

Provider manual

aetna™

Aetna.com

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Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies (Aetna).

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Your provider resource

You've told us what's important to you. And we listened. Through your feedback, we continually update this manual to make it easier for you to work with us. This manual applies to any health care provider, including physicians, health care professionals, hospitals, facilities and ancillary providers, except when indicated otherwise. It includes policies and procedures. Aetna may add, delete or change policies and procedures, including those described in this manual, at any time. Please read this manual carefully. Your agreement requires you to comply with Aetna policies and procedures including those contained in this manual. Visit **Aetna.com** or our provider website, **Availity.com**, to find additional policies, procedures and information. You'll find programs we offer that could benefit your Aetna patients. Electronic transaction tools that save you time. And of course, our contact information, so you can reach us whenever you need to.

You'll also find information on how to get your claims paid faster, your preauthorization requests processed promptly, and your administrative burdens lessened. We want you to find what you need, quickly and efficiently.

Have questions? Contact us via **Aetna.com** — we're here to help.

Creating a diverse, equitable and safe workplace
We are an equal opportunity employer. We believe in and promote a diverse, equitable and safe workplace environment. We count on you to do the same in your hiring practices and workplace policies.

Here to help you

This manual is for you — the physicians, the hospital and facility staffs, and the providers that participate in our network and care for our members. It aims to:

- Help you understand our processes and procedures
- Serve as a resource for answering your questions about our products, programs, or doing business with us

You'll find almost everything you need to do business with us. Go to our website, **Aetna.com**, to find other policies and procedures that are not documented in this manual.

A word about compliance
The policies and information stated in this manual should align with the terms of your agreement with us. If they don't, the terms of your agreement override this manual.

You're responsible for complying with all applicable laws and regulations. We may issue notifications regarding legal requirements as laws or regulations change. However, you're responsible for compliance regardless of whether we've issued a notification.

State or federal laws, regulations or guidance may include requirements that this manual doesn't mention. In that event, those requirements apply to you and/or to us. If those requirements are not consistent with — or are more stringent than our policies and procedures — they may override the policies and procedures in this manual.

Changes and updates

When things change, we'll let you know
By providing us with your email addresses, we can contact you with important information, such as updates about our members and group health plans. Likewise, we update this manual annually and as needed. When we make changes that affect you, such as to clinical policies, procedures, plan names or ID cards, we'll let you know. We'll notify you either by mail, by email or by OfficeLink Updates™, our provider newsletter. If your office hasn't heard from us or your contact information has changed, let us know.

Our newsletter is published quarterly — March 1, June 1, September 1 and December 1. It can include changes to policies that may affect your practice or facility.

Note: OfficeLink Updates is available via email and on **Aetna.com**, in the "Health Care Professionals" section.

New to the Aetna® network?

We have tools and resources to introduce you to working with us.

- **Aetna at a Glance:** This quick reference guide will help you learn about various tools and transactions. It also has key contact information.
- **Aetna Benefits Products booklet:** This handbook contains information on Aetna benefits products. It includes primary care physician (PCP) selection, referral requirements and precertification instructions. To find these tools, just go to **Provider Manuals**.
- **Provider portal:** You'll notice the term "**provider website**" used throughout this manual. You can perform most electronic transactions through this website. That includes submitting professional claims, checking patient benefits and eligibility, requesting precertifications, making edits to existing authorizations and submitting clinical information. You must register to use the website. Just go to **Availity.com**, select "Register" and then follow the instructions.

Webinars: On our provider site, you can **sign up for webinars** and learn how to work with us.

Local network information

Regulations and Aetna program requirements will vary from state to state. You can find regional information in our regional manual supplements at **Provider Manuals**. They include some market-specific information and provide access to important contacts, including website addresses, telephone and fax numbers.

Note: The term "precertification" (used here and throughout the office manual) means the utilization review process used to determine if a requested service, procedure, prescription drug or medical device meets our clinical criteria for coverage. It does not mean precertification as defined by Texas law. Texas law defines precertification as a reliable representation of payment of care or services to fully insured health maintenance organization (HMO) and preferred provider organization (PPO) members.

Provider data demographic

It is important for you and Aetna to keep your information current and to periodically confirm its accuracy upon request. We may need to take corrective action if you don't notify us of your changes (e.g., changes in notice address, location, staff and demographics) within a reasonable time frame.

Provider office panel status changes

Use the following steps to change your office's enrollment status.

- Send a letter to your local Aetna office notifying us of your request. For the mailing address, call your local Aetna office or **1-800-872-3862 (TTY: 711)**. There are two exceptions to this rule:
  1. In Oklahoma and Texas, mail correspondence or call our Provider Contact Center at **1-800-624-0756 (TTY: 711)**.
  2. In Connecticut, Massachusetts, Maine, New Hampshire, New York, northern New Jersey, Rhode Island and Vermont, contact the Provider Contact Center at **1-800-624-0756 (TTY: 711)**.
- Indicate the status you are requesting for your office.
  - Open: Your office is open and accepting all Aetna members.
  - Accepting current patients only: Your office is not accepting any new Aetna members unless the member is currently a patient in your practice.
  - Frozen: Your office is not accepting any new Aetna members as patients even if the patient is currently a patient in your practice under another type of coverage. ("Frozen" status does not apply to primary care offices in Connecticut, Massachusetts, Maine, New Hampshire, New Jersey, New York, Rhode Island and Vermont.)

Closed panel

A broad selection of physicians is important to our members. And they expect the physicians listed in our directories to be available. Therefore, we require:

- 90-day advance written notice of a change in the enrollment status of an office
- That if you decline to accept new members as patients, you won't accept additional members from any insurer, entity or organization which competes with us

Provider roster requirements

This section outlines the standards and requirements for any provider that submits a roster of providers to us for loading into our systems. This includes our online provider search tool, DocFind®.

Delegated Entity

"Delegated Entity" or "Delegate" is a hospital, group practice, credentials verification organization (CVO) or other entity that we have given the authority to perform specific functions. These include credentialing, claims handling, medical management or other clinical and administrative functions.

When these responsibilities are delegated to you, you are known as the "Delegated Entity." A Delegated Entity must be compliant with our policies and continue to maintain compliance. Should we find that a Delegated Entity is noncompliant with the standards (as laid out below), the Delegated Entity risks its delegated status and we may revoke any or all delegated activities.

The information contained on rosters directly impacts our provider directories and other systems and must be accurate, updated and complete before we will accept the roster. We will analyze and score each roster received and will return poor-quality rosters with an explanation. We expect the errors to be corrected and the roster sent back to us.

Continued submission of incorrect roster information may result in:

- Our refusal to accept any further rosters from your group
- Potential termination of delegate status
- A requirement for your group to directly attest to your data on a quarterly basis through one of our vendors
- Financial penalties if your group remains noncompliant

Noncompliance will be measured based on vendor attestations. We will provide several warnings and opportunities to rectify noncompliant status.

Delegated Entity requirements

1. Delegates or other groups who are approved by us to submit rosters are required to submit a complete and accurate roster in Excel or similar format. Word and PDF files are not acceptable. Examples of roster fields are listed in number 2.
   a. Approved provider groups and entities will submit to us:
      - A monthly roster with adds, changes and deletions
      - A quarterly roster that includes all providers
   b. We'll ask approved provider groups and entities to correct rosters we returned because:
      - We could not intake and process them
      - They contain formatting issues
   c. Approved provider groups and entities are required to contact each provider in their network at least once a quarter to validate that their demographic information is correct.
   d. We will measure the quality of the roster. Rosters determined to be of low quality (incorrect information or missing information or using an unacceptable format) will be returned to the provider group or entity.
   e. In the event of noncompliance, we may take action. This action may include but not be limited to:
      - A request for corrective action plans
      - Omission of providers from the search tool
      - Our refusal to accept any future rosters from the provider group or entity

2. Roster fields

   The roster shall contain separated fields for each element. This includes but is not limited to the following elements:

   - Tax ID number
   - Tax ID owner name
   - Provider last name
   - Provider first name
   - Provider middle initial
   - National Provider Identifier (NPI) number
   - NPI type
   - Specialty
   - Medicare number
   - Medicare expiration date
   - U.S. Drug Enforcement Administration (DEA) registration number
   - DEA registration number expiration date
   - State license number
   - State of issue
   - State license expiration date
   - Service location street address
   - Service location city
   - Service location state
   - Service location ZIP code
   - Service location appointment phone number
   - Service location fax number
   - Service location email
   - Accepting new patients (Y or N)
   - Languages spoken by staff
   - Office hours
   - Accessible to persons with disabilities
   - Age treated
   - Gender treated
   - Billing location street address
   - Billing location city
   - Billing location state
   - Billing location ZIP code

Helpful links

Here are the websites to use to access related content and information.

