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Aetna OfficeLink Updates™

Northeast Region

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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

Changes to the National Precertification List (NPL)

The following precertification changes are effective on July 1, 2013 unless otherwise noted:

Additions:

- Actimmune® (interferon gamma-1b)
- Zaltrap® (ziv-afilbercept) – Effective 2/15/13 precertification required (**Coverage Policy Bulletin (CPB) #0701**)
- Xeljanz™ (tofacitinib) – Effective 2/15/13 precertification required (**CPB #0839**)

To precertify these medications, call **1-866-503-0857** or fax the precertification request form of each drug to **1-888-267-3277**.

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

Deletions:

- Medical precertification is no longer required for these oral Hepatitis C medications – Incivek™ (telaprevir) and Victrelis™ (boceprevir). For members with pharmacy precertification requirements, call **1-866-503-0857**.
- Outpatient surgical scopes – Effective 12/14/12, we no longer require notification for colonoscopy and upper GI endoscopy

Review the **NPL** online.

Health Insurance Exchanges are coming – learn more about them

The Affordable Care Act includes guidelines for a new kind of marketplace for health insurance – Health Insurance Exchanges.

Overview

Exchanges are online marketplaces where consumers can go to shop for and buy health insurance.

Each state has the option to create and operate its own Exchange. States that decide not to offer an Exchange will either partner with the federal government to offer an Exchange or simply use a federal Exchange. Starting October 1, 2013, the federal and state-based Exchanges will be available for small employers and individuals.

What this means to you

With about 20 million new consumers expected to buy individual insurance by 2016, you can expect some changes. To find out more, visit our **Health Reform Connection** website for more on Exchanges and other health reform topics, including:

- **Exchanges at a Glance** – Understanding the basics
- **How am I impacted?** – What the introduction of Exchanges may mean to your practice

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48.22.808.1-Q2-NE (3/13)

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
DRG transfers: Expansion to long term care facilities and skilled nursing facilities*	6/1/2013	Our payment for transfers out of acute care facilities is changing. This policy applies when Aetna Medicare members are transferred earlier than the average length of stay for the Diagnosis Related Group (DRG). We will pay per diem rates when patients are transferred from an acute care facility to a skilled nursing facility or long term care facility. Listed below are the criteria we will use for the facility transferring the patient: • The transferring acute care facility has a contract based on DRG-defined payment rates and does not have defined rates for transfers to skilled nursing facilities or long term care facilities. • The actual length of stay is at least one day less than the average length of stay for the DRG. • The DRG is subject to post-acute care as defined by CMS. How we will calculate the per diem: • DRG contracted rate (divided by) the average length of stay for the DRG = per diem rate • Per diem rate (multiplied by) the patient's actual length of stay + 1 additional day = allowed amount Note: The addition of transfers to skilled nursing facilities and long term care facilities expands our current DRG transfers policy that took effect 11/1/12.
Code editing, clinical & payment policy code lookup tool enhancement	Available now	The tool now combines our clinical, payment, and coding policies all in a single source. It's accessible via the Claims navigation bar. The tool allows you to determine how procedure codes billed alone or in combination with other procedure codes may be processed and to determine eligibility of an assistant surgery procedure. The tool also allows you to enter specific criteria including diagnosis codes, modifiers and place of service to determine procedure code eligibility.
Hot or cold packs, application of a modality to 1 or more areas*	6/1/2013	We will consider 97010 as incidental to all other procedure codes. It is not eligible for separate payment.
87621 – Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique*	6/1/2013	We will allow 87621 three (3) times per date of service.

