profile.”

After accessing NaviNet, if you have questions, 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.

If you don't have access to or use NaviNet, then you can update information by going to **DocFind** and clicking on “Update Provider Demographic Data.”





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“Aetna” is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefit coverage include Aetna Better Health Inc., Aetna Health Inc., Aetna Health of California Inc, Aetna Dental Inc., Aetna Dental of California Inc., Missouri Care, Incorporated, Aetna Life Insurance Company, Aetna Health Insurance Company of New York, and Aetna Health Insurance Company. Aetna Pharmacy Management refers to an internal business unit of Aetna Health Management, LLC.

Updates to our patient safety policy

We’re combining our current Hospital Acquired Condition (HAC) policy and Serious Reportable Event (SRE) policy into one Patient Safety Event policy*. This consolidated policy is effective January 1, 2012.

How to report

As a reminder, our policy requires facilities to report all Patient Safety Events to Aetna. Call the Provider Service Center to report an event.

The listing of Patient Safety Events was modified based on updates from the National Quality Forum (NQF) and

*This policy applies to all facilities.

guidelines from the Centers for Medicare & Medicaid (CMS). Aetna reserves the right to revise this policy based upon updates from these entities.

What’s new

Specifically, six SREs were added – three fall under Reimbursement Review and three are Reporting Only. There are also changes to some of the other SREs based upon the NQF update.

View the modified list on [our secure provider website](#). Once logged in:

- Select “Claims” from the Aetna Plan Central home page
- Choose “Policy Information (Step 3)”
- Click on “Claim Payment and Coding Policies”
- Search by “P” for “Patient Safety Event”

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.