Aetna and Cofinity Updates

MiMGMA Conference

Kiley Radel - Network Manager
Aetna Resources
Tons of Features and Resources available at Aetna.com (without secure login)

Go to Providers Tab
Initiate credentialing process / New or Adding Providers / New Contracts

Here’s how it works

First, you can request participation in the Aetna network online. Next, we’ll evaluate the current need to service our membership in your area. If we don’t intend to pursue a contract, you’ll be notified by letter or email. If we do intend to pursue a contract, a local network manager will reach out to you to begin the contracting process.

After contracting, we’ll get your credentialing application from the Council for Affordable Quality Healthcare (CAQH)* to begin the credentialing process. When you complete credentialing, your contract will be finalized and you’ll receive welcome materials to get up and running. Ready to get started? Choose a link below.

Step one: Request participation

You can do this by choosing a link below. During the review, we evaluate the current need to service our membership in your area. We don't want you to wait, so we'll make sure to let you know within 45 days whether you're eligible for participation.

Medical professionals
Dental professionals
Behavioral health professionals
Facilities

Get the answers you need here

To help us direct your question or comment to the correct area, please select a category below.

- Address/phone number changes
- Contact us online
- Contact us by phone
- For non-participating health care professionals
- Practice changes/Provider termination
- Request medical application

Step two: Review your contract

After requesting participation, you'll receive your contract for review. After you sign it, please send it back to us. Once we receive your signed contract, we'll review it again. Then, we'll send your final contract back to you.

If you haven't received your contract yet, it's important to check the spam folder in your email. Just as a reminder, this isn't the final step. Signing your contract doesn't mean you're in network. You'll need to complete credentialing next.

Step three: Complete credentialing

We'll get your credentialing application from the Council for Affordable Quality Healthcare's ProView® (CAQH)* to begin the credentialing process. This step can take 45 to 180 days depending on the status of your CAQH application and whether you've authorized Aetna to access your application. If you're already registered with CAQH, make sure your attestation has not expired and you have authorized Aetna to access your application. This will help speed things up. You'll receive a written notification when your credentialing is finished.

It's important to know that credentialing and contracting are separate processes. Both must be completed before you're considered in network. After you complete both, your network representative will let you know your participation effective date. If you're joining an existing group, please check with your group administrator for your effective date.
Request medical application

If ONE of the following criteria applies to you, please request a medical application form using the link below:

- I am a physician

- I am a non-physician health care professional who is not employed by an Aetna-contracted provider (physician group, hospital, etc.) I practice independently and I want to contract with Aetna

- I am a non-physician health care professional who wants to be available for selection as a primary care provider (PCP), and my state regulations allow me to serve as a PCP. I may or may not be employed by an Aetna-contracted provider.

Request a medical application ▶ - credentialing is required

Note: If you are a hospital based provider seeking to join an already contracted group, you do not need to complete the application independently.

If none of these criteria apply

If none of the above criteria apply, you may be able to fill out a mid-level practitioner form. This will add your demographic information to our provider database. This process does not require credentialing.

Do both of these situations apply to you?

- I am a Nurse Practitioner, Registered Nurse Anesthetist, Physician Assistant, Clinical Nurse Specialist or Certified Nurse Midwife who is employed by an Aetna-contracted provider (physician group, hospital, etc.)

- I will not be practicing as a primary care provider (PCP)

Yes - I want to fill out the mid-level practitioner form ▶
No - I need something else ▶

Mid-Level Practitioner Form

Aetna ▶ Health Care Professionals ▶ Mid-Level Practitioner Form

Credentialing is not required. Welcome letters will not be sent. However, please complete this form to be listed in DocFind, our online provider directory. Please check DocFind to verify your listing within 45 days of submitting form.
Precertification information

Precertification applies to all benefits plans that include a precertification requirement. Participating providers are required to pursue precertification for procedures and services on the lists below.

- 2019 Participating Provider Precertification List
  - Effective date: November 1, 2019
- Behavioral Health Precertification List
  - Effective date: January 1, 2019

Note: If we need to review applicable medical records, we may assign a tracking number to your precertification request. The tracking number does not indicate approval. You will be notified when a coverage decision is made.