Procedure	Implementation date	What's changed
After hours and weekend care*	6/1/2013	We will deny 99050, 99051, 99053, 99056, 99058, and 99060 when billed by urgent care facilities.
Hiatal hernia procedures billed with bariatric surgery*	6/1/2013	We will deny hiatal hernia codes (39599, 43280, 43281, 43289 and 49659) billed with bariatric surgery codes. Modifier 59 will not override.
Monitored anesthesia care (MAC) billed with varicose vein procedures*	6/1/2013	We will deny MAC when billed with varicose vein procedures (36470-36479 and 36468-36469).
Default participating providers fee schedule – pharmacy services (HCPCS Level II J codes) *	Reminder	As a reminder, the default fee rate for J code pharmacy services billed $600 and greater will be paid at 85 percent of the Average Wholesale Price.
Arthroscopy	6/1/2013	We will allow 29822 (debridement, limited) when billed with 29824 (distal claviculectomy including distal articular surface).
Cardiopulmonary exercise testing – **Clinical Policy Bulletin #0825**	6/1/2013	We will allow 94621 for the following diagnoses only: • 162.2 – 162.9 • 425.0 – 425.9 • 428.0 – 428.9 • 491.0 – 492.8 • 494.0 – 496 • 516.3 • 754.81 • 786.05 • V10.11
Inappropriate billing or coding	Annual reminder	We make code adjustments for inappropriate billing or coding. Examples of these adjustments include rebundling of services that are considered part of, incidental to, or inclusive to the primary procedure as well as adjustments for mutually exclusive procedures.

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

New national ambulance agreement with American Medical Response

We have a new, three-year national agreement with **American Medical Response** (AMR) for ground and fixed-wing air ambulance services.

The agreement started on October 1, 2012 and adds 134 new operator sites to our network.

AMR is now the national preferred medical transportation provider for all Aetna commercial members. It is also the only national ambulance provider for Aetna Medicare members. Aetna members will now have the benefit of using AMR as a par provider. Members and plan sponsors will also see increased savings when they choose AMR over transportation providers that don't participate with us.

Visit **AMR** for more information and to find a transportation site near you.

Office News

Specialists: We may request patient medical records

Under a current program, we may ask to review selected medical records. We do these reviews to compare the clinical coding to the corresponding clinical services provided to our members.

We base these requests on either:

- The characteristics of the claim (such as the charges billed in conjunction with the procedure performed).
- The provider who submitted the claim (due to different billing practices compared to those of his/her peers).

Affected specialties:

- Dermatology
- ENT
- Hand surgery
- Neurology
- Neurosurgery
- Orthopedic surgery
- Pain management
- Physiatry
- Plastic surgery
- Podiatry
- Sports medicine
- Urology

Affected procedures

We may request to review medical records for the following procedures:

- Dermatology – excisions, complex repair, tissue transfer and flaps.
- Urology – cystoscopy, urethroscopy, transurethral surgery and prostate procedures.
- Other specialties – spine surgery, breast reconstruction, hand surgery, arthroscopy, debridement, complex closures, tissue transfer, endoscopic sinus surgery, anesthesia by surgeons, excisions, flaps and unlisted procedures.

When we request medical records, fax them to Aetna at **859-455-8650** with "ONET" on the coversheet.

Medicare Advantage plans now cover annual wellness visit

Effective January 1, 2013, Aetna Medicare Advantage (MA) plans include coverage for an annual wellness visit. The CPT codes for a wellness visit are G0438 and G0439.

MA plans no longer cover annual physical exams. The CPT codes for the annual physical exam are 99381-99397, 99401-99404, 99201-99205 and 99211-99215 with primary diagnosis of preventive. The preventive diagnosis codes not covered are:

- V03.0-V03.9
- V04.0-V04.89
- V05.0-V05.9
- V06.0-V06.9
- V20.0-V20.2
- V70.0
- V70.3
- V70.5

This change was made as a result of a change in coverage made by the Centers for Medicare & Medicaid Services (CMS).

To avoid claims rejection, bill appropriately for annual wellness exams. For more information, CMS offers these reference guides:

- **The ABCs of Providing the Annual Wellness Visit**
- **The ABCs of Providing the Initial Preventive Physical Examination**

Keeping you and your patients informed

Here is important program information that can help you and your patients.