Website	Link
Aetna	**Aetna.com**
Aetna Compassionate Care℠ program	**AetnaCompassionateCare.com**
Aetna Medicare	**AetnaMedicare.com**
The Aetna medication search tool (formulary)	**Aetna.com/fse/plantype.do?businesssectorcode=CM**
The Aetna provider website	**Availity.com**
Aetna Signature Administrators®	**Aetna.com/healthcare-professionals/documents-forms/aetna-signature-administrators.pdf**
The Aetna site for health care professionals	**Aetna.com/health-care-professionals/provider-education-manuals.html**
Aetna Women's Health℠ program	**WomensHealth.Aetna.com**
CAQH®	**CAQH.org**
Coventry	**DirectProvider.com**
Coventry Auto Solutions	**CoventryAutoSolutions.com**
Coventry Health Care Workers Compensation, Inc.	**CoventryWCS.com/content/Menu/Home/Providers.html**
Drug formularies	**Aetna.com/health-care-professionals/clinical-policy-bulletins/pharmacy-clinical-policy-bulletins.html**
First Health and Cofinity	**ProviderLocator.firsthealth.com/home/index**
Harvard Health	**Health.Harvard.edu**
Online referral search tool	**Aetna.com/docfind**

Key contacts

Here are the numbers to call for questions or requests on behalf of your patients.

Department	Contact information
Provider Contact Center • Member eligibility and benefits • Claim status and questions • Patient management • Precertification	For HMO-based and Aetna Medicare Advantage plans: **1-800-624-0756 (TTY: 711)** For all other plans: **1-888-MD-Aetna (TTY: 711)** or **1-888-632-3862 (TTY: 711)**
Aetna Credentialing Customer Service Department	**1-800-353-1232 (TTY: 711)**
Aetna Health Connections℠ Disease Management program	**1-866-269-4500 (TTY: 711)**
Aetna Signature Administrators®	Refer to the member ID card.
Aetna Specialty Pharmacy® self-injectable medication mail order	Phone: **1-866-782-2779 (TTY: 711)** Visit our **website**.
Aetna Student Health℠ plans	Visit our **website**.
Aetna Voluntary Plans and Limited Benefits Insurance Plan (formerly "Aetna Affordable Health Choices")	**1-888-772-9682 (TTY: 711)**
Aetna Maternity Program	**1-800-272-3531 (TTY: 711)**
Behavioral health services	**1-888-632-3862 (TTY: 711)**
Breast Health Education Program	**1-888-322-8742 (TTY: 711)**
BRCA Genetic Testing program (genetic testing for breast and ovarian cancers)	**1-877-794-8720 (TTY: 711)**
Coventry Auto Solutions	**1-800-937-6824**
Coventry Health Care Workers Compensation, Inc	**1-800-937-6824**
CVS Caremark Mail Service Pharmacy™	Phone: **1-888-792-3862** Fax: **1-800-378-0323**

Department	Contact information
Dispute submission Write to the PO box listed on the Explanation of Benefits (EOB) statement or the denial letter related to the issue you're disputing. Include the reason(s) for the disagreement.	HMO-based and Aetna Medicare Advantage plans: **1-800-624-0756 (TTY: 711)** All other plans: **1-888-MD-Aetna (TTY: 711)** or **1-888-632-3862 (TTY: 711)** **Note:** Callers should have the EOB statement and the original claim for reference.
Infertility program	**1-800-575-5999 (TTY: 711)**
Informed Health® Line	**1-800-556-1555 (TTY: 711)**
Medicare expedited organization determinations (EODs)	Fax: **860-754-5468** **Note:** Use this fax number only for Medicare EODs. For non-expedited requests and all requests for Part B medical injectable items, continue using your current process.
Medicare Service Center	**1-800-624-0756 (TTY: 711)**
Mental health and substance abuse (provider services)	Refer to the member ID card
Meritain Health®	Refer to the member ID card
National Medical Excellence Program® (transplants)	**1-877-212-8811 (TTY: 711)**
Pharmacy management precertification	Commercial plans: Phone: **1-855-240-0535 (TTY: 711)** Fax: **1-877-269-9916** Med D pharmacy management precertification: Phone: **1-800-414-2386 (TTY: 711)** Fax: **1-800-408-2386** Specialty drug precertification: Phone: **1-866-503-0857 (TTY: 711)** Fax: **1-888-267-3277** Medicare part B fax: **1-844-268-7263** Go **online**.

Electronic solutions

From the time a member schedules an appointment through the claim payment, we're committed to making it easy for your office or practice to work with us electronically. Take advantage of our suite of electronic transactions and increase your office's efficiency. Below are key features and benefits of our electronic transactions.

Note: If you perform transactions through a vendor other than our **provider website** on Availity®, functionality may vary.

Eligibility and benefits inquiry

Our Eligibility and Benefits Inquiry transaction enables you to request patient eligibility status quickly and easily. It can help you:

- Verify member eligibility and demographics
- Find detailed financial information, including deductible, copayment and coinsurance for individual and family levels

Patient cost estimator*

Our patient cost estimator tool enables you to request estimates for patients on, or prior to, the date of service so you can:

- Learn our estimated payment amount
- Get reliable estimates of patient copayments, coinsurance and deductibles
- Access printable information to help guide financial discussions with patients prior to (or at the time of) care
- Reduce, and possibly remove, after-the-fact financial surprises for you and your patients

Precertification adds, inquiries and updates

Our Precertification Add and Precertification Inquiry transactions are quick, easy ways to request or check the status of a precertification. Benefits include:

- The ability to access all Aetna benefits plans 24 hours a day, Monday through Saturday
- The ability to determine if medical precertification is required via the precertification code search tool
- For Precertification Inquiry, the ability to confirm whether a valid precertification is present and to check the status of previously submitted requests
- The ability to make updates to a precertification before the date of service through our **provider website** on Availity

  Complete a Precertification Inquiry transaction and click on the Amend link in the upper right corner of the response. From there you can:

- Change an admitting or attending provider, facility or vendor
- Add up to five new diagnosis codes or a note in the comments field (there is space for 264 characters)
- Update or change admission details, such as changing the admit date or adding a discharge date
- Add, update or cancel up to five procedure codes and the associated details
- Make additional changes like canceling an already-submitted request and adding an end date to an initial request (as long as the request isn't more than 180 days from the date of service)
- Submit clinical information in support of pending and new precertification requests and open concurrent review cases.

  Providers can upload supporting information (like medical records) through our **provider website** on Availity using a Precertification Submission or Precertification Inquiry transaction or through Precertification Status Updates. Users can upload up to 10 documents at a time of 16 MB each by clicking the Attach button. We accept the following file types:

  - Microsoft® Word (.doc, .docx)
  - Microsoft® Excel® (.xls, .xlsx)
  - Adobe® PDF (.pdf)
  - Images (.gif, .jpg, .jpeg, .png, .tiff)
  - Text (rtf)

  Documents are uploaded securely, so you don't need to password-protect them. By uploading clinical information electronically, you no longer need to fax or mail requested information to us.

*The patient cost estimator does not apply to any Aetna Medicare Advantage plans.

Referral add and inquiry

Referral Add and Referral Inquiry transactions are quick, easy ways to request or check the status of a referral. You can:

- Request referral authorization
- Inquire about the status of a referral
- Use for any Aetna plans that require a referral

Claims submissions

You can submit all claims electronically and get reimbursed faster than submitting paper claims. In doing so, you can:

- Receive an automatic acknowledgement for all submitted claims
- Submit coordination of benefits (COB) claims electronically

Go to **Aetna.com/provider/vendor** to see our claims submission vendor list. On our **provider website**, you can submit professional claims at no charge, including COB claims and corrected and voided claims.

If we pend your claim for additional information from you, you can upload your supporting documents electronically through our **provider website**. Log in and complete a Claim Status Inquiry transaction. Then, upload your documents through the Attach link. Users can upload up to 10 documents at a time of 16 MB each by clicking the Attach button. We accept these file types:

- Microsoft Word (.doc, .docx)
- Microsoft Excel (.xls, .xlsx)
- Adobe PDF (.pdf)
- Images (.gif, .jpg, .jpeg, .png, .tiff)
- Text (.rtf)

Be sure to include an electronic copy of your Explanation of Benefits (EOB) statement or Explanation of Provider Payment (EPP) as one of your documents. The EOB statement contains a code we use to route your documentation to the correct area for handling. We suggest that you complete a "Search by Patient" on the Claim EOB tool on Availity.

Documents are uploaded securely, so you don't need to password-protect them.

By uploading information electronically, you no longer need to fax or mail requested information to us. Allow us a reasonable amount of time to review your documentation and claim.

Note: This solution isn't meant to resolve claim reconsiderations or appeals. Continue to follow your normal procedures for those events.

Claims status transactions

Our claims status transactions allow you to check on the status of submitted claims. You can:

- Use Claim Status Inquiry for single member inquiries
- Use Claim Status Report to review multiple claims over a certain time period
- Request financial status as a follow-up to both Claim Status Inquiry and Claim Status Report to provide additional financial details

Rules for electronic submission

You can submit claims electronically using:

- The Health Insurance Portability and Accountability Act (HIPAA) ASC X12N 837 format for professional claims and the ASC X12N 837 format for institutional claims
- An industry standard successor format, unless your state requires another format

We ask that you use electronic real-time, HIPAA-compliant transactions for:

- Eligibility
- Precertification
- Claims status inquiry
- Referrals

Electronic funds transfer (EFT)

EFT allows you to discontinue paper checks and get your payments up to a week faster than waiting for checks to arrive in the mail. This option also allows you to:

- Save paper and manage your business effectively with a convenient audit trail
- Sign up to receive emails when payments have been transmitted to your bank

Online claims Explanation of Benefits (EOB) statements

Through our **provider website**, you can save more paper by accessing your EOB statements online. You can also:

- Access all available EOB statements online, 7 days a week, within 24 hours of claims processing

- View, download and save as a PDF, or print EOB statements
- Receive notification when EOB statements become available

Electronic remittance advice (ERA)

Our ERA transaction provides EOB statement information electronically. This allows you to:

- Automate your posting processes
- Receive separate ERAs for the same tax ID number for all associated billing addresses and National Provider Identifiers (NPIs)

Capitated providers

If you're paid on a capitated basis, you need to provide us with member encounter data. To ask for more information on submitting encounters, visit our website and select the **Contact Aetna** link.

