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Important information for your office

As published in the June 1, 2021, edition of Aetna OfficeLink Updates™

Diagnosis-related group (DRG) transfer policy expansion

Our current DRG transfer policy applies to facilities contracted with a DRG Base x Weight (DRGWTJ methodology payment. The policy focuses on paying per diem rates as follows:

Commercial members

Commercial members transferring from an acute care facility to acute care facilities

Medicare members

Medicare members transferring from an acute care facility to:

- Acute care facilities
- Long-term-care facilities
- Skilled nursing facilities
- Cancer centers
- Children's hospitals
- Receiving home health care services
- Inpatient rehab facilities
- Psychiatric hospitals or facilities

Beginning September 1, 2021, our DRG transfer policy is expanding.

Commercial members

Commercial members transferring from an acute care facility to:

- Long-term-care facilities
- Skilled nursing facilities
- Cancer centers
- Children's hospitals





- Receiving home health care services
- Inpatient rehab facilities
- Psychiatric hospitals or facilities
- Critical access facilities

Medicare members

Medicare members transferring from an acute care facility to:

- Critical access hospitals

We convert to a per diem rate when the case meets these criteria:

- The transferring acute care facility has a contract based on DRG-defined reimbursement rates and does not have defined rates for transfer cases
- The actual length of stay is at least one day less than the average length of stay for the DRG.
- The patient discharge status code is any of the following as indicated on the transferring facility claim: 02, 03, 05, 06, 07, 62, 63, 65, 66, 82, 83, 85, 86, 90, 91, 93 or 94.
- For post-acute care settings only: the DRG is subject to post-acute care as defined by the Centers for Medicare & Medicaid Services (CMS).

The converted per diem rate is then calculated as follows:

1. $\text{DRG contracted rate} / \text{the average length of stay for the DRG} = \text{per diem rate}$
2. $\text{Per diem rate} \times \text{the patient's actual length of stay} + 1 \text{ additional day} = \text{allowed amount}$

This policy does not apply to facilities paid based on Medicare Allowable contracting.

Note: This is subject to regulatory review and separate notification in Washington state. This article is also a notice of material amendment to contract in Ohio and a notice of material change in Kentucky.

Incidental supplies, materials and equipment

Our standard payment policies don't allow us to pay for services, including related supplies, material and equipment, that are incidental to the overall episode of care. Examples of supplies, materials and equipment include the following:

- Digital analysis of electroencephalogram
- Lab sample preparation

Starting September 1, 2021, we will deny CPT® codes 88380, 88381 and 95957 as incidental for facility providers. (Facility providers include but are not limited to hospitals, ambulatory surgical centers and skilled nursing facilities.)

We will continue to deny these services as incidental for nonfacility providers.

Note: This is subject to regulatory review and separate notification in Washington state.

Technical-component-only codes



As of September 1, 2021, we will no longer pay for professional services performed in a hospital setting for technical-only procedure codes. The Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule lists these codes as diagnostic only. They do not have a related professional code.

Note: This is subject to regulatory review and separate notification in Washington state.

Pay percent reductions for multiple endoscopies

Effective September 1, 2021, we will adjust payment for multiple endoscopy procedures in the same family when billed by the same surgeon or assistant surgeon on the same date of service for the same member. Multiple surgery reductions can also apply, and the multiple procedures will be ranked according to their Centers for Medicare and Medicaid Services (CMS) Relative Value Units (RVUs). The payment reduction is based on a formula using CMS guidelines.

Here's an example:

Elbow Arthroscopy procedures 29837 and 29834 from the same endoscopic family reported with same surgeon or assistant surgeon are submitted for the same member, provider and date of service. The procedures will be ranked according to the RVU. Procedure 29837 has the higher RVU and will be assigned a rank of 1; procedure 29834 has the lower RVU and will be assigned a rank of 2. A pay percent value of 0.16 will be assigned to procedure code 29837 and a pay percent value of 0.011 (0.07×0.16) will be assigned to procedure code 29.

Note: This is subject to regulatory review and separate notification in Washington state.

Changes to our National Precertification List (NPL)

Starting **September 1, 2021**, these precertification changes apply:

- We'll require precertification for the following drugs for the multiple myeloma indication only:
 - Kyprolis® (carfilzomib)
 - Velcade® (bortezomib)
 - Bortezomib (generic Velcade®)
- We'll no longer require medical precertification for oral hepatitis C drugs. We may still require precertification through pharmacy plans.

Submitting precertification requests

Be sure to submit precertification requests at least two weeks in advance.

To save time, request precertification online. Doing so is fast, secure and simple. You can submit most requests online through **our provider portal on Availity**. Or you can use the Electronic Medical Record (EMR) system portal.

Are you asking for precertification on a specialty drug for a commercial or Medicare member? Then submit





your request through NovoLogix®, also available on Availity®.

Not registered for Availity?

Visit **Availity** or call **1-800-AVAILITY (1-800-282-4548)**.

For one-on-one guided support from us, call **1-866-752-7021**. Then ask to talk with the Availity team.

