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Aetna OfficeLink Updates

Northeast Region



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Options to reach us

Select **Health Care Professionals**

Select “Log In/Register”

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

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

Updates to our National Precertification List

These changes to **Aetna’s National Precertification List (NPL)** will take effect as noted below.

A new drug class, injectable respiratory drugs, will require precertification on July 1, 2016. This class includes Nucala (mepolizumab) and Xolair (omalizumab) which currently require precertification.

Reminders and updates

On January 14, 2016, the following new to market drugs required precertification:

- Coagedex (coagulation factor X [Human])
- Adynovate (antihemophilic factor [recombinant], PEGylated)
- Strensiq (asfotase alfa)
- Nucala (mepolizumab)
- Kanuma (sebelipase alfa)

Amevive (alefacept) and Iplex (mecasermin rinfabate) no longer require precertification.

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

Send observation notifications over 24 hours electronically

Use our **secure provider website** on NaviNet® to notify us about observations over 24 hours. Here’s how:

- From Precertification Submission, enter the patient’s information.
- On the next screen, choose “Medical” then “Outpatient.”
- Select an outpatient place of service in step 3.
- In step 5, be sure to include an observation CPT code. Also include the number of hours you’ve been observing the patient as of the time of your notification.

Remember — you don’t need to notify us until you’ve been observing the patient for more than 24 hours.

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 advises us on issues of importance to physicians. The chart below outlines coding and policy changes:

Procedure	Effective date	What's changed
Modifier 59 — Distinct Procedural Service	June 1, 2016	Effective June 1, 2016, our Modifier 59 policy will apply to facility claims. When a procedure or service is billed with Modifier 59 on the same date of service as another procedure, Aetna may consider both codes as eligible for payment. Refer to the “Modifier 59 — Distinct Procedural Service” payment policy and exceptions on our secure provider website under the Claim Payment and Coding Policies section for more information.
Presumptive and Definitive Drug Testing*	January 1, 2016	We will follow the 2016 CMS coding recommendations for definitive and presumptive drug testing. The frequency limit for each (definitive and presumptive) is 8 times per 365 days, from the time the service is first rendered.
Procedure: Payment for professional services	August 1, 2016	According to Aetna policy, professional services billed by a hospital on a UB form are to be denied. When denied, we provide instructions for the services to be rebilled on a HCFA form. This general policy has been in place for E&M codes for several years. In 2008, we made updates to include professional fees for minor surgery codes. But that update was only made to our HMO system. We're now updating our traditional system.

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



DRG transfers policy expanding to more facilities and services

Our payment for transfers out of acute care facilities is changing effective **June 1, 2016**. This policy applies when Aetna Medicare members are transferred earlier than the average length of stay for the Diagnosis Related Group (DRG).

We'll pay per diem rates when patients are transferred from an acute care facility to one of these settings:

- Cancer Center
- Children's Hospital
- Home Health Care Service
- Inpatient Rehabilitation Facility
- Psychiatric Hospital

Here are the criteria we'll 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 the above-mentioned settings.
- The actual length of stay (LOS) is at least one day less than the average LOS for the DRG.
- The DRG is subject to post-acute care as defined by CMS.

How we'll calculate the per diem:

- DRG contracted rate (divided by) the average LOS for the DRG = per diem rate
- Per diem rate (multiplied by) the patient's actual LOS + 1 additional day = allowed amount

Note: The addition of transfers to these settings expands our current DRG transfers policy. **This policy does not apply in North Carolina.**

When out-of-state patients seek your care

Some health insurance plans may not offer coverage outside the member's home state. This means members will be financially responsible for the care they receive from out-of-state providers.

How to help these members

- Verify eligibility and coverage before seeing patients.
- Use our **provider online referral directory** for referring patients to another provider. Some plans have smaller networks, so make sure the provider you're referring to is in the patient's network.

Be aware of premium grace period for exchange members

Members who buy insurance on a public exchange may qualify for a subsidy to help pay for their coverage. Subsidized members have different grace period rules as outlined below.

