Aetna Better Health® of Kentucky
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223

AETNA BETTER HEALTH® OF KENTUCKY

Please note our newly formatted fax blast – A copy of this communication is available on our website: www.aetnabetterhealth.com/kentucky, go to Provider News

To: All Network Providers **Fax:** <<location fax>>

In the News: eviCore Pain Management & Cardiology Updates
New Policy Updates – Clinical Payment, Coding & Policy Changes – 2nd Quarter Updates July 2016
Provider Portal Enhancement to Member Eligibility File
August 2016 Provider Newsletter

1. eviCore Pain Management & Cardiology Updates

Pain Management Update

****Effective September 26, 2016 eviCore is implementing a change of process for initiating Musculoskeletal pre-certification requests via the web.**

Beginning **September 26, 2016**, online requests for ABH Musculoskeletal procedures will be initiated via the eviCore web portal located at **https://evicore.com/Pages/ProviderLogin.aspx**. You will need to complete a brief one-time registration to access the web portal. Utilizing the web is the quickest, most efficient way to initiate a request and obtain the status of an existing request. **Please note**: the contact phone and fax numbers will change as well, please see below:

Have questions about requesting authorizations? Attend our online orientation! The orientation schedule, program training resources, Clinical Guidelines, CPT codes managed, and fax request forms are available at **http://www.medsolutions.com/implementation/abhky**. Please email our client services department at **clientservices@eviCore.com**, if you have any questions or need more information.

Prior Authorization Update

Effective **September 26, 2016**, Aetna Better Health of Kentucky members will require prior authorization for Cardiology services from eviCore healthcare for dates of service **October 03, 2016** and after. Services performed without authorization may be denied for payment, and you may not seek reimbursement from members.

New Authorization is required for:

- **Myocardial Perfusion Imaging**
- **Echo**
- **Echo Stress**
- **Diagnostic Heart Catheterization**

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Only elective and scheduled procedures require prior authorization. Services performed in conjunction with an inpatient stay, 23-hour observation or emergency room visit are not subject to these authorization requirements.

To request an authorization, submit your request online, by phone or fax:

- Log onto **https://evicore.com/Pages/ProviderLogin.aspx**, utilizing the web is the quickest, most efficient way to initiate a request.
- Call us at **1-888-693-3211**
- Fax an eviCore healthcare request form (available online) to **1-844-82AETNA**

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, please call our toll-free number for expedited authorization reviews. Be sure to tell our representative the authorization is for medically urgent care.

Orientation Session Invitation - Web Orientation Sessions

eviCore healthcare will be leading orientation sessions designed to assist you and your staff with the case creation process. We encourage you to attend one of these informative sessions to ensure your understanding of the new precertification process and to review the registration process for the web portal.

During these sessions, we will discuss in detail the precertification requirements for Aetna Better Health of Kentucky's members and how to locate additional training materials to navigate the eviCore web portal, **https://evicore.com/Pages/ProviderLogin.aspx**. Topics to be discussed include the new prior authorization process, accessing information from the website and a review of the Quick Reference Guide. Time and participation permitting, this orientation session will be followed by a question-and-answer session. We encourage you to attend one of these informative sessions to ensure your understanding of the new precertification process.

Pain Management Sessions - WebEx may display Central Times

Date	Day of the Week	Time
September 13, 2016	Tuesday	11:00 a.m., ET
September 22, 2016	Thursday	3:00 a.m., ET
October 4, 2016	Tuesday	1:00 p.m., ET
October 5, 2016	Wednesday	9:00 a.m., ET

Prior Authorization Sessions - WebEx may display Central Times

DATE	Day of the Week	Time
September 15, 2016	Wednesday	9:00 a.m., ET
September 16, 2016	Friday	3:00 p.m., ET
September 21, 2016	Wednesday	10:00 a.m., ET
September 22, 2016	Thursday	1:00 p.m., ET
October 3, 2016	Monday	2:00 p.m., ET
October 7, 2016	Friday	11:00 a.m., ET
October 11, 2016	Tuesday	12:00 p.m., ET

How to Register

Please read the following instructions carefully to register for and participate in a session:

1. Once you have chosen a date and time, please go to **http://medsolutions.webex.com**
2. Click on the "Training Center" tab at the top of the Web page
3. Find the date and time of the conference you wish to attend by clicking the "Upcoming" tab. All of the Provider Orientation Sessions will be named "ABH KY Provider Training Session - Cardiology"
4. Click "Register"
5. Enter the registration information

After you have registered for the conference, you will receive an e-mail containing:

1. The toll-free phone number and pass code you will need for the audio portion of the conference
2. A link to the Web portion of the conference
3. The conference password

2. New Policy Updates – Clinical Payment, Coding & Policy Changes – 2nd Quarter Updates July 2016

We regularly augment our clinical, payment and coding policy positions as part of our ongoing policy review processes. In an effort to keep our providers informed, please see the below chart of upcoming new policies.

