Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

FDR Compliance Newsletter

January 2017 – Issue 12

Enroll today to prescribe Medicare Part D drugs

The Centers for Medicare & Medicaid Services (CMS) has delayed the full enforcement date for prescribers to be enrolled in Medicare or validly opt out to January 1, 2019.

CMS will, however, begin phasing in targeted enforcement of the regulation in 2017 to include:

- **Precluded physicians and other prescribers**
  Enforcing preclusion of individuals who are currently excluded by the OIG, revoked by the Medicare program, or non-enrolled with a felony conviction within the last 10 years
- **Easy enroll application process**
  Allowing prescribers to review, update, electronically sign and submit a pre-populated enrollment application online
- **Targeted risk-based prescriber outreach**
  Targeting prescribers of Schedule II drugs or a high volume of Part D drugs
- **Direct mailing to all non-enrolled prescribers**
  Direct mailings via email and/or paper to all prescribers that are not enrolled in the program

CMS encourages all physicians and eligible professionals who prescribe Part D drugs to **enroll in the Medicare program now**. Enrolling now will provide CMS contractors with enough time to process both the prescriber applications and opt out affidavits.

In this issue

- Enroll today to prescribe Medicare Part D drugs
- Are you keeping record?
- Make sure you're protecting your data
- Ban of Advanced Beneficiary Notices for Medicare Advantage
- Get help with OIG exclusion list screenings

Quick links

- **Archived newsletters**
- **Aetna's FDR Guide** (updated 7/2016)
- **Medicare Managed Care Manual**
- **Medicare Prescription Drug Benefit Manual**
- **Aetna's Code of Conduct** (updated 10/2015)
- **CMS's General Compliance Training**
- **CMS's FWA Training**
- **Exclusion lists:**
  - **OIG's List of Excluded Individuals and Entities (LEIE)**
  - **GSA's System for Award Management(SAM)**

Aetna maintains a comprehensive Medicare Compliance Program. It includes communication with Aetna Medicare FDRs. Dedicated to Aetna's Medicare Compliance Program is John Wells, Medicare Compliance Officer. He's based in Maryland. You can send questions or concerns for John and/or his Medicare compliance subject matter experts to ***MedicareFDR@aetna.com*****.**

We won't be able to cover claims for Medicare Part D drugs from prescribers who haven't enrolled or chosen to opt out. This may cause your patients to have a disruption in therapy if you haven't enrolled.

How to enroll

Visit the **CMS Provider Enrollment** website to:

- Enroll immediately
- Check your enrollment status
- Learn more about opting out

Are you keeping records?

Did you know that FDRs are required to retain records for a period of at least 10 years? Examples of records that must be retained are training records, including key elements such as time, attendance, certificates of completion, and test scores, as applicable. In the event of an audit or other such monitoring activities, you must be able to provide evidence that your applicable employees completed the CMS General Compliance and Fraud, Waste and Abuse trainings.

View our grid to find out who needs to complete training.

Make sure you're protecting your data

Keep cyber attackers from targeting you

Cyber criminals continue to target health care professionals, including hospitals and providers. You should know how to reduce the information attackers could use, like Social Security numbers (SSN). Our SSN protection, elimination and remediation plan can help reduce the use of SSNs. Keep working with us in this initiative.

You can fight against cyberattacks

Don't worry, there are ways you can help reduce cyberattacks. One way to stop using your SSN is to get an Employer Identification Number (EIN). Also, don't use your SSN as your Tax Identification Number (TIN). Please check with your tax advisor and/or visit the IRS website for more on this option.

The only requirement for health care services is a member ID. You don't need to collect patient SSNs. To help you reduce the risk of identity theft and medical fraud, refrain from collecting, storing or using SSNs.

If you have questions, just call us at **1-800-624-0756**.