Working through clearinghouse vendors: transactions by vendor

Learn more about our various **electronic transactions**, connectivity options and web-enabled products on our website.

You can also view a listing of our **electronic vendors** and the transactions they support.

Our products

Aetna Benefits Products booklet

The Aetna Benefits Products booklet is an easy-to-use tool that puts basic product information at your fingertips. It provides clear, concise information about our plans including:

- PCP selection and referral requirements
- Precertification instructions
- Laboratory and radiology services

You can go online to access the **Aetna Benefits Products booklet**.

Joining our network

Credentialing and recredentialing

We use a standard application and a common database called the Council for Affordable Quality Healthcare (CAQH) to gather credentialing information.

Our recredentialing process
We review a provider's qualifications, practice and performance history every three years, unless otherwise required by state and federal regulations and accrediting agency standards. This process is seamless to providers who are due for recredentialing and whose applications are complete within CAQH.

Providers whose applications aren't complete within CAQH are notified to update their credentialing data.

How to check the status of your recredentialing application
Call our Credentialing Customer Service department at **1-800-353-1232 (TTY: 711)**.

Adding a new provider or facility to your group
Go to the **Request to join the Aetna® Network section of our website to start the application process.**

Radiology accreditation

We require accreditation to be eligible for reimbursement for the technical component of advanced diagnostic imaging procedures. Accreditation can be from:

- The American College of Radiology (ACR)
- The Intersocietal Accreditation Commission (IAC)
- The Joint Commission (TJC), and/or RadSite

The following types of providers require this accreditation:

- Independent diagnostic testing facilities
- Freestanding imaging centers
- Office-based imaging facilities
- Physicians
- Nonphysician practitioners

• Suppliers of advanced diagnostic imaging procedures

For these purposes, advanced diagnostic imaging procedures exclude X-ray, ultrasound, fluoroscopy and mammography. Included are:

• Magnetic resonance imaging (MRI)

• Magnetic resonance angiography (MRA)

• Computed tomography (CT)

• Echocardiograms

• Nuclear medicine imaging, such as positron emission tomography (PET)

• Single photon emission computed tomography (SPECT)

Note:
Providers not accredited by the ACR, IAC, TJC and/or RadSite will not be eligible for payment for advanced diagnostic imaging services. The accreditation process can take 9 to 12 months.

Provider identification numbers

To comply with HIPAA regulations, providers who are required to have an NPI should include their NPIs on HIPAA standard transactions.

The HIPAA standard transactions are:

• Claims

• Eligibility and Benefits Inquiry

• Claims Status Inquiry

• Precertification add

• Referral add

In addition to an NPI, claims must also include the billing provider's tax identification number (TIN).

Share your National Provider Identifier (NPI)
If you're a provider who's required to have an NPI, make sure you include **this link** to share NPIs with us. In addition, share your NPI with other providers who may need it to conduct electronic claims, referrals or precertification requests.

Aetna provider identification number (PIN)
Physicians, hospitals and health care professionals contracted with us also have an Aetna-assigned PIN, which is used in our internal systems.

You should use your NPI in electronic transactions for purposes of identifying yourself as a provider. However, you can use your PIN or TIN to identify yourself when contacting us by other methods.

Accessibility standards and participation criteria

You can find details on our standards in our **Participation Criteria**.

Primary care provider (PCP) responsibilities
PCPs will arrange the overall care and covered services for members according to their plan. This includes urgently needed or emergency services.

We have standards for member access to primary care services. Each PCP is required to have appointment availability within these time frames:

• Regular or routine care: within 7 calendar days

• Urgent complaint: the same day or within 24 hours

In addition, all participating PCPs must have a reliable 24/7 answering service or machine with a notification system for call-backs. A recorded message or answering service that refers members to emergency rooms is not acceptable. State requirements supersede these accessibility standards and are located in the Regional Office Manual Supplements.

Specialty care provider responsibilities
We have standards for member access to specialty care services. Each specialty care provider is required to have appointments available with these time frames:

• Routine care: within 30 calendar days

• Urgent complaint: the same day or within 24 hours

In addition, all participating specialty care providers must have a reliable 24/7 answering service or machine with a notification system for call-backs. A recorded message or answering service that refers members to emergency rooms is not acceptable. State requirements supersede these accessibility standards and are located in the Regional Office Manual Supplements.

Physician-requested member transfer
Some cases may require a participating physician to ask an Aetna member to leave their practice when repeated problems prevent an effective physician–patient relationship. Such requests can't be based solely on:

• The filing of a grievance, appeal, a request for external review or other action related to coverage by the patient

• High usage of resources by the patient

• Any reason that's not permitted under applicable law

You are required to take the following actions when requesting to end a specific physician–patient relationship:

- Send the patient a letter informing them of the termination. The letter should be sent by certified mail. A copy of it must also be sent to your local Aetna network manager. For the mailing address, call your local Aetna office or **1-800-872-3862 (TTY: 711)**.

In the case of a PCP, we 'll send the member a letter informing the member that he or she must select a new primary care physician and providing instructions on how to select another primary care physician.

- Support the patient's continuity of care by giving them enough notice to make other care arrangements. This is consistent with the American Medical Association Code of Medical Ethics, Opinion 8.115.

In addition, upon request, within 30 days of the initial notification to the member, the physician shall:

- Provide resources or recommendations to the patient to help locate another participating physician
- Offer to transfer records to the new physician upon receipt of a signed patient authorization

Medical clinical policy bulletins

Aetna Clinical Policy Bulletins (CPBs) are internally developed policies that we use as a guide for determining health care coverage for our members. Our CPBs are written on selected clinical issues, especially addressing new medical technologies such as devices, drugs, procedures and techniques. The CPBs are used as a tool to be interpreted in conjunction with the member's specific benefits plan and after discussions with the treating physician. Our benefits plans generally exclude from coverage medical technologies that are considered experimental and investigational, cosmetic and/or not medically necessary.

CPBs are continually reviewed and updated to reflect current information.

We review new medical technologies and new technology applications regularly. We determine whether and how such technologies will be considered medically necessary and/or not experimental/investigational under our benefits plans.

Our process of assessing technologies begins with a complete review of the peer-reviewed medical literature and other recognized references concerning the safety and effectiveness of the technology. This evaluation involves analyzing the results of studies published in peer-reviewed medical journals.

We consider the position statements and clinical practice guidelines of medical associations and government agencies, including the Agency for Healthcare Research and Quality (AHRQ). When applicable, we consider the regulatory status of a drug or device, including:

- Review by the U.S. Food and Drug Administration (FDA)
- Centers for Medicare & Medicaid Services (CMS) coverage policies

We develop our CPBs from a review of relevant information regarding a particular technology. CPBs are published on our website for public reference.

Note: Under most plans, the term **"medically necessary"** refers to health care services that a physician provides to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These services adhere to the following generally accepted standards of medical practice:

- They are clinically appropriate
- They are not primarily for the convenience of the patient, physician or other health care provider
- They are not more costly than an alternative or sequence of services which are at least as likely to produce equivalent results

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. These standards are generally recognized by the relevant medical community or otherwise consistent with the standards above.

Compliance

Nondiscrimination

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of a number of factors. These include:

- Race
- Ethnicity
- Gender
- Creed

- Ancestry
- Lawful occupation
- Age
- Religion
- Marital status
- Sex
- Sexual orientation
- Gender identity
- Mental or physical disability
- Medical history
- Color
- National origin
- Place of residence
- Health status
- Claims experience
- Evidence of insurability (including conditions arising out of acts of domestic violence)
- Genetic information
- Source of payment for services
- Status as private purchasers of a plan or as participants in publicly financed programs of health care services
- Cost or extent of Provider Services required
- Medicare or Medicaid beneficiary status

All participating physicians should have a documented policy regarding nondiscrimination.

All participating physicians or health care professionals may also have accommodation obligations under the federal Americans with Disabilities Act. The Act requires that they provide physical access to their offices and reasonable accommodations for patients and employees with disabilities.

There are additional requirements for physicians or health care professionals that are covered entities under the Section 1557 Nondiscrimination in Health Programs and Activities Final Rule.

They are required to provide access to medical services, including diagnostic services, to an individual with a disability.

Participating physicians or health care professionals may use different types of accessible medical diagnostic equipment. Or ensure they have enough staff to help transfer the patient, as may be needed, to comply.

Members rights and responsibilities
We want you to have a good relationship with our members and vice versa. That's why we advise our members of their **rights and responsibilities** as they relate to their selection and interactions with providers.

Advance directives and the Patient Self-Determination Act (PSDA)
The PSDA is a federal law designed to raise public awareness of advance directives. An advance directive is a written statement, completed in advance of a serious illness, about how one would want medical decisions to be made for themselves if he or she is incapable of making them. The two most common forms of advance directives are the Living Will and the Durable Power of Attorney for Health Care.