Effective for dates of service beginning, **September 30, 2016:**

POLICY
Diagnosis and Procedure Consistency-Vestibular Function and Audiometry Threshold Testing-Based on CMS guidelines, vestibular function testing and audiometry threshold testing should be reported with a diagnosis that indicates a potential issue with balance (for vestibular function testing) OR as a basis from which to decide to conduct vestibular testing (for audiometry threshold testing). Generic screening diagnoses alone are not sufficient to support this testing.
Ulcer Debridement and Ulcer Stages-According to the ICD Manual, there are specific diagnosis codes that reflect the stage of a pressure ulcer. When debridement of a pressure ulcer is performed, the procedure code should also reflect the stage of the pressure ulcer. By definition, a stage 1 pressure ulcer has intact skin. The area may be red, swollen or firm and these signs are considered warning signs of impending tissue breakdown. A stage 2 pressure ulcer does not have intact skin but has not penetrated into the subcutaneous tissue. The area may show abrasion, blister or partial thickness skin loss but only involves the epidermis and/or dermis. According to the AMA CPT Manual, debridement of an ulcer that is limited to the skin (epidermis and/or dermis) should not be reported with CPT codes for surgical debridement.
Global Obstetric Package-The American College of Obstetricians and Gynecologists defines the postpartum period of obstetrical deliveries as six weeks starting the day after the delivery. Additionally, separate E/M services for uncomplicated postpartum care, contraceptive management and/or family planning advice provided by any physician are included in the delivery care only service if billed within 42 days (6 weeks) of the delivery care only.
Cardiovascular Implant Device Monitoring Services-According to CMS policy, when a cardioverter-defibrillator analysis is performed for monitoring purposes only, in the absence of symptoms or discharge of the device, it is expected that the service be performed no more than once every three (3) months.
Nail Care and Other Foot Care Services-According to CMS policy, nail care in certain circumstances requires more than one appropriate diagnosis to justify treatment by a professional provider. In the setting of mycotic or thickened nails, an additional diagnosis is required to indicate that a complication, such as pain or infection, exists or that severe systemic disease exists that has resulted in severe circulatory impairment or desensitization to the patient's feet or legs.

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Chest X-Rays for Asymptomatic Patients- According to CMS policy and the American College of Radiology, a chest x-ray should not be performed for screening purposes in the absence of pertinent signs, symptoms or diseases.
Psychotherapy-According to CMS policy, psychotherapy services or psychoanalysis are never covered for patients with severe and profound intellectual disabilities.
Photochemotherapy - Photochemotherapy is a type of ultraviolet radiation treatment used for severe skin diseases. According to CMS policy photochemotherapy should be reported with an appropriate diagnosis, including but not limited to atopic dermatitis, psoriasis, lichen planus, and vitiligo
Frequency of Comprehensive Audiometry (92257, 0212T) - According to CMS policy, comprehensive audiometry threshold evaluation and speech recognition studies are not required to be performed more than once in a year, unless it is billed with a diagnosis to support necessity for more frequent testing, such as acoustic neuroma, other acoustic nerve disorders, multiple sclerosis, Eustachian tube or tympanic membrane disorders, Meniere's disease, tinnitus, labyrinthitis, sensorineural hearing loss, temporal bone fracture, acoustic trauma to ear, or ototoxicity from antibiotics.
Nasal Fracture - According to our policy, a procedure with diagnosis of nasal fracture must have been billed within the 6 months previous of an uncomplicated open treatment of nasal fracture, complicated open treatment of nasal fracture or open treatment of nasal fracture with concomitant open treatment of fractured septum being performed.
Professional/Technical/Global Policy- Diagnostic tests and radiology services are procedure codes that include two components: professional and technical. The professional component describes the physician work portion of a procedure and is represented by a procedure code with a modifier 26. The technical component describes the technical portion of a procedure, such as the use of equipment and staff needed to perform the service, and is represented by a procedure code with modifier TC. The global service represents the sum of both the professional and technical components, and is represented by the CPT/HCPCS code for the service without modifiers 26 and TC. Only procedure codes designated as diagnostic tests or radiology services have the two individual components. Professional/Technical/Global policies will follow CMS logic and use only diagnostic testing/radiology services codes that are valid based on the CMS Medicare Physician's Fee Schedule.

3. Member Eligibility File

An enhancement has been made to with our secure online provider portal for member eligibility verification. Members who are in the warning status for being dis-enrolled are now flagged with "W".

4. August 2016 Provider Newsletter

Our most recent version of our Provider Newsletter is now available for viewing on our website at **www.aetnabetterhealth.com/Kentucky, go** to "For Providers" and then click on "Provider News."