We integrate quality management and metrics into all we do. For details on our quality management program, its goals and our progress toward those goals, log in to our **secure provider website**.

Select "Aetna Support Center" then "Doing Business with Aetna" and "Quality Management Program." If you don't have Internet access, call our Provider Service Center for a paper copy.

Using peer-to-peer discussion

If your office gets a service coverage denial letter from Aetna precertification on behalf of a patient, a doctor may schedule a call with the Aetna medical director who sent that letter.

These peer-to-peer (P2P) discussions are for the doctor to provide new information not previously disclosed to the medical director before the standard appeal process begins. More information may result in changing the denial to an approval.

This discussion is optional. If a doctor wants one, it must occur within 14 days of the date on the denial letter.

Appealing a decision

The P2P call does not replace or delay an appeal; it supplements it. However, the call is faster than going through an appeal. If the P2P discussion does not change the coverage decision, a doctor may still appeal using the process outlined in the letter.

To schedule a P2P discussion, call the number on the denial letter. Have the patient's name and birth date or Aetna ID number when you call.

Note about Connecticut members: Aetna medical directors cannot change prior coverage decisions through a P2P discussion for members in fully insured plans written in Connecticut. This does not affect members in Medicare Advantage plans, self-insured plans or those living in Connecticut but covered under plans written in another state. Our medical directors will still be available to discuss coverage decisions, but requests to change the coverage decision must be made through the formal appeal process.

Help patients lower heart disease and stroke risks

Aetna supports the U.S. Department of Health and Human Services in the **Million Hearts**™ campaign. The campaign's goal is to prevent one million heart attacks and strokes over five years.

The Million Hearts website offers free tools, videos and educational materials you can use to help your patients:

- Manage their high blood pressure and cholesterol
- Control their risk factors for heart disease and stroke
- Lead heart-healthy lives

Aetna programs

Aetna also offers programs that can help your patients reduce their risk of heart disease and stroke:

- Aetna Health Connections℠ Disease Management Program.
- Get Active! – a year-round program that offers inviting seasonal challenges to keep people moving and motivated.
- Healthy Lifestyle Coaching Tobacco Free – an individualized program that addresses tobacco dependence and helps people achieve health goals.

Guidelines to help treat ADHD

We encourage you to use evidence-based clinical practice guidelines (CPGs) to help screen, assess and treat common disorders, such as ADHD. These guidelines can help you give the best health care possible.

View AAP guidelines

The American Academy of Pediatrics (AAP) guidelines state that children who are treated with medication for ADHD should have at least one follow-up visit with a prescribing practitioner within 30 days of the initial prescription fill and every quarter thereafter. We monitor compliance monthly through Healthcare Effectiveness Data and Information Set (HEDIS®)* data collection and review. **Read** the full guideline.

Learn more online

You can **find more information** on the Centers for Disease Control and Prevention's website.

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

Electronic Transactions

Use correct member IDs for HMO-based plans

Aetna is making it easier for you to send information to us about your patients enrolled in Aetna medical plans. Be aware of the information below when submitting electronic transactions for these individuals.

More members have "W" ID numbers

You recently may have seen more Aetna members with a "W" ID number in HMO-based plans (HMO, QPOS, Health Network Option and Health Network Only).

Eventually, all of our medical product members will have a "W" ID number.

As this occurs, document those members whose IDs changed to this new format. Submit all of your electronic transactions using the new "W" ID number. This helps ensure that you receive accurate benefit details on your electronic inquiries, including "Batch Encounter" submissions.

Prevent encounter rejections

When an HMO member visits a doctor for services that are paid for by capitation or through a delegated payment arrangement, the visit report that is sent to Aetna is called an "encounter." Be sure to include the new "W" ID on your submission, or the encounter will be rejected.

It's easy to send us drug approval requests

You can now quickly and easily send us drug approval requests. Use our **secure provider website** and the NaviNet® Drug Authorizations transaction.