The Centers for Medicare & Medicaid Services (CMS) strongly urges all practitioners to include documentation in the medical record regarding whether a Medicare member has completed an advance directive. This is also an Aetna medical record documentation requirement.

The patient should complete the Advance Directive Notification Form. We recommend that each patient return this form to their PCP so that it may be placed in their medical file.

We encourage you to discuss advance directives with your patients.

Note: The PSDA impacts all Aetna members over the age of 18.

Informed consent
All participating physicians and other health care professionals should:

- Understand and comply with applicable legal requirements regarding patient informed consent
- Adhere to the policies of the medical community in which they practice and/or hospitals where they have admitting privileges

In general, it's the participating physician's duty to:

- Give patients adequate information
- Be reasonably sure the patient understands this information before treating them

Rights and responsibilities: commercial plan members
We inform our commercial plan members that they have the following rights and responsibilities.

Information

- Know the names and qualifications of health care professionals involved in your medical treatment.
- Get up-to-date information about the services covered or not covered by your plan and any limitations or exclusions.
- Know how your plan decides what services are covered.
- Get information about copayments and fees that you're required to pay.
- Get up-to-date information about the health care professionals, hospitals and other providers that participate in the plan.
- Be advised how to file a complaint or appeal with the plan.
- Know how the plan pays network health care professionals for providing services to you.
- Receive information about your medications. This includes what the medications are, how to take them and their possible side effects.
- Receive as much information about any proposed treatment or procedure as you may need in order to consent to or refuse a course of treatment. Except in an emergency, this information should include:
  - A description of the proposed procedure or treatment
  - The potential risks and benefits involved
  - Any alternate course of treatment (even if not covered) or nontreatment and the risks involved in each
  - The name of the health care professional who will carry out the procedure or treatment
- Be informed about continuing health care requirements after you're discharged from inpatient or outpatient facilities.
- Be informed if a health care professional plans to use an experimental treatment or procedure in your care. You have the right to refuse to participate in research projects.
- Receive an explanation about noncovered services.
- Receive a prompt reply when you ask the plan questions or request information.
- Receive a copy of the plan's Member Rights and Responsibilities statement.

Access to care

- Obtain primary and preventive care from the primary care physician you chose from the plan's network.
- Change your primary care physician to another available primary care physician who participates in the plan.
- Get necessary care from participating network specialists, hospitals and other health care providers.
- Be referred to participating network specialists who are experienced in treating your chronic illness.
- Be told by your health care professionals how to schedule appointments and get health care during and after office hours. This includes continuity of care.
- Be told how to get in touch with your primary care physician or a back-up physician 24 hours a day, every day.
- Call **911** or go to the nearest emergency facility when you could reasonably expect that the lack of immediate medical care could seriously endanger your health.
- Receive urgently needed, medically necessary care.

Freedom to make decisions

- Use these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, genetic information or source of payment for your care.
- Have any person who has legal responsibility to make medical care decisions for you make use of these rights on your behalf.
- Refuse treatment or leave a medical facility, even against the advice of doctors (providing you accept responsibility and the consequences of the decision).
- Complete an advance directive, Living Will or other directive and give it to your health care professionals.
- Know that you or your health care professional cannot be punished for filing a complaint or appeal.

Personal rights

- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when permitted by law or with your approval.
- Be involved in deciding on the kind of care you do or do not want.

Input

- Have your health care professional's help when:
  - You must decide about the need for services
  - You are involved in the complaint process
- Suggest changes to us regarding your plan's policies and services, including our Member Rights and Responsibilities policy

As an **Aetna commercial plan member**, you have a responsibility to:

Exercise your rights

- Choose a primary care physician from the plan's network and form an ongoing patient-physician relationship.
- Help your health care professional make decisions about your health care.

Follow instructions

- Read and understand your plan and benefits. Know your copayments and what services are covered and what services are not covered.
- Follow the directions and advice you and your health care professionals have agreed upon.
- See the specialists your primary care physician refers you to.
- Make sure you have the correct authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Show your member ID card to health care professionals before getting care from them.
- Pay the copayments required by your plan.
- Promptly follow your plan's complaint procedures if you believe you need to submit a complaint.
- Treat doctors and all providers, their staff and the staff of the plan with respect.
- Do not be involved in dishonest activity directed to the plan or any health care provider.

Communicate

- Tell your health care professionals if you don't understand your treatment or how to care for your illness.
- Tell your health care professional promptly when you have unexpected problems or symptoms.
- Consult with your primary care physician for referrals to nonemergency covered specialist or hospital care.
- Understand that network doctors and other health care professionals who care for you are not employees of Aetna and that we don't control them.
- Call the Aetna Member Services Department about your plan if you don't understand how to use your benefits.
- Give correct and complete information to doctors and other health care professionals who care for you.
- Tell Aetna about other medical insurance coverage you or your family members may have.
- Ask your treating doctor about all treatment options, and how we pay them.

You may have additional rights and responsibilities depending upon any state law applicable to your plan.

Rights and responsibilities for Aetna Medicare Advantage HMO and PPO plan members *with* a prescription drug benefit

We inform our Aetna Medicare Advantage HMO and PPO plan members with a prescription drug benefit included in the plan design that they have the following rights and responsibilities.

Information

- Get information about our plan. This includes information about how we're doing financially, and how our plan compares to other Medicare health plans.
- Get information about our network providers, including our network pharmacies.
- Have questions from non-English-speaking beneficiaries answered. We make individuals and translation services available. And the information we provide about our benefits must be accessible and appropriate for people who are eligible for Medicare because of disability.
- Get an explanation about any prescription drugs and Part C medical care or service not covered by our plan.
- Receive in writing:
  - Why we will not pay for or approve a prescription drug or Part C medical care or service
  - How you can file an appeal to ask us to change this decision even if you obtain the prescription drug or Part C medical care or service from a pharmacy or provider not in the Aetna network
- Receive an explanation about any utilization management requirements, such as step therapy or prior authorization, which may apply to your plan.
- Make a complaint if you have concerns or problems related to your coverage.
- Be treated fairly (that is, not retaliated against) if you make a complaint.
- Get a summary of information about the appeals made by members and the plan's performance ratings, including how it's been rated by plan members and how it compares to other Medicare health plans.
- Get more information about your rights. If you have questions or concerns about your rights and protections, you can:
  - Call Aetna Member Services.
  - Get free help and information from your State Health Insurance Assistance Program (SHIP).

- Visit **Medicare.gov** to view or download the publication. It's available at **Medicare.gov/Publications**.
- Call **1-800-Medicare (1-800-633-4227)** 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- Call the Office for Civil Rights at **1-800-368-1019** if you think we've treated you unfairly or not respected your rights. TTY users should call **1-800-537-7697**.

Access to care

- Choose a network health care provider. If you're a member of a Medicare PPO plan or PPO plan with an Extended Service Area, you have the right to seek care from any health care provider in the United States who is eligible to be paid by Medicare and agrees to accept the plan. You may pay more for services obtained from an out-of-network provider.
- Go to a women's health specialist in our plan (such as a gynecologist) without a referral.
- Get timely access to providers. "Timely access" means getting services within a reasonable amount of time.
- Get your prescriptions filled within a reasonable amount of time at any network pharmacy.

Freedom to make decisions

- Get full information from your health care providers when you go for medical care. This includes knowing about all of the treatment options that are recommended for your condition, no matter the cost or whether they're covered by our plan.
- Participate fully in decisions about your health care. Your health care providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter the cost or whether they're covered by our plan.
- Know about the different medication therapy management programs you may join.
- Be told about any risks involved in your care.
- Be told beforehand if any planned medical care or treatment is part of a research experiment. You must be given the choice to refuse experimental treatments.
- Refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication.
- Receive a detailed explanation if you think a health care provider has denied care you believe you were entitled to receive or should continue to receive. In these cases, you must request an initial decision, called an "organization determination."
- Ask someone such as a family member or friend to help you with decisions about your health care. You may fill out a form to give someone the legal authority to make medical decisions for you.
- Give your doctors written instructions about how you want them to handle your medical care. This includes "Advanced Directives," a "Living Will," and a "Power of Attorney for Health Care," if you become unable to make decisions for yourself. You can contact Aetna Member Services to ask for the forms.

Personal rights

- Be treated with dignity, respect and fairness at all times. We must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, mental or physical disability, religion, gender, sexual orientation, health status, ethnicity, creed, age, claims experience, medical history, genetic information, evidence of insurability, geographic location within the service area or national origin. Receive privacy of your medical records and personal health information according to federal and state laws that protect the privacy of your medical records and personal health information. There are exceptions allowed or required by law, such as the release of health information to government agencies that are checking on quality of care.
- Receive a written notice called a "Notice of Privacy Practice" that tells you about privacy of your medical records and personal health information rights and explains how we protect the privacy of your health information.
- Look at medical records held at the plan, and get a copy of your records.
- Ask us to make additions or corrections to your medical records.
- Know how we've given out your health information and used it for nonroutine purposes.
- Get information from us about our network pharmacies, providers and their qualifications, as well as information about how we pay our doctors.
  - For a list of the providers and pharmacies in the plan's network, see the Provider Directory. For more detailed information about our providers or pharmacies, visit **AetnaMedicare.com** or call Aetna Member Services.