For Aetna’s commercial plans, there is no precertification required for buprenorphine products to treat opioid addiction.
Using Clinical Policy Bulletins to determine medical coverage

Medical Clinical Policy Bulletins (CPBs) detail the services and procedures we consider medically necessary, cosmetic, or experimental and unproven. They help us decide what we will and will not cover. CPBs are based on:

- Peer-reviewed, published medical journals
- A review of available studies on a particular topic
- Evidence-based consensus statements
- Expert opinions of health care professionals
- Guidelines from nationally recognized health care organizations

Find our Clinical Policy Bulletins

What's New ➔
CPB Alphabetic List ➔
CPB Numerical List ➔
Periodic Reviews for 2019 ➔

Search by keyword

Enter your keyword or 4-digit CPB number (for example, enter 0059 to find CPB 59) to find related Medical Clinical Policy Bulletins.

Go

Policy

I. Aetna considers intravascular ultrasound (IVUS) medically necessary for any of the following situations:

A. As a clinical decision-making tool to evaluate the need for an intracoronary interventional procedure in a symptomatic member whose angiogram shows 50 to 70% stenosis(es); or
B. As a conduit study to assess suspected left main stem coronary artery disease not revealed by coronary angiography; or
C. As a guidance for placement of a vena caval filter; or
D. As a method for both guidance of placement of endoluminal devices and immediate assessment of the results of intracoronary interventional procedures (i.e., angioplasty, atherectomy, stenting), including those performed on coronary grafts; or
E. As a method for evaluation of cardiac allograft vasculopathy in post-cardiac transplantation recipients; or
F. Diagnosis of iliac vein compression syndrome (May-Thurner syndrome) of the left lower extremity.

II. Aetna considers the clinical application of IVUS experimental and investigational in screening for coronary artery disease, diagnosing coronary vulnerable plaques, and its use in other coronary procedures because its effectiveness for these indications has not been established.

III. Aetna considers the clinical application of IVUS experimental and investigational for any of the following (not an all-inclusive list) because its use for these indications has not been validated by clinical studies.
Our process for disputes and appeals

Health care providers can use the Aetna dispute and appeal process if they do not agree with a claim or utilization review decision.

The process includes:

- Peer to Peer Review - Aetna offers providers an opportunity to present additional information and discuss their cases with a peer-to-peer reviewer, as part of the utilization review coverage determination process. The timing of the review is prior to an appeal and incorporates state, federal, CMS and NCQA requirements.

- Reconsiderations: Formal reviews of claims reimbursements or coding decisions, or claims that require reprocessing.

- Appeals: Requests to change a reconsideration decision, an initial utilization review decision, or an initial claim decision based on medical necessity or experimental/investigational coverage criteria.

To help us resolve the dispute, we’ll need:

- A completed copy of the appropriate form
- The reasons why you disagree with our decision
- A copy of the denial letter or Explanation of Benefits letter
- The original claim
- Documents that support your position (for example, medical records and office notes)

Initial Claim / Recon / UM or Exp/Inv Denials Filing Period = 180 Days

Appeals after Reconsideration Filing Period = 60 Days

Have dispute process questions?

Read our dispute process FAQs

Or contact our Provider Service Center (staffed 8 a.m. – 5 p.m. local time)

- 1-800-624-0756 for HMO-based benefits plans
- 1-888-632-3862 for indemnity and PPO-based benefits plans

Aetna Appeals Mailing Address:
Aetna Provider Resolution Team
P.O. Box 981106
El Paso, TX 79998-1106

Aetna Fax Center:
859-455-8650

(Both must be accompanied by and Appeal Form and any and ALL Notes and Documents needed to support)
Effective January 1, 2020, Aetna is introducing an updated payment policy that will allow Healthcare practitioners to be compensated when telemedicine services are rendered via interactive audiovisual conferencing in all 50 states.

Historically, Aetna has required direct patient contact (face to face) between the Healthcare practitioner and member. Under the new payment policy, Aetna will pay for synchronous two-way, real-time interactive audiovisual communication between the Healthcare practitioner and member. Healthcare practitioners will be reimbursed for Telemedicine services (interactive audiovisual) at the level as if the service was rendered face to face.