How you'll benefit

- Find, complete and send us drug approval requests.
- Manage all drug prior authorization forms and follow-up in one place.
- Store patient, pharmacy and physician data.
- Find the right drug authorization form quickly.
- Save time on the phone.
- Get drug authorization requests from pharmacies and complete them online.
- Keep the physician's signature, which allows you to fax requests directly without printing.

Getting started

Log in to our **secure provider website**. From there, choose the "Drug Auths" menu option from Aetna Plan Central. Or, choose the "Drug Authorizations" option under the "Services" menu.

We'll still fax the authorization directly to you.

EOB Tool enhancements

Enhancements to our Electronic Claim EOB Tool make it even easier to access the information you need. New features include:

- **EOB activity two clicks away.** The EOB Activity page gives you a daily accounting of new EOBs for the TINs in your office. Just locate the date, select the TIN and the EOB list results for the date and TIN selected will display.
- **Downloadable data files.** We've added download buttons to the EOB and Claim List results screens. These let you access the content in a spreadsheet that you can save to your computer.
- **Large EOBs?** No problem. EOBs +1500 pages are now available online.

To take advantage of these enhancements, visit the EOB Activity page on our **secure provider website**.

Use secure site to update demographic data

If you need to update your office's demographic information – new e-mail addresses, mailing address, phone or fax numbers – use our **secure provider website**. Also update your demographic information if your name changes due to marriage or another life event.

Our secure site lets you verify the information you submit. It prevents unauthorized individuals from submitting wrong information about your office or facility.

Electronic transactions

You also can do most electronic transactions through this website. This includes submitting claims, checking patient benefits and eligibility and requesting precertifications.

So, if you've been calling our Provider Service Center for demographic changes or with questions about electronic transactions, we ask that you use the secure site instead.

NaviNet Security Officers have access to Aetna's "Update Provider Profiles" 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 first **register** to do so.

Learning Opportunities

Log in or register at **AetnaEducation**

New and updated courses for physicians, nurses and office staff

Live webinars

- New Precertification Tools

Reference Tools

- Updated Seasonal Flu Resources: Vaccination Recommendations for Health Care Professionals
- Updated Products, Programs and Plans: Nonparticipating Provider Information: Aetna Medicare Plan (PPO)

Free courses can help improve patient relationships and outcomes

Learning about cultural competency can help you improve communication with your patients. You can help patients of all backgrounds better understand your communication about their diagnosis, treatment and compliance.

Free courses to help you

These courses give examples of quality interactions with patients in a clinical setting. You'll learn skills for administering effective cross-cultural care.

Choose from:

- Quality Interactions® for Health Care Employees (non-accredited)
- Quality Interactions® for Physicians (2.5 CME credits)*
- Quality Interactions® for Oncologists (2.5 CME credits)*
- Four different Quality Interactions® Refresher Courses (1 CME credit each)*
- Quality Interactions® Introductory Course for Nurses (1.0 contact hours)
- Quality Interactions® for Nurses & Case Managers (2.5 CEU credits)

Get started in three steps

- Log in or register at **Aetna Education**.
- Type "Cultural" in the search field.
- Click "Go."

*These courses meet state licensure requirements in CT, MA, NV, PA, NJ and TX.

Our Toolkit keeps you and your patients informed

Our Health Care Professional Toolkit (Online Office Manual) is available on our **secure provider website**. There, you'll find information about our case management and disease management programs.