Input

- Suggest changes in the plan's policies and services, including our Member Rights and Responsibilities policy.

As a member in a Medicare Advantage HMO and PPO plan **with a prescription drug benefit** included in the plan design, you have a responsibility to:

Exercise your rights

- Learn about your coverage and the rules you must follow to get care as a member.

Follow instructions

- Unless it's an emergency, when seeking care, let health care providers know that you're enrolled in our plan. And, be sure to present your member ID card to them.
- Give your doctor and other health care providers the information they need to care for you.
- Follow the treatment plans and instructions that you and your doctors agree on.
- Act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals and other offices.
- Tell our plan if you have additional health insurance or drug coverage and use all of your insurance coverage.
- Pay your plan premiums and copayments/coinsurance for your covered services.
- Pay for services that aren't covered.

Communicate

- Ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Tell your doctor or other health care providers that you're enrolled in our plan. Show your member ID card whenever you get your medical care or Part D prescription drugs.
- Let us know if you move.
- Let us know if you have any questions, concerns, problems or suggestions.

Rights and responsibilities for Aetna Medicare Advantage HMO and PPO plan members *without* a prescription drug benefit

We inform our Aetna Medicare Advantage HMO and PPO plan members without a prescription drug benefit, that they have the following rights and responsibilities.

Information

- Get information about our plan. This includes information about our financial condition and how our plan compares to other Medicare health plans.
- Get information about our network providers.
- Get information in a way that works for you. Our plan has people and free language interpreter services available to answer questions from non-English-speaking members. We can also give you information in Braille, in large print or other alternate formats if you need it.
- Get an explanation about any Part C medical care or service not covered by our plan. Receive in writing:
  - Why we will not pay for or approve a Part C medical care or service
  - How you can file an appeal to ask us to change this decision, even if you obtain the Part C medical care or service from a provider not affiliated with our organization
- Make a complaint if you have concerns or problems related to your coverage.
- Be treated fairly (that is, not be retaliated against) if you make a complaint.
- Get information about the appeals made by members and the plan's performance ratings, including how it compares to other Medicare health plans.
- Get more information about your rights. If you have questions or concerns about your rights and protections, you can:
  - Call Aetna Member Services
  - Get free help and information from your State Health Insurance Assistance Program (SHIP)
  - Visit **Medicare.gov** to view or download the publication. Find it at **Medicare.gov/publications?pubs/pdf/10112.pdf**.
  - Call **1-800-Medicare (1-800-633-4227)** 24 hours a day, 7 days a week. **TTY** users should call **1-877-486-2048**.
  - Call the Office for Civil Rights at **1-800-368-1019** if you think we've treated you unfairly or not respected your rights. **TTY** users should call **1-800-537-7697**.

Access to care

- Choose a network health care provider. If you're a member of a private fee-for-service plan, you have the right to seek care from any health care provider in the United States who is eligible to be paid by Medicare and agrees to accept our terms and conditions of payment.
- Get timely access to providers. "Timely access" means getting services within a reasonable amount of time.
- Go to a women's health specialist in our plan (such as a gynecologist) without a referral.
- If you have a disability and need help with access to care, just call member services.

Freedom to make decisions

- Get full information from your providers when you go for medical care.
- Participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter the cost or whether they're covered by our plan.
- Be told about any risks involved in your care.
- Be told beforehand if any planned medical care or treatment is part of a research experiment. You must be given the choice of refusing experimental treatments.
- Refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication.
- Receive a detailed explanation if your provider denied care that you believe you were entitled to receive. Or care you believe you should continue to receive. In these cases, you must request an initial decision called an "organization determination."
- Ask someone such as a family member or friend to help you with decisions about your health care. You may fill out a form to give someone the legal authority to make medical decisions for you.
- Give your doctors written instructions about how you want them to handle your medical care. This includes "Advanced Directives," "Living Will" and "Power of Attorney for Health Care," if you become unable to make decisions for yourself. You can contact member services to ask for the forms.

Personal rights

- Be treated with dignity, respect and fairness at all times. We must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's:
  - Race
  - Mental or physical disability
  - Religion
  - Gender
  - Sexual orientation
  - Health status
  - Ethnicity
  - Creed
  - Age
  - Claims experience
  - Medical history
  - Genetic information
  - Evidence of insurability
  - Geographic location within the service area
  - National origin
- Receive privacy of your medical records and personal health information according to federal and state laws that protect the privacy of your medical records and personal health information. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.
- Receive a written notice called a "Notice of Privacy Practice" that tells you about privacy of your medical records and personal health information rights and explains how we protect the privacy of your health information.
- Look at medical records held at the plan, and get a copy of your records.
- Ask Aetna to make additions or corrections to your medical records.
- Know how your health information has been given out and used for non-routine purposes.
- For a list of the providers in the plan's network, see the Provider Directory. Call Member Services or visit **AetnaMedicare.com** to find out more more information about our providers.

Input

- Suggest changes in the plan's policies and services, including our Member Rights and Responsibilities policy.

As an Aetna Medicare Advantage HMO and PPO plan member **without a prescription drug benefit**, you have a responsibility to:

Exercise your rights

- Learn about your coverage and the rules you must follow to get care as a member.

Follow instructions

- Tell your doctor or other health care providers that you're enrolled in our plan. Show your member ID card whenever you get medical care.
- Give your doctor and other health care providers the information they need to care for you.
- Follow the treatment plans and instructions that you and your doctors agree upon.
- Act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals and other offices.
- Tell our plan if you have additional health insurance and use all of your insurance coverage.
- Pay your plan premiums and copayments/coinsurance for your covered services.
- Pay for services that aren't covered.

Communicate

- If you have any questions, ask your doctors and other health care providers and have them explain your treatment in a way you can understand.
- Let us know if you move.
- Let us know if you have any questions, concerns, problems or suggestions.

Physician–member communications policy

Our contracts with participating providers do not contain "gag clauses." Nothing about the contract prevents the physicians or other health care professionals from discussing issues openly with their patients. We include language in our contracts to promote open physician–member communication. The objective is to give our members the comfort of knowing their physicians and other health care professionals have the right and the obligation to speak freely with them.

We encourage providers to discuss with their patients:

- Pertinent details regarding the diagnosis of their conditions
- The nature and purpose of any recommended procedure
- The potential risks and benefits of any recommended treatment
- Any reasonable alternatives to such recommended treatment

Verifying member eligibility and benefits

How to interpret a member ID card

There are several types of cards, which differ by member ID number style and copayment information. The information on member ID cards may also vary depending on several factors, like the plan sponsor's benefits selections, state mandates and plan availability.

For certain products (for example, Workers' Compensation and Coventry Auto Solutions), there are no member ID cards. Contact the payer (the claims adjuster, if known) or employer to confirm.

Member identification and verification of eligibility

The following are ways to identify whether a patient is an Aetna plan member.

Digital ID cards

Twenty-four hours after the plan effective date, members can access and view their digital ID cards on their member website, **Aetna.com**, and on the Aetna Health℠ mobile app. Members can easily print replacement ID cards from their Aetna member website. Digital ID cards are identical to plastic ID cards. Providers can also view an electronic version of the member's physical ID card. ID cards allow you to easily see all the information you need and verify the patient's eligibility at the same time. You can view your Aetna patient's ID card right from our **provider website**.

Member ID cards

- Members should receive an ID card within four weeks of enrollment. At each visit, the health care provider's office should ask to see the member's ID card and collect the appropriate copayment, as applicable. Note: Some members will have digital ID cards. These members may present their mobile device or a printed copy when getting care.
- Members can access and print some of the information that appears on their ID card via the Instant Eligibility feature on their Aetna member website, including:

- Member ID number
- Member name
- Group number
- Member Services telephone number(s)
- Claims address

• Providers can access and print member ID cards from our **provider website**.
  - To access the electronic image of the card, the user must first submit an eligibility request for a member.
  - When a successful eligibility response is returned, a tab which contains an image of an ID card will display on the screen.
  - The user can click the image to view a copy of the actual member ID card.

A paper or digital version of the member's information should be accepted in lieu of an actual member ID card.

No ID card? Use the Eligibility and Benefits Inquiry transaction. It's available on both our provider website and Availity. Enter the patient's full name and date of birth to easily find patient coverage and detailed benefits information. It's accurate and provides greater detail than the ID card.

Group enrollment form

• Members may present a copy of a group enrollment form to your office. If they do, you should accept it as a temporary ID. This temporary form is valid for 30 days after the effective date specified on the form.

• Federal Employees Health Benefits Program (FEHBP) members may present to your office:
  - A copy of the Federal Form 2809 Enrollment Form
  - An electronic confirmation of their enrollment from Employee Express or Annuitant Express.

• When accepting an allowable temporary form of identification, note the following.
  - Primary care physicians should check the form to ensure their Aetna primary care office number is designated (if applicable for the plan). If the incorrect doctor or office is listed, claims may be denied or payments may be misdirected.
  - Examine the form to verify the correct copayment.
  - Verify the plan sponsor's signature is present on the bottom of the form.
  - With the EZEnroll® online enrollment option, members may enroll with Aetna online. Members fill out the application online and send it to their employer and then the employer submits it to Aetna. As proof of enrollment, members should present an enrollment validation form printed from their personal printer. The EZEnroll option is not available to Aetna Medicare℠ Plan (HMO) members or in certain states.