Once these members pay at least one full month's premium, they qualify for a three-month grace period. This means if the member can't pay their monthly premium, they have three extra months to pay before we can cancel coverage.

If a member doesn't pay their monthly premium:

- We'll pay providers for services the member received during the first month of the grace period.
- We'll pend claims for services the member received in the second and third months of the grace period.
- If we don't get full payment by the end of the third month, the member's coverage will be terminated retroactively to the beginning of the grace period. We won't pay any pended claims.

Verify eligibility

For a member who hasn't paid his monthly premium, providers will receive an Explanation of Benefits (EOB) indicating the claim was pended. Providers in the Southeastern PA, Northern VA Innovation Health, Charlotte and Phoenix markets may receive a notice letter instead of an EOB. This will occur for all claims received during the second and third months of the grace period.

So, if coverage is terminated for lack of premium payment, it is the member's responsibility to pay the provider directly for these claims. We'll pay claims as long as full payment is received before the end of the grace period.

Follow guidelines for appropriate lab testing

Your influence is crucial in helping members get recommended lab tests. We want to remind you of the evidence-based recommendations for annual lab testing for patients who are prescribed certain categories of medication.

Here are recommended lab tests for each medication category¹:

Medication category	Annual lab test(s)
Angiotensin-converting enzyme (ACE) inhibitors Angiotensin receptor blockers (ARBs)	Serum potassium and serum creatinine or Serum potassium and blood urea nitrogen
Digoxin	Serum potassium and serum creatinine or Serum potassium and blood urea nitrogen
Diuretics	Serum potassium and serum creatinine or Serum potassium and blood urea nitrogen
Anticonvulsants	Serum concentration for the prescribed drug

¹HEDIS Technical Specifications, Volume 2

Member ID card on a smartphone is valid

If Aetna members show you their ID card on their smartphone or other mobile device, your office or facility should accept that as valid proof of insurance coverage.

The digital ID card is an electronic version of the member's ID card. It still allows you to easily get all of the information you need.

You should expect to see an increasing number of members using this technology in the future. Of course, many members will continue to use ID cards in plastic or paper formats.



Office News

Use our secure site to update data about your office

To update your office's demographic information, go to our [secure provider website](#) and sign in. Use this for:

- New e-mail addresses
- New phone or fax numbers
- New mailing addresses
- Name changes due to marriage or another life event

If you've been calling our Provider Service Center to make these changes, we ask you to use the secure site instead. The site lets you confirm the information you submit. It prevents unauthorized individuals from submitting wrong information about your office or facility.

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage plans and Qualified Health Plans (QHPs) to maintain accurate directories. Having your up-to-date information allows us to do that.

Electronic transactions

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

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 [register](#) first.

Limiting radiation exposure in pediatric patients

Pediatric patients are at higher risk from radiation exposure during diagnostic CT scans. Children have an increased sensitivity to radiation due to their young age and long lifespan.

We encourage you to:

- Be aware of the appropriate CT scan for your patients to reduce radiation exposure, limiting your scan order to only the area of interest. For example, for a CT to evaluate the liver, order a CT abdomen only (without pelvis).
- Avoid unnecessary two-phase CT scans (non-contrast then contrast) which doubles the radiation dose. For example, a CT head for headache is typically only done as single phase.

We support reducing the radiation dose for children. To learn more, visit the Alliance for Radiation Safety in Pediatric Imaging [website](#).

Our Office Manual keeps you informed

Aetna's [Office Manual for Health Care Professionals](#) (Manual) is available on our [website](#).

The Manual has information to help you serve your patients efficiently and accurately, including:

- Clinical Practice Guidelines and Preventive Service Guidelines. These are also on our [secure provider website](#). Once logged in pick "Clinical Resources" from the Aetna Support Center.
- Policies and procedures.
- Patient management and acute care.
- Case management and disease management programs.
- Special member programs/resources, including the [Aetna Women's Health](#)SM Program and [Aetna Compassionate Care](#)SM.
- Member rights and responsibilities.
- What utilization management is and how we make decisions, including our policy against financial compensation.
- How our Quality Management program can help you and your patients. We integrate quality management and metrics into all that we do. You can find details on the program goals and how we're progressing toward those goals.