Ban of Advanced Beneficiary Notices for Medicare Advantage

Our April 2016 edition featured an article on Ban of Advanced Beneficiary Notices (ABN). Updates have been made since then. New provider organizations should know that an ABN isn't a valid form of denial notification for members of Medicare Advantage (MA) plans. ABNs, sometimes referred to as "waivers," are used in the Original Medicare program. However, you can't use them for patients enrolled in Aetna's MA plans, as CMS prohibits use of ABNs for MA members.

As a provider who's elected to participate in the Medicare program, you should know which services are covered by Original Medicare and which aren't. Aetna's MA plans are required to cover everything that Original Medicare covers, and in some instances may provide coverage that is more generous or otherwise goes beyond what Original Medicare covers. We encourage you to call and verify coverage if you're unsure or have questions about what's covered for an MA member.

As a provider contracted with Aetna's MA plan, you aren't permitted to hold a MA member financially responsible for payment of a service not covered under their plan *unless* you've gone through the pre-service Organization Determination (OD) process and the member has received an OD notice of denial from Aetna **before** you render services**.** If the member doesn't have a pre-service OD notice of denial, you must hold the member harmless for the non-covered services and you can't charge them any amount beyond the normal cost-sharing amounts (i.e., copayments, coinsurance, and/or deductibles).

However, where a service is *never* covered under Original Medicare or is listed as a clear exclusion in the member's plan materials, a pre-service OD isn't required for you to hold the member financially liable for such non-covered services. Just note— services or

supplies that aren't medically necessary or are otherwise determined to be not covered based on clinical criteria don't constitute "clear exclusions" under the member's plan. Members can't be expected to know when a service is medically necessary or not.

You or a member can initiate an OD to determine if the requested/ordered service is covered prior to the member receiving it or prior to scheduling a service such as a lab test diagnostic test, or procedure.

Holding members responsible

Remember, unless a service or supply is never covered under Original Medicare, you'll only be able to hold an Aetna Medicare member financially responsible for a non-covered service if the member has received a pre-service OD denial from Aetna and decides to proceed with the service knowing they'll be financially liable.

Services not covered under any condition

- Personal items in the member's room at a hospital or a skilled nursing facility, such as a telephone or a television
- Full-time nursing care in the member's home
- Custodial care provided in a nursing home, hospice or other facility setting when the member does not require skilled medical care or skilled nursing care
- Homemaker services/basic household assistance, including light housekeeping or light meal preparation
- Fees charged for care by the member's immediate relatives or members of their household
- Reversal of sterilization procedures and or non-prescription contraceptive supplies
- Acupuncture
- Naturopath services using natural or alternative treatments

Some of our Medicare plans cover certain "extra" benefits, such as routine dental and hearing exams. If the plan doesn't cover these extra benefits, the member's materials will usually include explicit statements about non-coverage.

Questions and answers

Below are answers to some of the frequently asked questions we get about ABNs.

Q: All my patients sign an ABN stating they'll be financially responsible for anything their insurance doesn't cover. Can I still use this process?
A: No. ABNs are for use in Original Medicare and aren't permitted for MA members. An ABN doesn't allow you to hold an MA member financially responsible for services that Aetna won't cover. To hold an MA member financially responsible for a service, the MA member must be notified through Aetna's OD process that the item or service won't be covered. This OD process must be completed prior to providing the item or service.

Q: An item or service is sometimes covered based on medical necessity. I'm not sure if my patient qualifies. What should I do?
A: If you aren't absolutely sure the service is covered, you or your MA patient should request an OD from Aetna. This OD should be completed prior to the service being rendered. Aetna will make a decision after reviewing the request and any relevant medical records. ODs can be standard (14 days or less) or expedited (72 hours or less) if you believe the delay would place your patient's life, health or ability to regain maximum functioning in serious jeopardy.

Q: If a service has been regularly covered for MA members in the past, do I need to request an OD?
A: Past OD approvals don't guarantee an item or service will be covered in the future. Remember, unless the service or supply is never covered, you won't be able to hold the MA member financially responsible for the non-covered service unless the member has a pre-service OD denial from Aetna and decides to proceed thereafter.

