PROVIDER DISCLOSURE FORM

DOING BUSINESS WITH AETNA IN CALIFORNIA

This statement contains information regarding certain regulatory notice requirements, Claim Settlement procedures, the Provider Dispute Resolution process, and Aetna Payment Policies.

If you have any questions, please contact our Provider Service Center at the following:
For Medicare HMO plans only: 1-800-624-0756; **For all other plans (PPO and Commercial HMO plans)**: 1-888-MD-Aetna (632-3862); Or visit the Aetna website at www.aetna.com.

NOTICE

California Notification Timely Access to Care Requirements under Sections 10133.5 of the California Insurance Code and 1367.03 of the Health and Safety Code
California regulations require that each health plan's contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees timely access to care and reasonable appointment wait times. These include:

- *Urgent care within 48 hours of the request*
- *Non-urgent primary care within 10 business days of the request*
- *Non-urgent specialty care within 15 business days of the request*
- *Non-urgent mental health care within 10 business days of the request*
- *Non-urgent ancillary care within 15 business days of the request*

There may be exceptions to appointment wait times when the Department of Managed Health Care or the Department of Insurance allows such exceptions.

For complaints related to accessing medical care in a timely manner, you may contact Aetna, The California Department of Managed Care or the California Department of Insurance at the following phone numbers:

- Aetna at **1-800-325-6541** for help; **and**
- The California Department of Managed Health Care at **1-888-466-2219**, or the California Department of Insurance at **1-800-927-4357**, as applicable, to report any inaccuracy with Aetna's provider directory.

California Provider Directory Requirements under Sections 10133.15 of the California Insurance Code and 1367.27 of the Health and Safety Code require that we annually validate each participating provider's demographic information. This includes product and network participation and certain other items displayed in our provider directory. Aetna sends letters explaining the validation process.

How to validate your information with us:

- Review your provider demographic information, product and network participation and other key information below.

- If **no changes** are needed, complete our online confirmation form at **www.aetnavalidation.com**. Then we'll automatically update our records to show your validation is done. (This will prevent us from sending follow-up validation requests to your office.)
- **If changes are needed**, you can note them on the letter you received in the mail and fax it to us at **844-812-7722**.

Special notice for providers not accepting new patients: What to do if you're contacted by a member or potential member

If you're not accepting new patients, but are contacted by a member or a potential member who wants to become a new patient, you must tell them to contact:

- Aetna at **1-800-325-6541** for help; **and**
- The California Department of Managed Health Care at **1-888-466-2219**, or the California Department of Insurance at **1-800-927-4357**, as applicable, to report any inaccuracy with Aetna's provider directory.

CLAIM SETTLEMENTS

Clean Claim

A clean claim submitted on paper or on its electronic equivalent must be on a CMS 1500 form or a UB-04 form and must include all information and attachments listed. A claim will not be a clean claim if it is missing any of the information or attachments specified below.

Electronic Claims

An electronic claim is a HIPAA-compliant electronic submission equivalent to the UB-04 (for institutional providers), the CMS 1500 (for physicians and other professional providers), or any other format adopted by the National Uniform Billing Committee or National Uniform Claim Committee that includes all relevant information. To submit claims electronically, please contact your Practice Management System vendor and determine whether the vendor can send claims electronically to Aetna. If you do not have a Practice Management System vendor, or if that vendor cannot accommodate the request, then please contact one of Aetna's clearinghouse vendors listed at www.aetna.com.

From the menu bar, select "Health Care Professionals", then scroll down to the "Claims & Transactions" section and select "Submitting a claim".

Electronic Transaction Vendors

For information on Aetna's electronic vendors, visit www.aetna.com.

From the menu bar, select "Health Care Professionals", then scroll down to the "Claims & Transactions" section and select "Electronic transaction vendors".

Paper Claims – HMO & PPO Products – Mail claims to:

Aetna
P.O. Box 14079
Lexington, KY 40512-4079

Claims Inquiries – To confirm the recorded date of claims receipt or to make other inquiries about claims, you may call Aetna at **1-800-624-0756 for Medicare HMO Products / 1-888-MD-Aetna (632-3862) for All Other Products**, or contact your clearinghouse vendor.