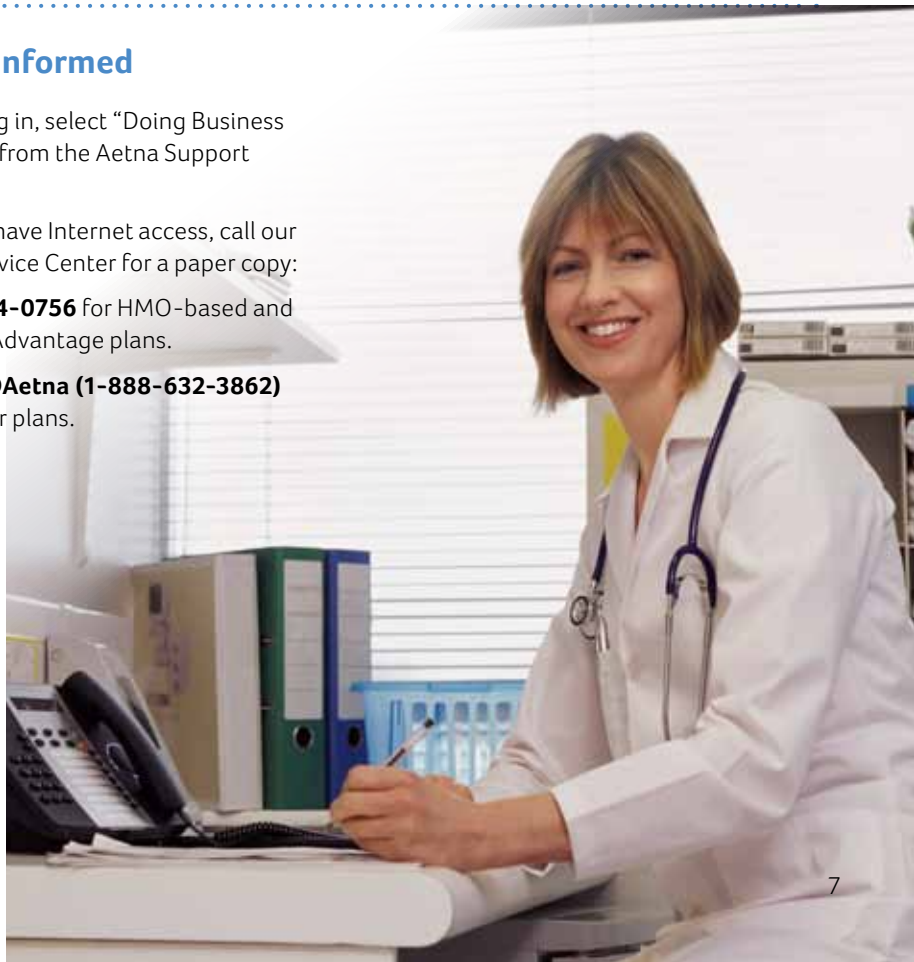
The Toolkit has information that we designed to help you serve your Aetna patients efficiently. It's a streamlined office manual that has information about:

- Clinical Practice and Preventive Service Guidelines.
- Policies and procedures.
- Patient management and acute care.
- Special member programs/resources, including the Aetna Women's Health℠ Program, Aetna Compassionate Care℠ and others.

After logging in, select "Doing Business with Aetna" from the Aetna Support Center.

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

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



Pharmacy

Changes to Precert, Quantity Limits and Step-Therapy programs

We'll make changes to our commercial Pharmacy Management Precertification, Quantity Limits and Step-Therapy programs on June 1, 2013, and July 1, 2013.

To precertify a drug:

- Call **1-800-414-2386**
- Or, fax the appropriate medication request form to **1-800-408-2386**

Starting March, 1, 2013, you can **view** the list of drugs we're adding to these programs:

- Select "Non-Medicare Plans" and any plan type from the drop-down box.
- Choose "2013 Preferred Drug (Formulary) List Changes."
- Select "2013 Mid-Year Edit Changes" from the drop-down box.

NPL addition

Effective July 1, 2013, Actimmune will be subject to precertification for all commercial members. To precertify, call **1-866-503-0857**, or fax the appropriate medication request form to **1-888-267-3277**.

Medication request forms

You can find forms on our **secure provider website**. Once logged in, select "Aetna Support Center" from the Aetna Plan Central home page, then "Forms Library" and "Pharmacy Forms."

Where to see our Medicare and Commercial formularies

We update the Aetna Medicare and Commercial (non-Medicare) Preferred

Drug Lists, also known as our formularies, at least annually and from time to time throughout the year.