**Aetna will require the 02 location code and the GQ, GT and 95 modifiers as necessary to report a telemedicine service.**

*Note: Asynchronous telemedicine services such as e-mail, fax, text, store and forward will not be covered, unless state mandated or included in a custom plan sponsor exception. This Policy update is for commercial only, Medicare will continue to follow CMS guidelines.*

**How will Healthcare practitioners be made aware of this updated payment policy?**
Healthcare practitioners will be alerted of this new policy in the December Office Link Update. Look for email when newsletter available or access via Aetna.com. Policy will also be updated on our Secure Provider Portal with link providing specific code ranges covered and other details.
1. How will this updated payment policy impact Healthcare practitioner’s reimbursement payments?
   Telemedicine Healthcare practitioner reimbursement will be the same as if the service was rendered face to face.
   (Example: If the Healthcare practitioner contracted rate is $130 for a face to face visit, an interactive audiovisual telemedicine visit will be paid at $130.)

2. What is the member’s cost share for Telemedicine services?
   Member cost share will be the same as if the service was rendered face to face.
   Example: If member’s copay is $25 per office visit, the interactive audiovisual telemedicine visit will require a $25 co pay.

3. How does a member request a telemedicine appointment?
   Members will need to contact their Healthcare practitioners to make a telemedicine appointment just as they would to make an in-office appointment.

4. What equipment do I need for Telemedicine?
   Healthcare practitioners must use electronic communication that is interactive audiovisual, secure and compliant with the Health Insurance Portability and Accountability Act.
- Quarterly updates, will find previous couple years of newsletters.
- Recommend Sign up for mailbox delivery - On Navinet under Communications / Newsletters or www.aetna.com to access once released
- Includes sections for updates to National Precertification List, Clinical Payment, Coding and Policy changes, and changes to preferred drug list.
- Learning opportunities and more.
COFINITY RESOURCES
As part of our ongoing efforts to improve efficiency and better serve our providers, clients and members, we’re consolidating our claims repricing and provider data platforms. The work needed to transition our data and processes is already underway and will conclude on December 31, 2019. As of Dec. 1, 2019 Cofinity will reject claims with message to send directly to payer.

New claim submission workflow
The change in claims repricing platform requires a change to the traditional Cofinity claim workflow. In the new workflow, you’ll submit claims to the payer, instead of directly to Cofinity. All Payers have completed migration to the new workflow as of Oct. 1, 2019. When the payers migrated, they issued new member ID cards that included the following information:

- The payer’s electronic payer ID
- The mailing address for non-electronic claims
- Cofinity Logo on front of card

Check your patient’s member ID card for the electronic payer ID
It’s important that you check each patient’s member ID card so that you send Cofinity claims to the correct electronic payer ID. Sending a claim to the wrong place will result in a delay in the processing of that claim. Cofinity will still be pricing the claims for the payers, so nothing is changing contractually.
COFINITY INTRODUCES EXCITING NEW CHANGES

New Enhanced Website

Coming Soon!

Cofinity.net is being sunset in January 2020 and will be replaced by the new Firsthealth.com website. As a Cofinity provider, you will have access to start registering to use the new site as early as Monday, September 23, 2019. The Firsthealth.com site will give you access to features we offered in the past, plus more. We'll post more information about this change on Cofinity.net soon. If we have your current email, we'll even send those details directly to your inbox.

KEY DATES:

• **November 30, 2019**
  Cofinity will no longer accept claims directly from the provider. All claims will need to be submitted through the payer listed on the back of the ID card.

• **September 23, 2019**
  Cofinity providers can start registering and using the new Firsthealth.com enhanced site.

• **January 2020**
  Cofinity.net will retire, the new and improved Firsthealth.com website will replace Cofinity.net.