Note: Aetna Open Access® HMO, Aetna Choice® POS, Aetna Choice® POS II, and Aetna Medicare℠ Plan (PPO) members are not required to select a primary care physician. However, these members are encouraged to select one so they can take advantage of certain programs that require members to access care through their primary care physicians.

Newborn enrollment

This policy applies to most plans, excluding Aetna Medicare Advantage plans. Contact Member Services for additional information on newborn enrollment.

Members are instructed to contact their human resources department to find out their employer's rule for the time frame to enroll a newborn.

Members are required to list the selected primary care office for the newborn on the newborn's enrollment form.

Note: Under Federal Employees Health Benefits (FEHB) Program guidelines, FEHB members do not need to complete an enrollment form if they are currently enrolled for "family" coverage. They should call Member Services to add additional members to a family contract.

It may take several weeks to process the newborn's member ID card once the newborn is enrolled. In the meantime, use the parent's member ID card. If the newborn does not receive his or her own member ID card after the appropriate time frame, check for a digital ID card using Availity. You can also contact our Provider Contact Center with the number on the subscriber's ID card. If the subscriber does not enroll the child as a dependent within the appropriate time frame, the subscriber must wait until their next open enrollment period to enroll the child. The child will not be eligible for coverage in the interim.

Note for primary care physicians: If your office provided routine newborn hospital care, submit your bill electronically to us. If a referral is necessary for a newborn not yet appearing on the primary office member list, use the parent's member ID number.

Verifying benefits

Use the Eligibility and Benefits Inquiry transaction to obtain member-specific plan details. Check eligibility prior to a patient's visit since coverage could have expired or been suspended. Depending on plan details, transaction fields may include:

- Copay, deductible and coinsurance
- Exclusions and limitations
- Visits used and visits remaining
- Referral and precertification requirements

Here are some tips to help you complete a transaction.

- Search using the patient's full first and last names and date of birth if you don't have the member ID number.
- Use the "Benefit Type" drop-down box to narrow down to a specific benefit.
- Under the "Eligibility" link, access your rosters for Managed Choice plan, Choice plan, and HMO capitation.

Verifying your network participation

To verify your network participation, you can use any of the options below.

- Review your contract.
- Call the Provider Contact Center.
- Go to **Aetna.com** and check the online provider search tool.

You can also visit **the search tool** directly. This search tool shows those providers that are working with us at a product level. You can also find network participation in Availity as you're viewing eligibility.

Precertification

Precertification occurs before inpatient admissions and select ambulatory procedures and services. Use our online tools to help you determine if precertification is required for a particular procedure. Then, submit precertification requests for those services.

- Precertification Code Search tool — allows you to enter up to five Current Procedural Terminology (CPT®) codes at a time to determine whether a medical precertification is required for your patient.
- Online Precertification transaction — allows you to add a precertification request for those services that require it and inquire to see if a precertification has been approved.

You can submit a precertification by electronic data interchange (EDI), through our provider website or by phone, using the number on the member's ID card.

Based on historical experience, we may sometimes allow particular providers to follow a streamlined precertification process for certain services.

Visit our website for more information on **precertification**.

Emergencies

Medical emergencies

If an Aetna member requires emergency care, they're covered 24 hours a day, 7 days a week, anywhere in the world. In the event of a medical emergency, we advise our members to follow the guidelines below when accessing emergency care. This is regardless of whether they are in or out of an Aetna service area.

- Call **911** or go to the nearest emergency facility. If a delay would not be detrimental to the patient's health, call the primary care physician.
- After assessing and stabilizing the patient's condition, the emergency facility should contact the primary care physician so they can assist the treating physician by supplying information about the patient's medical history.
- If the member is admitted to an inpatient facility, the patient, a family member or friend acting on behalf of

the patient should notify the primary care physician or Aetna as soon as possible.

- All follow-up care should be coordinated by the primary care physician, where applicable (medical only).

An "emergency medical condition" involves acute symptoms that are severe enough that someone with an average knowledge of health could expect that the absence of medical attention would result in serious harm. For pregnant women, the health of both the woman and her unborn child must be taken into consideration. State mandates may apply.

Depending on the benefits plan, members traveling outside their service area or students who are away at school are covered for emergency and urgently needed care.

Claims submitted to us by the provider that supplied care must appear to meet the standards for emergency or urgent care. Otherwise, we may need to review the records from the emergency visit. In this situation we will send a request to the treating facility for the records of the visit and notify the member of the request. If the member wishes, they may provide us with additional information regarding the circumstances of the visit.

Follow-up care after emergencies

The primary care physician should coordinate all follow-up care. In all cases, the primary care physician must record all information regarding the emergency visit in the patient's chart. We require precertification before we cover any out-of-network follow-up care, either inside or outside the Aetna service area. You can obtain precertification electronically or by calling the number on your patient's member ID card. Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.

Note: State regulations and contractual provisions regarding emergency admissions may, in some cases, overrule the procedures described above.

Claims and billing

Member billing

Billing members for noncovered services — consent requirements

All of our member plans include certain exclusions. Common exclusions include services that are considered experimental and/or investigational (see **Medical Clinical Policy Bulletins** for examples). Of course, services that are not medically necessary are also generally excluded.

It's very important that our members have a clear understanding of their financial responsibilities before they accept services their plan does not cover. **For this reason, we look to you to inform them if their plan does not cover those services**. If you're uncertain whether a service is covered, call us before providing the service.

If you intend to provide a noncovered service to one of our members, we require that you do both of the following prior to providing the service:

1. Notify the member that their insurance will not cover the service. To avoid misunderstandings, we strongly recommend you provide this notification in writing at each specific occurrence of a noncovered service. A general financial responsibility form is not sufficient.
2. Obtain the member's signature to a written consent statement that says they:
   - Understand the service is not covered by their insurance
   - Agree to be financially responsible for the cost of the service.

It's important that you retain this signed consent statement. In the event of a dispute, we may hold you financially responsible if you can't produce it.

Billing and balance billing members

You may bill or charge our members applicable copayments, coinsurance and/or deductibles. Your provider contract addresses the circumstances under which you can bill our members.

However, we want to protect our members from unnecessary or inappropriate billing. Therefore, you may not balance bill members when any of the following occur.

- Claims are denied for administrative reasons such as lack of referral or authorization when one was required.
- There is a dispute or payment delay involving a payer (for example, a self-funded plan sponsor). If there is an issue with a payer, we require that you contact our Provider Services, advise them of the situation and see if they can provide guidance on the best way to move forward.

If a member is incorrectly balance billed, we ask you to remedy the situation. We may terminate you as a network provider if you incorrectly balance bill our members.

Other billing situations

- **Billing an Aetna member who has exhausted their benefits:** When a member has exhausted their benefits, you cannot charge them more than the contracted rate if you continue to see them. For example, if a plan covers 10 visits but you provide 12. In this situation, you cannot bill the member more than the contracted rate for the 2 extra visits. And as noted above, you are also required to:
  - Notify the member that their insurance does not cover the 2 extra visits
  - Obtain the member's prior written consent to pay for the 2 extra visits
- **Billing Aetna members for services we denied:** We may adjust or deny payment of covered services upon utilization management (UM) review. You cannot bill a member for a service that we denied as a result of our UM review. If your bill for a covered service is adjusted because of a UM or bill review, you cannot balance bill the member for the amount that we do not pay.

  An example of this would be if a member is approved to stay in a hospital for 8 days but the hospital does not release them for 10 days. In this situation:
  - We will not cover the 2 extra days
  - The hospital cannot bill the member for the 2 extra days
- **Billing Aetna members who were not with Aetna when services were provided:** You may bill or charge individuals who were not our members at the time that you provided services.

Initiating a collection action against a payer

We require that you provide written notice before you initiate any collection action against a payer (for example, a self-funded plan sponsor). We require that this notice:

- Be given to us and to the payer
- Be given at least 30 days in advance of the collection action

Concierge medicine

Concierge care is where a provider charges a membership or other fee for a patient to access services or amenities.

We do not cover membership or administrative fees for concierge care. And we discourage the provision of concierge care services by participating providers.

You may charge concierge fees to our members under the limited circumstances described in the next paragraph. However, participating providers may not charge concierge fees for a plan member to access covered services and/or standard administrative services. In other words, you can't charge a member an annual fee to join or remain in your practice. You also can't charge a separate concierge fee for any standard administrative services, such as prescription orders or renewals, referrals, medical record maintenance, or returning phone calls.

While discouraged, you may charge reasonable concierge fees for a member to access other amenities, such as a fee in return for preference in scheduling appointments. You can't ever discriminate against our members in concierge pricing and you can't bill our members more than you bill any other members for concierge services. Of course, all concierge fees must comply with all applicable state and federal laws and regulations. And you may never bill the member's plan for concierge fees.

If your practice is going to charge concierge fees, you must inform your Aetna Network Manager in advance. We reserve the right to indicate whether a provider practices concierge care in our provider search tool and other materials. Concierge fees are prohibited for Aetna Medicare Advantage members.

Claims information

Go to **Aetna.com/health-care-professionals/claims-payment-reimbursement.html** to find all our claims, payment and reimbursement tools and guidelines.

Electronic claims submission

Submit all claims electronically for your patients, regardless of their benefits plans.