CMS 1500 FORM

Required Data Elements, Clean Claim Elements, and Attachments for Emergency Services and Care Providers, Physicians and Other Professional Providers

The Form CMS-1500 is the standard claim form used by health care professionals and suppliers. The National Uniform Claim Committee (NUCC) maintains the Form CMS-1500. The NUCC previously updated the Form CMS-1500 to accommodate the National Provider Identifier (NPI), a unique provider number mandated by HIPAA. The form is designated as Form CMS-1500 (8/05) and was developed through a collaborative effort led by NUCC, in consultation with CMS.

A sample copy of the CMS 1500 Form is available for review at: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500805.pdf.

A clean claim submitted on paper or on its electronic equivalent must be on a CMS 1500 form and must include all information and attachments listed. A claim will not be a clean claim if it is missing any of the information or attachments below.

Box 1a – Patient or Member Plan ID Number
Box 2 - Patient Name
Box 3 – Patient Date of Birth and Gender
Box 4 – Subscriber's Name
Box 5 – Patient's Address (street or P.O. Box, city, zip)
Box 6 – Patient's relationship to Subscriber
Box 7 – Subscriber's Address (street or P.O. Box, city, zip)
Box 8 – Patient Status
Box 9 – COB Information
If the provider does not have the capability to submit this information electronically, then Aetna requires the billing entity to attach an Explanation of Benefits form from the additional payer.
Box 9D – Other Insurance Company Name
Box 10A – Injury Code
Box 10B and C – Accident Indicator
Box 11 – Subscriber's Policy Group Number
Box 11A – Subscriber's Birth Date and Gender
Box 11C – HMO or PPO Carrier Name
Box 11D – Other Insurance Indicator
Box 13 – Assignment on File

Box 14 – First Symptom / Onset Date
This field is required when the
Emergency indicator is 'Y' (Box 23I). This is the date of first symptoms of illness or injury. It may be either prior to or on the current date of service.
Box 15 – If Patient has had same or similar illness, give first date
Box 17 – Referring Physician Name
Box 18 – Inpatient Admit Date
Required for inpatient claims. Must be a valid date and may not be greater than the current billing date.
Box 21 – ICD 9 Codes
Box 24A – Date of Service
This field must meet standard date edit and must not be greater than the current date.
Box 24B - Place of Service Code
Box 24C – Type of Service
Box 24D – CPT Codes(s), any Appropriate Modifiers and Anesthesia Time (in minutes)
Box 24E – Diagnosis Code by Specific Service
Box 24F – Charges for Each Listed Service
Box 24G – Number of Days or Units
Box 24J – COB Information. Allowed and paid amounts required.
Box 24K – Reserved for Local Use
Box 25 – Tax ID Number (TIN)
Box 28 – Total Charge
Box 29 – Amount Other Carrier of Member Paid
Box 30 – Balance Due
Box 31 - Provider's Name/Signature
Box 32 – Facility where Services Rendered
Box 33 – Provider Billing Name, Address, Phone Number and Identification Number
Remarks - (No Box Available) – The Remarks field is designed for use in those limited situations where Aetna requires supplementary data, that is, data in addition to the information entered in the Boxes identified above. Note: The electronic definition of this field is established by vendors and may vary.

Additional information for the CMS 1500 form is available at the CMS.gov website, please use the link provided to access:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf

In order for a claim to be a clean claim, the following additional documents are required:

1. Modifiers

There are situations in which a claim must be submitted using a CPT modifier. The use of modifiers can indicate an unusual event occurred or that the procedure or service was altered in some way. When billing with certain CPT modifiers you must provide a complete description of the service performed including supporting documentation such as operative report, or anesthesia notes. Relevant information should include adequate description of the nature and events that occurred during the procedure or at the time of service.

Modifier-22 Unusual Procedural Service
Submit complete description of the procedure including operative report

Modifier-23 Unusual Anesthesia
Submit complete description of the procedure including operative report and anesthesia notes

Aetna Modifier policies are available to all providers for review and reference in NaviNet, a secure external vendor for healthcare networking and communications. Please use the link to sign in and/or register as a NaviNet user: https://navinet.navimedix.com/sign-in.

2. All Unlisted/Unspecified Codes

Include a complete written description of the procedure and written report for all unlisted/unspecified codes. See the requirements below for the following specific codes.

All Unlisted Anesthesia Codes / All Unlisted Surgical Procedures / All Unlisted Laboratory Procedures
For example: CPT 01999-Unlisted anesthesia procedure or CPT 19499-Unlisted procedure, breast or CPT 84999-Unlisted chemistry procedure
Submit complete description of the procedure including operative report.