Please see us for a Cofinity Migration Payer List with detailed billing information for all payers!
**NEW** Combined First Health and Cofinity Websites
Register Today for your new access at FirstHealth.com

At First Health we value

- Network quality and stability
- Service excellence
- Operational and administrative ease
- Flexibility

First Health®, one of the largest national PPO networks, and Cofinity®, a leading regional network, offer quality at an affordable price. We serve a wide range of payers, including:

- Third party administrators
- Carriers
- Employers
- Taft-Hartley trusts
- Government entities

Together, we offer more cost-saving solutions, including:

- A leading national network with urban, suburban and rural access
- Strong regional networks in Michigan and Colorado
- A range of solutions for out-of-network claims

Welcome Kiley

Provider

News & Events

- American Association of Payers, Administrators and Networks (AAPAN)
  - January 22-January 30
- Data Security
  - Originally published in the March
Locating a Provider

All users, registered and non-registered, can use the Locate a Provider tool.

- From the website home page, click on the **Locate a Provider or Create a Directory** button.

### Network Options

Select a Network Type:

- First Health Network
- Cofinity Network
- Client Specific Network (use when client code is required for specific network)

**Note:** When searching by name the provider may display several times if provider has offices in different locations
Secure Log in Functions

Log in/Forgot Password

- Click Login in and type **User ID**

- **Type Password** - *When logging in for the first time. You will be required to select an image that must appear at each login when typing in your password*

**Change your user ID &/or Password by answering the security questions**

*The image and caption displayed should match the security image and caption you selected. If they do not match and you entered your login ID correctly, DO NOT enter your password. Please report the problem to Cofinity Customer Service immediately at 1-800-831-1166*

![Security Image]

- **Forgot Password?**
Once logged in:

To access the secure functions, click on My First Health (this will only appear when logged in)

Providers have the following secure options:

- Client List
- Claim Activity Report
- Claim Attachment Look-up
- Search for Claims
- Claim Appeal form
- Demographic Update
- TIN Update
- Resources
- Notices and News
Registered providers can run an online list of contracted clients that have access to the networks the provider participates in.

- Type in Tax ID and CPD ID
- Click on Submit Tax ID and CPD ID (for provider information to populate)

**Only Show:** click drop down box to select which clients (via active date) you would like to view

**OPTIONAL:** Search for payor or client by name
- Click on Find Clients
  - Click on client name to view details
  - Click on Download to Microsoft Excel if you would like information on an Excel spreadsheet
Claims Activity Report

Providers can run a report of all claims for a specified time period for all providers or selected providers under a TIN.

The report is limited to only TIN’s/providers the registered provider has been given access to.

- Complete all sections
- Click **Generate Report** (bottom of screen)
Claim Activity Results:

Number of records found

First Health | 568 records found.  View

Entered report generation criteria
- Claim form: Both CMS 1500 (Professional) and CMS 1450 (UB 04 Facility)
- Provider TINs: 381459362
- Provider: All
- Report dates: All claims with date of service from 03/05/2018 to 06/04/2018

Save criteria
- Click **Filter** to filter by: TIN, Network, Service Date, Claim Form, Claims Start & End date
- Click on **Claim No** to view claim form
- Click on headers to filter alphabetically/chronologically
- Save the reports as a PDF or CSV
- Saved reports will be located under **My Downloads** and saved criteria will be under **Saved Criteria** on top right of page
Claims Attachment Look-up

Users can enter the Barcode to view any attachments on a claim.

- Type in **Barcode**
- Click **Search**
- Click the attachment to view
Registered users can search claim information for TIN(s) they have access to.

- Select your **Network** & the available search criteria

**Choose Network**

**Choose search criteria**

Search criteria: **Select**
- TIN Number
- Claim number
- Patient account number
- Member ID
- Member details (first initial, last name and DOB)

**Note:** for any search criteria selected, you may also search for multiple by selecting the search for multiple buttons

**Type in available search criteria**

- Click **Search**
- If claim is available, the below information will appear
Claims Appeal Form

Registered providers can submit an appeal on claim pricing they have questions on or dispute as to how a claim was priced.

- Complete the form in its entirety
- Hit Submit

Provider Claim Appeal Request Form

* Claim number:

* Reason for appeal:

* What is the total amount you are expecting?

Is this your first attempt at an appeal for claim?