- Go to our **Medicare formulary**
- Go to our **Commercial Preferred Drug List**

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

2013 data collection is underway

Aetna staff or our contracted representatives may contact your office to collect medical record information from our members' visits in 2012. Our largest contracted representatives include Inovalon™ and MediConnect.

Why we do this

Healthcare Effectiveness Data and Information Set (HEDIS) data collection is a nationwide, collaborative effort among employers, health plans and physicians to monitor and compare health plan performance as specified by the National Committee for Quality Assurance (NCQA).

As a Medicare Advantage organization, Aetna is required to submit member diagnosis data to CMS on an ongoing basis. Most of the data submitted is collected from claims and encounters. We also gather some diagnosis codes from members' medical records.

What we may need

If contacted by Aetna staff or our contracted representatives, we ask that you cooperate with their request for timely access to our members' medical records within the provided timeframe. Our contracted representatives will work with you and can provide many options for sending in medical records.

Meeting HIPAA guidelines

Our representatives serve Aetna in a role that is defined and covered by the Health Insurance Portability and Accountability Act (HIPAA). As defined by HIPAA, Aetna is a "covered entity" and a representative's role is as a "business associate" of a "covered entity." Providing medical record information to Aetna or our contracted representatives complies with HIPAA regulations.

Coverage determinations and utilization management

We use evidence-based clinical guidelines from nationally recognized authorities to make utilization management (UM) decisions.

Specifically, we review any request for coverage to determine if members are eligible for benefits, and if the service they request is a covered benefit under their plan. We also determine if the service delivered is consistent with established guidelines. The member, member's representative or a physician acting on his/her behalf may appeal this decision if we deny a coverage request. Members can do this through our complaint and appeal process.

Our UM staff help members access services that their benefits plans cover. We don't reward physicians or individuals (who conduct UM reviews) for creating barriers to care, or for issuing coverage denials.

Our medical directors are available 24 hours a day for specific UM issues. Physicians can contact patient management and precertification staff at the telephone number on the member's ID card. When the card only shows a Member Services number, we'll direct you through either a phone prompt or a Member Services representative.

CPBs and PCPBs

Clinical Policy Bulletins (CPBs) and Pharmacy Clinical Policy Bulletins (PCPBs) explain and guide our determination of whether certain services, medications or supplies are medically necessary, experimental and investigational or cosmetic. CPBs and PCPBs can help you assess if patients meet our clinical criteria for coverage. They can also help you plan a course of treatment before calling for precertification, if required.

Where to learn more

It's easy to find information about our UM criteria, CPBs and PCPBs. You can view the criteria for **CPBs** and for **Determining Coverage** on our public website. If you don't have Internet access, call our Provider Service Center for a hard copy. For a copy of the criteria upon which we base a specific determination, call our Provider Service Center.

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

Review our policies on non-discrimination, accessibility

Our Health Care Professional Toolkit (Online Office Manual) is available on our **secure provider website**. It includes important information on all member rights and responsibilities, including those about discrimination. It also has information about accessibility standards.

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

Non-discrimination policy

All participating physicians should have a documented non-discrimination policy.

Federal and state laws prohibit discrimination in the treatment of patients on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information or source of payment.

All participating physicians or health care professionals may also be obligated under the federal Americans with Disabilities Act to give physical access to their offices and reasonable accommodations for patients and employees with disabilities.

Accessibility standards

The Toolkit has accessibility standards for primary care physicians. Accessibility standards for specialists are specific to your state and specialty. Refer to your provider contract for details.

Northeast News

New Jersey, Pennsylvania

Facilities: When to transfer members directly to a SNF

Our policy allows for the transfer of our members from the emergency room (ER) or observation unit directly to a skilled nursing facility (SNF). A hospital stay is not required in these situations. We encourage your facility to make these transfers when medically appropriate.