All Unlisted Radiology/Imaging Procedures
For example: CPT 78799-Unlisted genitourinary procedure, diagnostic nuclear medicine
Submit complete description of the procedure including imaging report

All Unlisted Medical Procedures & Supplies
For example: CPT 93799-Unlisted cardiovascular service or procedure; CPT 99070-Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided). Submit complete description of procedure including office notes and report.

All Unclassified Drug Codes
For example: HCPCS J3490-Unlisted drugs
State the NDC code, name of drug, manufacturer's name, dose, number of doses and number of doses administered. Submit complete description of the service including itemized invoice.

All Other Unlisted, Non-specific HCPCS Codes
For example: HCPCS A0999-Unlisted ambulance service or HCPC E1399-Durable medical equipment, miscellaneous or HCPC A4649-Surgical supply, miscellaneous.
Submit complete description of the service, including itemized invoice.

All Non-specific ICD-9 Codes
For Example: ICD-9 799.8-ILL-Define condition nec or ICD-9 794.9-ABN Function study nec.
Submit complete description of the diagnosis, including office notes and history and physical

3. Coordination of Benefits (COB)

If indicating "yes" to COB in Box 9, the other carrier's payment and allowed amount must be submitted in the HIPAA 837 format **or** attached to the claim.

PRECERTIFICATION

A listing of Precertification procedures and services is available on the Aetna website, located in the Health Care Professional section. Please use the link for review and reference:
http://www.aetna.com/healthcare-professionals/policies-guidelines/medical_precertification_list.html

The Precertification list is updated twice annually, and periodically throughout the year.

If the claim is for a health care service that requires precertification, and the physician, practitioner, or member did not obtain precertification, then the physician or practitioner must do the following:
Attach data to support the clinical information requirements for coverage found in the Coverage Policy Bulletins section located at www.aetna.com. If the website address is not available, call Aetna's customer service department, using the phone number on the member's ID card, to obtain the Coverage Policy Bulletin requirements for coverage. If precertification was required for the member's plan and was not obtained, Aetna requires data that supports the clinical information requirements for the procedure performed. These requirements are available for review in the Coverage Policy Bulletins section on the Aetna website.

Enhanced Clinical Review Program

Note: This program is currently only applicable to PPO plans in California. For HMO-based plans, physicians affiliated with a Medical Group/IPA should follow the precertification and ordering process for services established by their Medical Group/IPA.

Aetna has implemented the Enhanced Clinical Review Program (ECR) as a comprehensive approach to both quality and utilization management for a variety of services. **eviCore Healthcare** (formerly **MedSolutions**) is Aetna's preferred national vendor that reviews preauthorization requests for services for Aetna members who live in and/or receive covered services in states/markets that have the Enhanced Clinical Review (ECR) Program implemented

Services included in the ECR program for preauthorization review are as follows:

High tech radiology services – MRI/MRA, CT/CCTA, PET,
Nuclear Cardiology,
Outpatient stress echocardiography,
Diagnostic left heart catheterization, and diagnostic right heart catheterization,
Cardiac rhythm implantable procedures/devices,
Attended sleep studies performed in a healthcare facility
Interventional pain management
Musculoskeletal (large joint hip and knee arthroplasties).

Aetna's ECR vendors, CareCore National (CCN) and MedSolutions, Inc. (MSI), have rebranded to become **eviCore healthcare**. Providers can click on the vendor name links for additional information and overview tutorials.

Providers can contact eviCore Healthcare to register for their online portal at : https://www.evicore.com/.

UB 04 Form

Required Data Elements, Clean Claim Elements, and Attachments for Institutional Providers and Emergency Services and Care Providers

The UB-04, also known as the Form CMS-1450, is the uniform institutional provider claim form suitable for use in billing multiple third party payers. The 837 Institutional electronic claim format is the electronic version of the form and is in use by providers who submit claims electronically.

A Fact Sheet containing information for electronic & paper UB-04 submissions and Education & Learning tools is available at the CMS.gov website; please use the link to access:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf.

A sample copy of the UB-04 form including field descriptions is available at the CMS.gov website; please use the link to access:
http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1196256.html?DLPage=1&DLFilter=1450&DLSort=0&DLSortDir=ascending.