Q: Can a member be held financially responsible for a non-covered service if he or she was advised to request an OD but didn't?
A: It depends. If the service is never covered by Original Medicare or is listed as a clear exclusion in the member's plan materials, then the member can be held financially responsible without an OD.

However, if the above doesn't apply, and even if the member was advised to obtain an OD but doesn't, you *won't* be able to bill the member for the non-covered service. It's for this reason that many providers choose to initiate the OD process on behalf of their patients.

Q: Is it really my responsibility to make sure my patient has an OD from Aetna?
A: Aetna doesn't require providers to obtain ODs on behalf of their patients. However, you can request an OD for the member or ask the member to request an OD from Aetna. No matter what, if an OD isn't obtained and a non-covered service is provided, the member can't be held financially responsible unless the service is never covered under Original Medicare or is listed as a clear exclusion in the member's plan materials.

Q: What should I do if an item or service is excluded from coverage and is explicitly listed as an exclusion in the member's plan materials?
A: If the member's plan materials clearly indicate that the service isn't covered under any circumstance, members and providers don't need to go through the OD process. Providers can hold the MA member financially liable for these services. However, you should educate the member that the service ISN'T covered by Medicare and they'll be held financially responsible.

Q: Do I need to get the member's permission before requesting an OD on the member's behalf?
A: In general, no permission or proof is needed for a provider to request an OD on behalf of a patient. Providers can, and often do, request ODs on behalf of their patients.

Q: How do I request an OD on the member's behalf?
A: You can call us, or fax or mail the information to us using the contact information below. Have ready the member's name, ID number, plan number and a description of the item or service being requested.

Call: 1-800-245-1206 (TTY: 711)

Fax: 1-859-455-8650

Mail: Aetna Medicare Precertification Unit
P.O. Box 14079
Lexington, KY 40512-4079

Get more information

Information about the OD process and the probation of ABNs can be found in Chapter 4, section 170, of the *Medicare Managed Care Manual* or the *Code of Federal Regulations* in section 42 CFR §§ 422.568 and 422.572. You can also reference the HPMS memo titled "*Improper Use of Advance Notices of Non-coverage*" issued on May 5, 2014.

Updates to the Aetna Code of Conduct

Aetna recently updated its Code of Conduct. The Code of Conduct is provided to our FDRs during their initial orientation/onboarding and annually thereafter. You can access our updated Code of Conduct here: Aetna's Code of Conduct .

If you want to request a copy of our current Code of Conduct, you can also send us an email to Aetna's FDR mailbox at MedicareFDR@aetna.com.

What is an FDR

First tier, downstream and related entities

A first tier entity is any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage organization or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare-eligible individual under the Medicare Advantage program or Part D program.

A downstream entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage organization or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

A related entity is any entity related to a Medicare Advantage organization or Part D sponsor by common ownership or control and:

- Performs some of the Medicare Advantage organization or Part D plan sponsor's management functions under contract or delegation; or
- Furnishes services to Medicare enrollees under an oral or written agreement; or
- Leases real property or sells materials to the Medicare Advantage organization or Part D plan sponsor at a cost of more than $2,500 during a contract period

Get help with OIG exclusion list screenings

Make sure you are doing OIG screenings correctly. The OIG has FAQs and tips to help you. You can also watch their videos on how to screen the online database or download the database.

If you have exclusion screening questions, we can help. Just email MedicareFDR@aetna.com.

Report to Aetna actual or potential fraud, waste and abuse OR non-compliance:

FDRs can have their own internal processes in place for reporting, however, instances which impact Aetna's Medicare business should be reported back to us by using one of the methods below:

By phone:
1-888-891-8910
(7 days a week, 24 hours a day)

Over the internet:
https://aetna.alertline.com

By mail:
Corporate Compliance
P.O. Box 370205
West Hartford, CT 06137-0205