This policy applies to our Medicare Advantage (MA) and commercial members. The guidelines to transfer an Aetna member directly from the ER or observation unit to a SNF are:

	Transferring MA members	Transferring Aetna members in commercial plans
Transfer criteria	Aetna MA members that meet daily skilled needs criteria per Centers for Medicare and Medicaid Services (CMS) guidelines may be considered for transfer. **There is no mandatory 3 day admission requirement.***	Aetna commercial members that meet Milliman Recovery Facility Guidelines may be transferred directly to an in-network SNF. **Prior-authorization is not required.**
Authorization process	• The hospital calls Aetna at **1-800-245-1206** between 8 a.m. – 8 p.m. ET to authorize the stay • An Aetna nurse case manager will call your designated contact person to confirm the benefit, and obtain the clinical information and name of the preferred facility for admission	• The SNF calls the toll free number on the member's ID card to notify Aetna that the transfer has taken place and includes the member and facility names • An Aetna nurse reviewer will call the contact person at the SNF on the next business day to obtain clinical information and provide coverage determinations.

These transfers to a SNF may:

- Reduce costs for our members and plan sponsors without reducing the quality of care
- Reduce the risks associated with being hospitalized

*CMS coverage guidelines require Medicare patients be admitted for 3 days prior to admission to a SNF. However, when medically appropriate, transferring Aetna MA members to the SNF sooner is allowed. To transfer, the member must meet SNF admission qualifications.

Connecticut

State program offers free vaccines

The Connecticut Vaccine Program (CVP) currently provides 13 of the 16 ACIP-recommended vaccines at no cost to you or your patients. CVP offers them to qualified children through age 18.

Key points to know

- Network physicians must be part of any available state immunization/CVP programs.
- Enroll in the CVP or learn more about it at **Connecticut Department of Public Health**.
- You should have had state-supplied vaccines available to administer by January 1, 2013 to be complaint with Public Act 12-1.
- We gave a 30-day Aetna grace period to providers who administered childhood vaccinations. This allowed time to deplete any pre-ordered vaccine supplies. As of February 1, 2013, we aligned our policy with the new state requirements.
- When you bill us for state-supplied vaccines, use modifier SL.
- We'll still pay the administrative fee for state-supplied vaccines.
- Call **1-800-624-0756** for HMO-based and Medicare Advantage plans, or **1-888-MD-Aetna (1-888-632-3862)** for all other plans.

New Jersey, New York

Refer Savings Plus patients to designated providers

The Savings Plus hospital and physician network is now available in metropolitan New York and New Jersey for New Jersey small employers.

The network is available to employers who are looking for plans to better control medical costs. We have notified all designated Savings Plus providers of their status.

Savings Plus members pay the least out of pocket when they use Savings Plus providers. **To help your Savings Plus patients save money, refer them to Savings Plus specialists and hospitals**. You'll find designated Savings Plus specialists and hospitals in our DocFind® online provider directory. Just look for providers with the $ symbol.

New Jersey

Where to find our appeal process forms

We have updated the information about internal and external **provider appeal processes** on our public website. The New Jersey-specific forms are at the bottom of the page.

If you use the NJ Health Care Provider Application to Appeal a Claims Determination form when submitting certain claims appeals, you should make sure your claim is eligible. You can find this form and the correct procedures on our public website by following the links above. Look for "New Jersey" under "State-specific forms."

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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

Consult Clinical Practice Guidelines for patient care

The National Committee for Quality Assurance (NCQA) requires health plans to regularly inform providers 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 located on our **secure provider website** under "Aetna Health Plan," "Aetna Support Center," then "Clinical Resources."

Preventive Service Guidelines *USPSTF prostate cancer screening recommendations *USPSTF perinatal recommendations	Adopted February 2012 Adopted July 2012 Adopted November 2012
Behavioral Health • Helping Patients Who Drink Too Much • Treating Patients With Major Depressive Disorder	 Adopted February 2012 Adopted February 2012
Diabetes • Treating Patients With Diabetes	 Adopted February 2013
Heart Disease • Treating Patients With Coronary Artery Disease	 Adopted April 2012

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.

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