A clean claim submitted on paper or on its electronic equivalent must be on a UB-04 form and must include all information and attachments listed. A claim will not be a clean claim if it is missing any of the information or attachments below.

Box 1 – Provider Information (Provider's name, address, and telephone number)
Box 4 – Bill Type
Box 5 – Provider's Federal Tax ID Number
Box 6 – From-date may not be earlier than admission date. Through-date may not be earlier than from-date. Through-date may not be later than from processing date.
Box 12 – Patient Name
Box 13 – Patient Address
Box 14 – Birthdate
Box 15 – Sex
Box 16 – Marital Status
Box 17 – Admission Date
Box 18 – Admission Hour
Box 19 – Type of Admission
Box 20 – Source of Admission
Box 21 – Discharge Hour (Applicable *only* if the patient was admitted as an inpatient or was admitted for outpatient observation.)
Box 22 – Discharge Status
Box 32, 33, 34, and 35 – Occurrence Codes and Dates (Applicable *only* if the UB-04 manual contains an occurrence span code appropriate to the patient's condition.)
Box 36 – Occurrence Span (Applicable *only* if the UB-04 manual contains an occurrence span code appropriate to the patient's condition.)
Box 38 – [Information]

Box 39, 40, and 41 – This field must be used when submitting DRG codes. Electronic transmission specifications vary so please contact your vendor to ensure correct placement. For example, one submission format requires that a ZZ value be present in block 39 in order for the DRG to be transmitted; likewise, it requires that DRG be present if the ZZ value exists.
Box 42 – A code that identifies a specific accommodation, ancillary service or billing calculation of the related service(s) provided. This is required for all claims. Please follow the guidelines specified in the National Uniform Billing Data Element Specifications or St. Anthony's UB-04 editor for code values. Note: For outpatient services, most revenue codes will require a HCPCS code attachment.
Box 43 – Revenue Description
Box 44 – This field must be valued when reimbursement is based on HCPCS codes.
Box 45 – For HMO claims, the service date is required for all outpatient claims when the statement covers period from and through dates are not equal.
Box 46 – Number of Units
Box 47 – Total Charges
Box 50 – Payer Name
Box 54 – Prior Payments (Applicable *only* if payment has been made to the provider.)
Box 58 – Insured's Name
Box 59 – Patient's Relationship to Insured
Box 60 – Member/Insured's ID Number
Box 62 – The identification number, control number, or code assigned by the carrier administrator to identify the group for which the individual is covered.
Box 67 – Principal Diagnosis Code
Box 68. 69, 70, 71, 72, 73, 74, and 75 – Other Diagnosis Codes (Applicable *only* if there are diagnoses other than the principal diagnosis.)
Box 76 – Admission Diagnosis Code
Box 78 – DRG Code
Box 79 – Principal Procedure Code (Applicable *only* if the patient has undergone a surgical procedure.)
Box 80 – Other Procedure Codes (Applicable *only* if additional surgical procedures were performed.)
Box 82 – Attending Physician ID Number
Box 84 – This field is designated for use in limited situations when supplementary data is required from health care providers that the format and data set do not provide for them.
Box 85 – Provider Representative (signature or signature on file)
Box 86 – Date Bill Submitted
Other – In the event that an "H" precedes the patient identification number, the "H" should be omitted for electronic submissions. Line charges greater than $9,999.99 should be submitted on paper. Total claim charges greater than $99,999.99 should be split and submitted electronically, if possible. Claims spanning 2 calendar years must be separated. NDC codes should be submitted in the remarks field. Principal procedure code required for specific revenue codes. Error message will indicate "Principal procedure code for services rendered". Revenue codes – some require a HCPCS code when billed.

Additional information documenting UB-04 form changes and updates is available through the National Uniform Billing Committee (NUBC) website; please use the link to access: http://www.nubc.org/.

In order for a claim to be a clean claim, the following additional documents are required.

1. **Modifiers**

Modifier information is available for review on Page 3 of this document. Click on the subject line above to review.

2. **All Unlisted/Unspecified Codes**

Unlisted/Unspecified Code information is available for review on Page 4 of this document. Click on the subject line above to review.

3. **Coordination of Benefits (COB)**

Coordination of benefits (COB) information is available for review on Page 4 of this document. Click on the subject line above to review.

4. **Precertification**

Precertification information is available for review on Page 5 of this document. Click on the subject line above to review.