Yes ☑️ No ☐

If no, please list reference number if available:

If additional claim appeals please list claims numbers, reason for appeal, amount expected & reference #’s if available:

* Contact name:

* Contact number:

* Contact email:

Submit  Reset
Demographic Update

Registered providers can submit a request to update, change, or terminate demographic information for the TIN records they have access to.

- Complete the form in its entirety when requesting a demographic information change
- Hit Submit

All information on form must also be put on providers letterhead and attached to the form.

![Provider Demographic Information Change Request Form]

* Provider Name:

* Tax Identification Number (TIN):
  (Note: Do not report change/updates to your FTIN on this form.)

* Identify the type of demographic change?
  Add ○ Update ○

* Reason for Demographic Information change (relocation: phone #, street address, suite #, street misspelled; add: new office location):

National Provider Identifier (NPI):

CAQH Identifier:

* Contact Name:

* Contact Number:

* Contact Email:

Attachment: [Choose File] No file chosen

Submit Reset

* This form is to report demographic practice updates only. Please refer to the TIN change form or the appeal form for any necessary TIN changes or any claim related questions.
TIN Update

Registered providers can complete the online form to request an update, change, or termination to a TIN.

This functionality is limited to the TIN’s/providers the user has been given access to.

- Complete the form in its entirety to request a provider TIN change
- Upload and attach W-9 and a provider roster when applicable
- Hit Submit

![Provider Tax Identification Number (TIN) Change Request Form](image_url)

Attach the W-9 and a provider roster when applicable.

- **TIN:**

- **Identify the type of TIN change?**
  - Add
  - Update

- **Reason for TIN change:**

- **Provider Name:**

- **Contact Name:**

- **Contact Number:**

- **Contact Email:**

- **Attachment:**

  ![Choose File](image_url) No file chosen

  ![Submit Reset](image_url)
Click links to view/download resource information on specific guidelines, billing rules, procedure manuals and more.

1. Claim Inquiry Guidelines
2. Cofinity Ambulatory/Outpatient Surgery Grouper
3. Cofinity Claim Migration FAQ
4. Cofinity CO Specialty Billing Rules
5. Cofinity Hospital & Provider Procedure Manual
6. Cofinity MI Specialty Billing Rules
7. Cofinity Network ID Card Standards
8. Cofinity Network Quick Overview
9. Cofinity Payer Migration Report
10. Cofinity Welcome Kit
11. First Health Network ID Card Standards
12. First Health Network Provider Reference Guide
13. First Health Network Quick Overview
14. Provider Service Model
Notices and News

Click links to view/download any Notices and News information when they become available.

1. Cofinity CO Regulatory Contract Changes
2. First Health Illinois Provider Notice WC Settlement
3. Indian Health Service Rule Change for Tribal Members

Questions? Contact us

Contact First Health

Members, Clients and Providers
1-800-226-5115
Monday-Friday
8am – 8pm ET

Individual Sales

- Medicare Advantage 1-800-894-3258, option 1
- First Health Medicare Part D 1-855-389-9688
- Individual health and dental coverage is not available through First Health

Note: Neither First Health nor Cofinity determines member eligibility, provides benefit information, maintains summary plan documents or pays medical or dental claims. Contact the claims administrator on the member's identification card for this type of information or to request records, subrogation or liens.

Contact Cofinity

Members, Clients and Providers
1-800-331-1168
Monday-Friday
8am – 5pm ET

Client, Broker, and Intermediary sales (Group Health products only)
1-800-247-2898, option 1.
CONTACT INFORMATION

www.aetna.com
Aetna Provider Service       Aetna Medicare Call Center
1-888-632-3862               1-800-624-0756
Aetna Credentialing          Aetna Fax Center
1-888-353-1232               1-859-455-8650

https://navinet.navimedix.com
Navinet Customer Service
1-888-482-8057

www.firsthealth.com
Cofinity Customer Service    First Health Customer Service
1-800-831-1166               1-800-226-5116
csmailbox@cofinity.net

Aetna Better Health
Aetna Better Health is a separate contract from Aetna Commercial. Please
reach out to your direct Aetna Better Health representatives.
Aetna Better Health Provider Relations: 1-866-314-3784