Please use our "Search by CPT code" search function on our **Precertification Lists web page** to find out if the code needs precertification.

You can learn more about precertification under the **General Information section of the NPL**.

Third-Party Claim and Code Review Program

Beginning **September 1, 2021**, you may see new claim edits. These are part of our Third Party Claim and Code Review Program. These edits support our continuing effort to process claims accurately for our commercial and Medicare members. You can view these edits **on our provider website, Availity**.

You'll have access to our prospective claims editing disclosure tool. To find out if our new claim edits will apply to your claim, log in to the **Availity provider portal**. You'll need to know your Aetna® provider ID number (PIN) to get access.

For all coding changes, go to Aetna Payer Space > Resources > Expanded Claim Edits.

Note: This is subject to regulatory review and separate notification in Washington state.

Starting August 30: request hip and knee arthroplasty authorizations on Availity®

We're introducing a new and better way to request prior authorization for hip and knee arthroplasties. Starting August 30, 2021, use our Availity provider portal to request these procedures. That means the last day you'll be able to request prior authorization for these procedures through eviCore healthcare is August 29.

How it works

Use Availity to request prior authorization for hip and knee arthroplasty procedures. This includes inpatient bed day requests. For certain procedures, we may ask you for more clinical details. Complete a short questionnaire on Availity. That'll help expedite our review. You may even receive an immediate approval.

Prepare now for the switch

We'll hold training sessions to show you how to use Availity to submit authorizations and complete the online questionnaire. Check out dates and times on **AetnaWebinars.com** or register for our Authorizations on Availity webinar. Before you join us, register for Availity at **Availity.com**.



Important dates

- August 29, 2021: the last day to request hip and knee arthroplasty prior authorizations through eviCore healthcare
- August 30, 2021: the first day to use Availity to initiate your prior authorization requests for hip and knee arthroplasty

Note: This is subject to regulatory review and separate notification in Washington state.

Enhanced clinical review physical medicine program will authorize telehealth

Beginning September 1, 2021, we will require authorization for our enhanced clinical review physical medicine program for telehealth services.

This affects members in our fully insured commercial and Medicare Advantage HMO/PPO Aetna® products in:

- Delaware
- New Jersey
- New York
- Pennsylvania
- West Virginia

Telehealth for COVID-19

Read [these COVID-19 FAQ documents](#), which provide details about our COVID-19 response and our telehealth guidelines.

How to get preapproval

Visit the [Magellan Healthcare portal](#).

We're here to help

If you have questions, call National Imaging Associates at **1-866-842-1542**. Or you can call us at:

- **1-800-624-0756 (TTY: 711)** for HMO and Medicare Advantage benefits plans
- **1-888-MD Aetna (1-888-632-3862) (TTY: 711)** for all other plans

Important update about service codes

We are assigning or reassigning individual service codes within contract service groups. Changes to a provider's compensation depends on the presence of specific service groupings in their contract. You'll find the changes in the [service codes table](#).

Unless noted, all updates take effect **September 1, 2021**.

Note: This is subject to regulatory review and separate notification in Washington state.





Changes to commercial drug lists

On **October 1, 2021**, we'll update our pharmacy drug lists.

You'll be able to view the changes as early as August 1, 2021. They'll be available on our **Formularies & Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug prior authorization

- Submit your completed request form through our **provider portal on Availity**.
- For requests for nonspecialty drugs on Aetna Funding AdvantageSM, Premier, Premier Plus, Small Group ACA and Value Plus plans, call the Precertification Unit at **1-855-240-0535 (TTY: 711)**. Or fax your completed **prior authorization request form** to **1-877-269-9916**.
- For requests for nonspecialty drugs on the Advanced Control, Advanced Control — Aetna, Standard Opt Out, Standard Opt Out — Aetna, Standard Opt Out with ACSF, Aetna Health Exchange and High Value formulary plans, call the Precertification Unit at **1-800-294-5979 (TTY: 711)**. Or fax your completed **prior authorization request form** to **1-888-836-0730**.
- For requests for drugs on the Aetna Specialty Drug List, call the Precertification Unit at **1-866-814-5506**. Or fax your completed **prior authorization request form** to **1-866-249-6155**.

These changes will affect all drug lists, precertification, quantity limits and step-therapy programs.

For more information, call the Provider Help Line at **1-800-238-6279 (TTY: 711) (1-800-AETNA RX)**.



Important pharmacy updates

Medicare

Visit our [Medicare Drug List](#) to view the most current Medicare plan formularies (drug lists). We update these lists at least once a year.

Commercial — notice of changes to prior authorization requirements

Visit our [Formularies & Pharmacy Clinical Policy Bulletins](#) page to view:

- Commercial pharmacy plan drug guides with new-to-market drugs that we add monthly
- Clinical Policy Bulletins with the most current prior authorization requirements for each drug

Note to all providers: to view the June 1, 2021 OfficeLink Updates™ (OLU) online and link to all information in this flyer, go to [aetna.com](https://www.aetna.com). Click on "Providers," then "News." Remember, OLU comes out in March, June, September and December.

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