- If you are already using a vendor, add Aetna to your list of payers.
- To view a list of our participating claims vendors, visit **Aetna.com/provider/vendor**.
- Send professional claims free of charge from our provider website.

We typically do not need attachments. If we do, we'll let you know what we need. Then, you can submit your supporting documentation electronically through our provider website.

Claims submission tips
To ensure accurate and timely claims payment:

- Review rejection reports from your vendor
- Correct and resubmit rejected claims electronically through your vendor
- Ensure the member and patient names and ID numbers are correct
- Ensure procedure and diagnosis codes are valid

Disagree with a claim decision?
Write to the PO box listed on the EOB statement or the denial letter related to the issue being disputed. Include the reason(s) for the disagreement. Or call our Provider Contact Center (see Contact Information on page 9).

For more information, go to **Aetna.com**. Select "Providers." Under "Working with us," choose "Dispute & appeal process."

Claims addresses
If your practice management or hospital information system requires a claims address for submission of electronic claims, or if your office does not have electronic capabilities, refer to the table below for the claims address for your state.

Medical provider location by state	Claims mailing address
AL, AK, AR, AZ, CA, FL, GA, HI, ID, LA, MS, NC, NM, NV, OR, SC, TN, UT and WA	Aetna PO Box 14079 Lexington, KY 40512-4079
CO, CT, DC, DE, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MT, ND, NE, NH, NJ, NY, OH, OK, PA, RI, SD, TX, VA, VT, WI, WV and WY	Aetna PO Box 981106 El Paso, TX 79998-1106

- For all Aetna Medicare Advantage and Aetna Student Health℠ plans, use the El Paso, TX, claims mailing address.
- For all Aetna Voluntary Plans, use the Lexington, KY, claims mailing address and the payer ID "57604."
- For Aetna Signature Administrators® plans, Coventry Health Care Workers Compensation, Inc. plans, Meritain Health® and Schaller Anderson (Medicaid), refer to the member ID card.

Clean claims
We know it's important to you that your office gets paid promptly. To reduce payment delays, have your office submit "clean claims." A clean claim is a claim that is received in a timely manner and includes all the information we needed to process it for payment.

Unless otherwise required by law or regulation, clean claims include all of the following:

- Detailed and descriptive medical and patient data
- A corresponding referral (whether in paper or electronic format), if required for the applicable claim
- All the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to member identification number, National Provider Identifier (NPI), date(s) of service, and a complete and accurate breakdown of services)

In addition, a clean claim:

- Doesn't involve coordination of benefits
- Has no defect or error (including any new procedures with no CPT codes, experimental procedures or other circumstances not contemplated at the time of execution of your agreement) that prevents timely adjudication

Coordination of benefits

We coordinate benefits as allowed by state or federal law. If there is no applicable law, then we coordinate according to the member's plan.

Coordination of benefits (COB) establishes the order in which benefits are paid and the amount by which the secondary plan may reduce its benefits. We follow the National Association of Insurance Commissioners Model Law in establishing the order of benefits. COB ensures that the combined payments of all plans do not add up to more than the covered health care expenses.

We use two different methods to calculate COB:

1. 100% Allowable (Standard Allowable Calculation)
   - This is the method used under most state laws.
   - The benefits paid by both plans will equal no more than the total allowable expense.
   - An allowable expense is defined as any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom the claim is made.
2. Maintenance of Benefits (MOB)

- This is a method used by many self-funded plans.
- Under MOB, a secondary plan may reduce its benefits to the lesser of the following two calculations.
  - What it would have paid had it been primary plan
  - What it would have paid minus the primary plan's payment

If the primary plan benefit is:	Then:
Equal to or more than the Aetna benefit	Aetna will not pay a benefit
Less than the Aetna benefit	Aetna will pay the difference between the primary plan's benefit and the Aetna benefit

Aetna is responsible for coordinating benefits based on the member's benefits plan and applicable law. The primary carrier's negotiated fee is not used to determine normal Aetna benefits. See the following example:

Primary plan contract with physician	Aetna contract with physician
$1,500 billed charges	$1,500 billed charges
$1,000 primary plan's negotiated fee	$1,200 Aetna negotiated
x 80% coinsurance rate =	x 80% coinsurance rate =
$800 primary plan payment	$960 normal Aetna benefit – $800 primary plan's payment = $160 Aetna payment

Birthday rule
Unless a court order dictates otherwise, we follow the birthday rule for all employer groups and provider contracts regarding dependent children of parents not separated or divorced.

- The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year.
- If both parents have the same birthday, we make the determination based on length of coverage.
- The benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

Medicare Secondary Payer
Medicare Secondary Payer (MSP) is the term used by Medicare when Medicare is not responsible for paying claims first. Under MSP, an active employee of a group plan with 20 employees has the group plan as their primary payer when covered by both the group plan and Medicare. MSP also establishes rules for individuals who are disabled and for those with end-stage renal disease.

The correct order of claims determination is established by identifying the type of Aetna coverage and the reason for Medicare entitlement.

Medicare and Medicaid dual eligibles
Medicare and Medicaid "dual eligibles" are individuals who are both entitled to Medicare Part A and/or Part B **and** are eligible for some form of Medicaid benefit.

Medicare and Medicaid relationship
People with Medicare who have limited income and resources may get help paying for their out-of-pocket medical expenses from their state Medicaid program. There are various benefits that may be available to "dual eligibles." These benefits are sometimes also called "Medicare Savings Programs."

For people who are eligible for full Medicaid coverage, the Medicaid program supplements Medicare coverage by providing certain services and supplies that are covered under their state's Medicaid program. Services or supplies that are covered by both programs will be paid first by Medicare. The difference will be paid by Medicaid, up to the state's payment limit.

Medicaid also covers additional services (for example, nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses and hearing aids). Limited Medicaid benefits are also available to pay for out-of-pocket Medicare cost-sharing expenses for certain other Medicare beneficiaries.

Aetna Medicare Advantage
Dual eligibles receive their prescription drug benefit (Part D) through Medicare. Dual eligibles may enroll in stand-alone Medicare prescription drug plans (PDPs) or Aetna Medicare Advantage (MA) plans that incorporate a prescription drug benefit (MA-PDs). We offer both types of insurance products to Medicare-eligible beneficiaries.

If a dual eligible enrolls in an Aetna Medicare Advantage plan, then the provider must bill Aetna as the primary payer and the state Medicaid plan as the secondary payer. The provider must notify patients prior to providing services if the provider does not accept payments from state Medicaid plans as payment in full.

Medicare Part D plans
It is possible that an individual may be covered under both a Part D Medicare prescription drug plan and another health plan that provides prescription drug coverage or financial assistance to Medicare Part D–eligible individuals (including non-Medigap individual market insurance policies). In that event, covered benefits must be coordinated between such plans in accordance with CMS requirements and any subsequent guidance from CMS.

Note: State mandates take precedence over Aetna standards.

Working aged
The "working aged" are employed people age 65 or older, and people age 65 or older with employed spouses of any age, who have Employer Group Health Plan (EGHP) coverage because of their or their spouse's current employment.

Aetna is the primary payer to Medicare for the "working aged" if the employer group has 20 or more employees. If the employer group has fewer than 20 employees, Aetna is the secondary payer to Medicare, except for certain multi-employer plans.

Motor vehicle accident
Benefits for injuries caused by a motor vehicle accident and compensable through the Personal Injury Protection (PIP) section of the patient's no-fault automobile insurance policy are primary over Aetna. If automobile insurance is not available to the patient and Aetna policies, procedures and programs were followed, we would consider the auto-related services for coverage.

Some states give the insured an option to choose their primary coverage for PIP. If the insured elects Aetna over their automobile insurance company, we will require proof that the insured has elected Aetna as primary insurer at the time the accident occurred. All procedures must be covered services and referred by the patient's primary care physician, when applicable (excluding emergency procedures). All Aetna policies, procedures and programs must be followed for benefits consideration.

Patients who have a motor vehicle accident, and whose Aetna coverage is secondary to PIP, should still have all care coordinated through the primary care physician (if applicable). The primary care physician should issue referrals to participating physicians and health care professionals and place the information in the patient's file.

Note: Subrogation is prohibited in Virginia. When providing covered services to a patient who has been involved in a motor vehicle accident and who has a fully insured plan, providers must seek payment from the patient's health insurer first.

Claims payment policy — rebundling

We rebundle claims to the primary procedure codes for those services considered part of, incidental to, or inclusive of the primary procedure. Rebundling allows for other adjustments such as inappropriate billing or coding. Examples of these include:

- Duplicative procedures or claim submissions
- Mutually exclusive procedures
- Gender and procedure mismatches
- Age and procedure mismatches

The commercial software packages that we use include rebundling logic. This logic is based on Medicare and/or other industry standards.

Audits

Hospital bill audit

The purpose of a hospital bill audit is to review the itemized bill against the claim and the medical record. This audit is used on claims where we pay a percentage of billed dollars (charges). In addition, the audits identify items that may not have been ordered by the physician or were not supported in the medical record.

The audits exclude outpatient hospital claims paying a percent of billed dollars (charges).

Diagnosis-related group (DRG) audit

DRG audits ensure diagnosis and procedures codes are assigned accurately through medical record audits. A detailed narrative and proposed DRG revisions are presented to the provider for acceptance.