5. **Enhanced Clinical Review Program**

The Enhanced Clinical Review Program Precertification information is available for review on Page 5 of this document. Click on the subject line above to review.

PROVIDER DISPUTE RESOLUTION PROCESS

Definition of Provider Dispute - Contracted Provider Dispute

A contracted provider's written notice to Aetna or to Aetna's capitated provider:

- Challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested
- Seeking resolution of a billing determination or other contract dispute (or a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered)
- Disputing a request for reimbursement of an overpayment of a claim.

Contents of Written Notice. The written notice must contain the following information:

- Provider's name
- Provider's identification number
- Provider's contact information
- For claims issues:
    - Clear identification of the disputed item;
    - Date of Service;
    - Clear explanation of the basis upon which the provider believes that the plan's action is incorrect regarding the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contested/denied/adjusted claim.
- For non-claims issues, a clear explanation of the issue and the provider's position.
- For issues involving enrollees:
    - The name and identification number(s) of the enrollee(s);
    - Clear explanation of the disputed item;
    - Date of service;
    - Provider's position.
- For filing substantially similar multiple disputes (claims, billing, contractual, or other) in batches:
    - Sort provider disputes by similar issue
    - Provide a cover sheet for each batch
    - Number each cover sheet
    - Provide a cover letter for the entire submission describing each provider dispute with references to the number cover sheets.

Deadline to Submit Provider Disputes: Provider must submit a dispute for an HMO-based claim within three hundred sixty-five (365) calendar days from the date of Aetna's last action on the claim, billing, or contractual issue. For PPO-based claims, Provider must submit a dispute within one hundred eighty (180) calendar days from the date of Aetna's last action on the claim, billing, or contractual issue.

Incomplete Disputes: Incomplete disputes will be returned to the provider for completion within thirty (30) working days.

Acknowledgement: Aetna will acknowledge receipt of the dispute within fifteen (15) working days, unless the dispute is resolved within that timeframe.

Resolution: Provider disputes will be resolved within forty-five (45) working days after receipt of the complete written dispute.

Provider Disputes – HMO Products: – Mail dispute to:

Aetna Correspondence Unit
P.O. Box 24019
Fresno, CA 93779-4019

Provider Disputes – PPO Products: – Mail dispute to:

TRAD: Provider Resolution Team
P.O. Box 14020
Lexington, KY 40512

For Medicare Products Provider Dispute Inquiries HMO plans only: Contact the Provider Service Center at 1-800-624-0756.

For all other Products' Provider Dispute Inquiries (PPO and Commercial HMO plans): Contact the Provider Service Center at 1-888-MD-Aetna (632-3862).

Additional information and Aetna policies for provider disputes, appeals, and reconsiderations are available on the Aetna.com website, in the "Health Care Professionals" section. Please use the link to access: http://www.aetna.com/healthcare-professionals/policies-guidelines/dispute_process.html

MEDICAL COST TRANSPARENCY*

Aetna has several tools to assist members with insurance cost sharing and payment estimates. The Member Payment Estimator tool delivers an estimate of what a member can expect to pay for a service, based on the provider the member chooses and the member's own benefits. It can show a member estimates for certain in-network and out-of-network non-emergency services.

The Medical Procedure by Facility Cost Tool is a guide that helps estimate a member's costs for certain medical procedures and treatments. It allows a member to compare costs by facilities within a specified area. Actual cost ranges depend upon the plan selected. Cost ranges (average-low to average-high) are based upon claim data for the past two (2) years and are subject to change.

The Pharmacy tool allows a member to check drug coverage and costs.

Aetna members can access information using Aetna's Member secure website at: https://www.aetna.com/individuals-families/using-your-aetna-benefits/secure-member-account.html by clicking on the "Register or log in" link to view/use the Member tools available.

*California Health & Safety Code section 1367.49 and California Insurance Code section 10133.64 information for hospitals and facilities: Hospitals/facilities will get twenty (20) days advance notice to review any methodology and data that is developed and compiled by Aetna before cost/quality information is provided to members. If a hospital/facility chooses to provide a response to the transparency information, Aetna will post a link to the hospital/facility's Internet Web site where the response may be found.