To access the [Innovation Health Manual](#), once on the website select "Physicians & Providers," then "Practice Resources."

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

Aetna Premier Care Network goes national

The Aetna Premier Care Network (APCN) is a provider network for employers with employees across the country. Employers can now offer a single benefit strategy to all employees, regardless of their geographic location.

New for 2016

This year, in some locations we're including our Aetna Whole Health (AWH) networks with the APCN network. However, your APCN patients will still have a limited provider network in certain areas for specific types of care.

It's important that they stay in network for their care. If not, they may pay more. You can identify these patients by their member ID cards:

- Aetna Premier Care Network only
- Aetna Premier Care Network will be above the AWH provider logo (if an AWH network is included)

When you issue referrals or recommend a consult/procedure, refer members to these Premier Care network providers by going to our **[provider online referral directory](#)** and then selecting "Aetna Premier Care" in the "Select a Plan" drop-down list.

For APCN questions, call our Provider Service Center at **1-888-MDAetna (1-888-632-3862)**.

NaviNet users can log in to send us questions through a secure connection.

Compassionate Care Program helps with end-of-life discussions

The Aetna Compassionate Care Program is enhanced care management program that can help your patients with advanced illnesses make choices that are best for them.

Who's eligible?

The program is free to our Medicare Advantage members enrolled in plans that include case management. Program services are available regardless of whether or not the plan sponsor or employer offers hospice benefits. You'll find more about the program on our **[website](#)**.

Being "conversation ready"

To learn how you can hold more effective end-of-life conversations, read "'Conversation Ready': A Framework for Improving End-of-Life Care" on the Institute of Healthcare Improvement (IHI) **[website](#)**. Also consider enrolling in IHI's free **[online course](#)**, "Having the Conversation: Basic Skills for Conversations about End-of-Life Care." You'll earn continuing education when you complete the course.

Note our utilization management policy

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.

Aetna does not specifically reward practitioners or employees for issuing denials of coverage or creating barriers to care or service. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Adhering to antidepressant medication treatment plans

Depression in adults is the most treatable behavioral health condition when patients follow their medication program. Behavioral health providers can help increase adherence by educating patients at the start of treatment about:

- How antidepressants work
- Benefits of antidepressant treatment
- Expectations about symptom remission
- How long medications should be used
- Coping with medication side effects

Remind your patients to:

- Talk to you about any side effects.
- Tell you about their current medical conditions and the medications they're taking, including over-the-counter drugs, herbs and supplements. This can help identify potential drug interactions.
- Schedule regular follow-up visits to see if the medication is working.
- Expect they may need to try a few different medications before finding which one works best.
- Keep taking their medication as prescribed for at least six months after they feel better.

How to monitor adherence

The National Committee for Quality Assurance (NCQA) has established two measures to monitor patients' adherence to their medications. You should monitor the percentage of patients who stay on their antidepressant medication for at least three months and for at least six months.

Refer patients to our Complex Case Management program

Patients with complex cases often need extra help understanding their health care choices and benefits. They may also need support navigating the community services and resources available to them.

Our Complex Case Management program is a collaborative process that involves the member, their provider and Aetna. It aims to produce better health outcomes while efficiently managing health care costs.

A provider referral is one way members can gain access to the program. To make a referral, call the phone number on the member's ID card. Our Case Management staff will call the member, explain the program to them and request their permission for enrollment.

Disease management programs target chronic conditions

Our disease management programs provide educational materials and, in some cases, individualized care management for members with chronic health conditions.

The programs help members with self-management of their disease by helping them better understand their condition and their doctor-prescribed treatment plan. The programs also educate members to accept the lifestyle changes that can help them achieve their optimal health status.

To enroll a member in a disease management program, call the phone number on their ID card.

Improving the quality of ADHD care

The American Academy of Pediatrics (AAP) recommends using the *Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition* (DSM-5) criteria to diagnose Attention Deficit Hyperactivity Disorders (ADHD). The AAP indicates information used to make a diagnosis should come from a range of informants, such as parents, teachers and other adults who care for the child.

We've adopted the **AAP clinical practice guideline** for diagnosing, evaluating and treating ADHD in children and adolescents. It states that children treated with medication for ADHD should have at least one follow-up visit with the prescribing provider within 30 days of the initial prescription fill and every quarter thereafter.

Monitoring adherence

You should use AAP guidelines to help ensure effective, appropriate, quality care. We monitor provider adherence to these guidelines through Healthcare Effectiveness Data and Information Set (HEDIS®) data collection and review. More information about HEDIS measures is available on the National Committee for Quality Assurance (**NCQA**) website.

*Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the NCQA.

Medical record audit results for PCPs

Every two years we conduct random audits to assess compliance of primary care physicians (PCP) with these medical record documentation criteria:

- Medical record content and organization of records
- Confidentiality of patient information
- Performance goals for participating practitioners

Our overall national compliance score for 2015 was 91.1 percent. This exceeded the goal of 85 percent. All regions met or exceeded the goal.

Opportunities for improvement

Identified opportunities for improvement include documentation of:

- A current immunization record for children or immunization history for adults
- Cigarette, alcohol and/or substance use/abuse for patients 14 years and older
- Advance directives, located in a prominent part of the medical record, for patients 18 years and older

More information

Specific documentation criteria are in our **Office Manual for Health Care Professionals**. Our **website** also has tools and forms to help you improve medical record documentation, including:

- Recommended immunization schedules and vaccine administration records for children and adults
- Examples of medical history forms

The Centers for Medicare & Medicaid Services requires documentation of advance directives for Medicare patients. Visit the **U.S. Living Will Registry®** website for more information.

Accessibility standards for specialty care

Aetna has established standards for member access to specialty care services. Each specialty care practitioner is required to have appointment availability within the following timeframes:

- Within 30 calendar days for routine care
- Same day or within 24 hours for urgent complaints

All participating specialty care physicians must have a reliable 24 hours-a-day, 7 days-a-week answering service or paging system. A recorded message or answering service that refers the member to the emergency room is not acceptable.

More stringent state requirements supersede these accessibility standards.

ASA and Government Employees Health Association expand relationship

Starting **January 1, 2016**, Government Employees Health Association (GEHA) members living in the nine states listed below began accessing the Aetna Signature Administrators® (ASA) PPO program and medical network nationally.

- Connecticut
- Florida
- Kentucky
- Maine
- Massachusetts
- Michigan
- New Hampshire
- Rhode Island
- Vermont

We expect this expanded relationship to result in approximately 125,000 members seeking care with providers nationally. GEHA is the second-largest national health association serving federal employees, federal retirees and their families. It provides health benefit plans to more than one million members worldwide.

As a reminder, as of January 1, 2015, GEHA members in these seven states began accessing Aetna Signature Administrators nationally in these states:

- Arizona
- California
- Nevada
- New Jersey
- New York
- Oregon
- Washington

Contact your local Aetna PPO account manager with questions.

Send ASA claims to the correct payer

As a reminder, you should send all claims for Aetna Signature Administrators (ASA) members electronically to the payer ID listed on the member's ID card. Send paper claims only to the address listed on the ID card. With the exception of transplant services, do not send ASA claims to Aetna.*

Claims questions and rework

Direct all ASA claims questions to the appropriate payer on the ID card. The payer will process the claims and contact Aetna as needed.

Recognizing ASA members

The ID card generally has two logos:

- Payer's logo
- Aetna Signature Administrators' logo

For more information, see our [flyer](#).

*The exception is when an Aetna Signature Administrators member accesses one of our Institutes of Excellence™ facilities for transplant services. Under this scenario, the facility will use the Special Case Customer Service Unit for submitting claims.

Learning Opportunities

New and updated courses for physicians, nurses and office staff

Visit www.aetnaeducation.com. Log in or registration may be required for some content.