PAYMENT POLICIES

Fee Schedules

California providers: How to access your fee schedule

In accordance with the regulations issued pursuant to the Claims Settlement Practices and Dispute Mechanism Act of 2000 (CA AB 1455 for HMO) and pursuant to the expansion of the Health Care Providers Bill of Rights (Cal. Health & Safety Code § 1375.7 and Cal. Insurance Code § 10133.65) we are providing you with information about how to access your fee schedule.

- If you are a provider affiliated with an IPA, contact your IPA for a copy of your fee schedule.
- If you are a provider directly contracted with Aetna, fax your request with the desired CPT Codes to 1-859-455-8650. Contact our Provider Service Center with questions.
- If your hospital is reimbursed through Medicare Groupers, visit the Centers for Medicare and Medicaid Services (CMS) website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html for Medicare Fee Schedule information.

Non-physician health care professionals should call the Provider Service Center to obtain rate information.

If you have additional questions, please contact our Provider Service Center at the following:
For Medicare HMO plans only: 1-800-624-0756; **For all other plans (PPO and Commercial HMO plans)**: 1-888-MD-Aetna (632-3862).

Information regarding detailed payment policies, global payment provisions, and other policies

NaviNet®, the secure external vendor website for Physicians, Hospitals, & Health Care Professionals, provides Aetna policy and payment information including (but not limited to):

- Consolidation of multiple services or charges
- Payment adjustments due to coding changes
- Reimbursement for multiple procedures
- Assistant surgeons (Physician and Non-Physician)
- Administration of immunizations and injectable medications
- Recognition of CPT modifiers

Please use the link to sign in and/or register as a NaviNet user: https://navinet.navimedix.com/sign-in.

PRE-PAYMENT AND POST-PAYMENT AUDITS

Inpatient Bill Review Program

Aetna authorizes CorVel Corporation to request itemized inpatient hospital bills

Aetna is contracted with CorVel Corporation to review itemized hospital and facility bills. The review applies to both contracted and non-contracted hospitals and other facilities. Aetna has authorized CorVel to request itemized bills/UB-04s directly from providers.

The Inpatient Bill Review (IBR) program focuses on inpatient hospital claims (on a prepayment basis). For contracted providers, the review occurs where contracted rates are:

- A percent of Billed Charges, or
- Meet a Stop Loss threshold that is contracted at a percent of Billed Charges.

For non-contracted providers, the review may occur (when an employer group has purchased Aetna's IBR program) where billed services are:

- Greater than $100,000 for inpatient services, or
- Greater than $50,000 for outpatient services.

How does the IBR process work?

□ Aetna will continue to receive claims directly from providers.
□ Aetna will identify claims that are eligible for IBR.
□ Aetna will send eligible IBR claims to CorVel.
□ CorVel will notify Aetna of their claims review findings.
□ Aetna will process and pay the claim.

If Aetna does not already have an itemized bill/UB-04, CorVel will call the applicable hospital or facility to request one.

Facilities and hospitals will be asked to deliver the requested information to CorVel via fax, so that the itemization is obtained in a timely manner. Additionally, the facilities and hospitals that CorVel contacts are asked to submit their bills and UB-04s as soon as they are requested. CorVel will provide the fax number or mailing address for each facility and hospital to submit the requested information. Lastly, CorVel will review the claim and provide their findings to Aetna, along with any disallowed amounts.

If a provider is in disagreement with the findings and wants to appeal, appeals will follow the Provider Dispute process described previously in this document.

Additional information regarding CorVel and the IBR program are available to all providers for review and reference in NaviNet, a secure external vendor for healthcare networking and communications. Please use the link to sign in and/or register as a NaviNet user: https://navinet.navimedix.com/sign-in.

OrthoNet Prepay Audit Program

Aetna has entered into a relationship with OrthoNet (ONET), a vendor that performs a comprehensive prepay claims and medical records audit review based on provider specialty and/or surgical procedures. The review applies to participating and nonparticipating providers.

Claims and medical records are sent to Aetna and ONET accesses them via the Aetna systems. ONET audits and verifies the claim by comparing the specific CPT codes billed on the claim to the physician medical notes and makes code allowance determinations, via peer specialist review. This is not a review of medical necessity. ONET ensures the services provided match what is being billed and considered for reimbursement.

Risk Arrangements and Corrective Action Plans

Aetna and provider organizations with contracted risk arrangements are required to participate in and comply with Corrective Action Plans (CAPs) administered by the California Department of Managed Health Care.