Courses:

- **NEW** – 2016 live webinar calendar
 - Account Management Tools
 - NaviNet Basics
 - Precertification Tools
 - Aetna Voice Advantage
 - Doing Business With Aetna
 - Claim eEOB and EFT
- **NEW** – Behavioral Health Continuing Education Courses:
 - Adherence to Prescription Medication
 - Eating Disorders and Treatment Updates
 - Psychopharmacology
 - Mood Disorders, Anxiety, Stress and Co-occurring Medical Conditions
 - Federal Mental Health Parity & Addiction Equity Act — A Compliance Overview for Clinicians
 - Technologies for post-traumatic stress problems: Assisting veterans and others with PTSD
- **NEW** – Money²_{SM} for Health recorded webinar
- **NEW** – Commercial Risk Adjustment recorded webinar

Reference Tools:

- **NEW** – How to read an Explanation of Benefits (EOB)
- **NEW** – Accountable care organizations (ACOs) and referrals
- **NEW** – Aetna Medicare Advantage plans resources
- **NEW** – National Advantage Program provider reference guide
- **NEW** – Quick reference guide – Aetna LeapSM Plans – Carolinas HealthCare System
- **NEW** – Quick reference guide – Aetna LeapSM plans – CaroMont Health
- **NEW** – Quick reference guide – Aetna LeapSM plans – Maricopa County, Arizona
- **NEW** – Quick reference guide – Aetna LeapSM plans – Southeastern Pennsylvania
- **NEW** – Quick reference guide – Innovation Health LeapSM plans – Northern Virginia
- **NEW** – Aetna Medicare HMO Florida
- **UPDATED** – Aetna Signature Administrators®
- **UPDATED** – Women's health programs and policies
- **UPDATED** – Behavioral Health Provider Manual
- **UPDATED** – Aetna Medicare Prime Plans

Medicare

Keep Medicare Advantage directory information up to date

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage organizations to contact you at least quarterly to confirm that the information in our directories is accurate. This includes:

- Ability to accept new patients
- Street address
- Phone number
- Any other changes that affect availability to patients

If you notify us of any changes, we have 30 days to update our online directory. For more information, refer to this [fact sheet](#).

CAQH solution

Working with Aetna and other health plans, the Council for Affordable Quality Healthcare® (**CAQH**) developed a solution to help ensure that directory information is accurate. This process uses data from your CAQH ProView™ profile. You simply review, update and confirm your information in ProView. CAQH will share it with all participating health plans that you authorize to receive it.

CAQH will e-mail you a directory validation invitation, which has instructions on how to update your profile. CAQH will call you if you don't reply, so respond promptly.

Centers for Medicare & Medicaid Services (CMS) compliance changes for 2016

Starting on January 1, 2016, each first tier, downstream and related entity (FDR) must complete the CMS' training to meet general compliance and fraud, waste and abuse (FWA) training requirements.

There are two options for having employees complete the required training. CMS' training course can be found on the **CMS Medicare Learning Network (MLN)** website. FDRs can have employees complete the training on the MLN. FDRs can also incorporate CMS' training, unmodified, into their existing employee training.

For more information on this change, read the October 2015 [FDR Compliance Newsletter](#).

Complete your attestation

Through your Aetna Medicare agreement, FDRs must meet CMS compliance requirements annually. You can confirm you've met them each year by completing an attestation as noted below.

Aetna 2016 attestation site changes to NaviNet

In 2016, we're moving the site to NaviNet — Aetna's secure provider website — with no limitations on attesting for more than 20 tax identification numbers. If you're contracted with Aetna or with both Aetna and Coventry and have never used NaviNet, we suggest you register for the site.

- **New users:** [Register for NaviNet](#), and complete your FDR annual attestation
- **Existing users:** [Log in to NaviNet](#), and complete your 2016 FDR annual attestation

An authorized representative must complete the attestation. One attestation meets Aetna and Coventry annual compliance requirements. **Failure to meet FDR compliance requirements may impact your participation status.** If you've already completed your 2016 Attestation, disregard this notice.

We're here to help

For more information visit www.aetnaeducation.com and search educational content or the list of requirements by typing "FDR" in the search box. Or, you can call **1-800-624-0756**.

Pharmacy

Upcoming changes to our commercial drug lists

On **July 1, 2016**, we'll make changes to our pharmacy plan drug lists (formulary). You can view these changes on our **website** starting April 1, 2016.

These changes may affect our:

- Pharmacy Management drug lists
- Precertification program
- Quantity limits program
- Step-therapy program

How to precertify certain drugs:

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

Questions?

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

Changes in drug coverage reviews may affect patients

We have new formulary guidelines to help your patients better manage costs and stay healthy.

These guidelines include precertification and step therapy for some drugs that didn't require them before. This may affect the drugs your patients take.

To see which guidelines apply to which drugs, check the drug tiers on your patients' **formulary**. You can still prescribe the drugs you think are best. Remember to contact us to request approval of coverage. If we don't approve it, your patient can still buy the drug, but they'll need to pay the full cost.

You'll begin to see these new formulary names: Aetna Value, Aetna Value Plus, Aetna Premier, and Aetna Premier Plus.

We have programs in place to help your patients transition to new coverage or medications. For example, when they switch to a new medicine, they may be able to fill their prescriptions for a limited time, for drugs that normally require precertification or for step therapy.

Where to find our Medicare and Commercial formularies

At least annually, and from time to time throughout the year, we update the Aetna Medicare and Commercial (non-Medicare) Preferred Drug Lists. These drug lists are also known as our formularies.

- Go to our **Medicare Preferred Drug Lists**
- Go to our **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)**.



Northeast News

Get ready for our new digital member ID cards

On January 1, 2016, we launched our new Individual plans (Innovation Health LeapSM). Refer to the [December 2015 article](#).

Tips to know

As more members come to your office with a digital ID card, here are some tips to remember:

- You can check eligibility on our secure provider website. And soon, you'll be able to view the member's ID card on our secure site as well.
- Members may use a smartphone to show you a digital copy of their card.
- They may also show you a plastic or self-printed copy of their card.
- *If the member doesn't have a digital image or paper copy, use the member name/date of birth to look up.*
- **All ID card formats (digital, paper, plastic) are valid.**

Checking eligibility

- If your patients ask whether you accept Aetna, first ask what plan they have. Then, check to make sure you participate with that specific plan via our [provider online referral directory](#).
- When submitting eligibility inquiries, you **must** use one of the following search options:
 - Member name/date of birth
 - Member ID/date of birth (using the patient's 12-digit ID listed on the ID card)
 - Member ID/member name (using the patient's 12-digit ID listed on the ID card)

We're here to help you and your patients

- If you have questions or need more information, call us at **1-888-MDAetna**.
- If your patients have questions, they can call **1-844-241-0208**.

Need more information? Check out our [Quick reference guide](#). Search for "leap."

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.

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.

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 us collect HEDIS®* data

Our staff or our contracted representatives from ArroHealth or HealthPort may soon contact you to collect medical record information for your patients who are Aetna members.

Although we acquired Coventry Health Care, Inc., you'll still get separate requests for Aetna and Coventry membership. You may also receive requests from more than one health plan operating under Coventry Health Care, Inc. This will continue until we have a single claims processing and data collection system.

Why we do this

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

We're required to regularly send health care quality data to the Centers for Medicare & Medicaid Services. We collect most of the data from claims and encounters. We also gather data on provided services and health status from our members' medical records.

What we may need from you

If we contact you, we ask that you provide timely access to our members' medical records. Our contracted representatives will work with you and give you options for sending the medical records.

Meeting HIPAA guidelines

Our representatives serve us in a role that the Health Insurance Portability and Accountability Act (HIPAA) defines and covers. As HIPAA defines, Aetna is a "Covered Entity" and our representative's role is as a "Business Associate of a Covered Entity." Giving medical record information to us or our contracted representatives meets HIPAA regulations.

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

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