A DRG short-stay audit is a post-service, post-payment review of Medicare risk inpatient claims paid under a DRG methodology to validate that the provider appropriately billed and received payment for the setting of care in which the patient was treated.

Implant audit

Implant audits ensure providers are complying with the contract cost limitation language on implants and high cost drug reimbursement. This audit focuses on claims that bill with revenue codes 274–279. Implant audits occur through review of implant log/invoice and Medication Administration Record. A detailed narrative is sent to the provider with the audit findings.

Prepay audit

We may review our members' medical records before certain claims are processed. This review includes, but is not be limited to, itemized bills or more specific detail for claims contracted on a percentage-of-charges basis. The review may result in payment being denied for duplicate charges, errors in billing or categorization of capital equipment.

OrthoNet

We use OrthoNet to review our members' medical records before certain claims are processed. When a claim is selected for review, we'll ask the provider for copies of the patient's medical records. OrthoNet will compare the claims coding to the services provided.

Affected specialties:

- Dermatology
- Ear, nose and throat (otolaryngology)
- Hand surgery
- Neurology
- Neurosurgery
- Orthopedic surgery
- Pain management
- Physiatry
- Plastic surgery
- Podiatry
- Sports medicine
- Urology

Where to send Aetna records

If your office is asked to send records to Aetna, you can:

- Fax to: **859-455-8650**
- Mail to: Aetna, PO Box 14079, Lexington, KY 40512-4079

When faxing or mailing records, be sure to include a cover sheet with "CODE: ONET" at the top of the page. We'll also need the following information:

- Aetna member ID
- Date of service
- Servicing provider name
- Servicing provider tax identification number and/or the Aetna provider ID number

Medical records

Record keeping

Participating practitioner medical record criteria
Aetna health plans have established medical record criteria and documentation standards. Their intent is to facilitate communication and coordination of care and promote effective patient care. These criteria provide a guideline for organizing and documenting diagnostic procedures and treatments.

We expect all participating practitioners to comply with these documentation standards, as well as state laws and regulations that require biennial medical record audits. We use the same criteria to score those audits, which are as follows:

- We award one point for each element documented compliantly.
- We award zero points for those that are not compliant.

Performance goals are established to assess the quality of medical record keeping practices, and audits are conducted no less than every two years. We calculate the audit score by dividing the number of compliant points by the total number of applicable points. The performance goal is 85%.

Organization

- Each page has member's name and date of birth on it.
  - The member's name and date of birth should be recorded on each page of the medical record (for example, all notes, lab reports and consult reports). (1 point)

- The member's personal data (gender, date of birth, address, occupation, home and work phone numbers, marital status) is documented.
  - Each record must contain appropriate biographical and personal data including age, sex, race, address, employer, home and work telephone numbers, emergency contact and marital status.
  - All members must have their own chart — no family charts. (1 point)
  - A centralized medical record for the provision of prenatal care and all other services must be maintained (prenatal only). (1 point)
- All entries in the record contain the author's signature or initials or electronic identifier (stamped signatures are not acceptable).*
  - The provider of service for face-to-face encounters must be appropriately identified on medical records via their signature and their physician-specialty credentials (for example, MD, DO and DPM). Examples of acceptable physician signatures follow.
    - Handwritten signature or initials.
    - Electronic signature with authentication by the respective provider.
    - Facsimiles of original written or electronic signatures.

    This means that the credentials for the provider of services must be somewhere on the medical record — either next to the provider's signature or preprinted with the provider's name on the group practice's stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider. (1 point)
- All entries are dated. (1 point)*
- All entries are legible to someone other than the writer.*
  - The medical record should be complete and legible. Illegible medical record entries can lead to misunderstanding and serious patient injury. (1 point)
- Medications are noted, including dosages and dated status of prescription (active or discontinued) or date of initial or refill prescription.*
  - Evidence of prescribed medications, including dosages and dates of initial or refill prescriptions must be present in the record. This list should be updated each visit. (1 point)
- Medication allergy and adverse reactions or lack thereof prominently noted.*
  - Allergies and adverse reactions to medications are prominently noted in chart or the lack thereof is noted as NKA (no known allergies) or NKDA (no known drug allergies). (1 point)
- An up-to-date problem list is completed including significant illnesses and medical and psychological conditions.*
  - A problem list recorded with notations must be present and include any significant illness or medical and/or psychological condition found in the history or in previous encounters. The problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-10 diagnosis code on the date of service. A problem list should be either a classical separate listing of problems or an updated summary of problems in the progress note section (usually a periodic health exam). The latter type list should be updated at least annually and should include health maintenance. A repetitive listing of problems within progress notes is acceptable. A blank problem list receives a score of zero. (1 point)
- Past medical history is completed (for members seen three or more times) and is easily identified and includes dates of serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to dates of prenatal care, birth, operations and childhood illnesses.*
  - Past history including experiences with illnesses, operations, injuries and treatments must be documented. Family history including a review of medical event, diseases and hereditary conditions that may place the member at risk must be documented. (1 point)
- History and physical (H&P) documents have subjective and objective information for the presenting problem.*
  - Past medical history including physical examinations, necessary treatments and possible risk factors for the member relevant to the particular treatment are noted. (1 point)
- For members 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for members seen 3 or more times, substance abuse history must be queried).
  - For members 14 years and older, a score of 1 requires a response to an inquiry concerning alcohol, smoking and/or substance abuse history as part of risk screening

*This is assessed for Medical Record Keeping Practices based on guidelines from the National Committee for Quality Assurance (NCQA), CMS, insurance regulations and Aetna.

in support of preventive health. For members under the age of 14 years, the score will be N/A. (1 point)

- Note regarding follow-up care, calls and visits. Specific time of return is noted in weeks, months or as needed.
- Encounter forms or notes have a notation regarding follow-up care, calls or visits when indicated. The specific time of return is noted in weeks, months or as needed (i.e., PRN). (1 point)

• An immunization record has been initiated for children and history for adults.

- An immunization record (for children) which includes the name of the vaccine and date of administration or disease (for example, chickenpox) is up to date or an appropriate history has been made in the medical record (for adults). Member-reported data is acceptable. (1 point)

• Preventive screenings and services are offered according to Aetna guidelines.*

- There is evidence that preventive screenings and services are offered in accordance with the organization's practice guidelines. Preventive screenings specific to the member's age, gender and illness (for example, mammography, immunizations, pap (named for George Papanicolaou) smear, human papilloma virus (HPV), body-mass index (BMI) value for adults, BMI percentiles for ages 15 and under, colorectal cancer screening, diabetic eye exams) are documented. Documentation should include screening date and result. (1 point)
- For children and adolescents there should be documentation of counseling for nutrition and physical activity.

• Documentation about advance directives (whether executed or not) is in a prominent place in the member's record (except for those under age 18).*

- There is evidence of advance directives noted in a prominent place in the record (1 point) and whether or not the advance directive has been executed in the chart for members over 18 years of age. (1 point)

• Treatment plan is documented.*

- There is documentation of clinical findings and evaluation for each visit (presenting complaints, pain management, diagnosis and treatment plan, prescription, referral authorization, studies, instructions). (1 point)

• Working diagnoses are consistent with findings.*

- There is a documented reason for the visit. The progress note contains appropriate subjective and objective information pertinent to the member's presenting complaints for each visit. (1 point)

• There is no evidence that the member is at inappropriate risk. Possible risk factors for the member relevant to particular treatment are noted.*

- There is no evidence that the member is placed at inappropriate risk by a diagnostic or therapeutic procedure. Diagnostic and therapeutic procedures are appropriate for the member's diagnosis and risk factors. Examples: a) Member has complaint of right-hip pain and an X-ray of the right hip is ordered. b) Abnormal lab and imaging study results do not have an explicit note regarding follow-up plans. (1 point)

Examination

Blood pressure, weight, height, BMI value or BMI percentile measured and recorded at least annually, if the member accesses care. (1 point)

Studies

• Lab and other studies are ordered, as appropriate.

- If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the evaluation and management (E/M) encounter, the type of service — for example, lab work or an X-ray — should be documented. (1 point)

• There is evidence that the physician has reviewed lab, X-ray or biopsy results (signed or initialed reports), and the member has been notified of results before filing in the record.

- There is evidence of physician review of lab work, X-ray or biopsy results or other studies by either signing or initialing reports or documentation of the results in the progress notes. Abnormal lab and imaging study results have an explicit note regarding follow-up plans. (1 point)

Communication

• There is documentation of communications contact with referred specialist.*

- The PCP or managing practitioner coordinates and manages the care of the member. If a consultation or referral is made to a specialist, there is documentation of communication between the specialist and the PCP

*This is assessed for Medical Record Keeping Practices based on guidelines from the National Committee for Quality Assurance (NCQA), CMS, insurance regulations and Aetna.

with a notation that the physician has seen it. And there is evidence of discharge summaries from hospitals, home health agencies (HHAs) and skilled-nursing facilities (SNFs), if applicable. If there is no evidence of referral or other facility services, mark N/A. (1 point)

- There is documentation indicating the patient's preferred language (California only).*
- There is documentation of an offer of a qualified interpreter, and the enrollee's refusal, if interpretation services are declined (California only).*

Records maintenance and access

Maintenance

You need to maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards. You are required to keep our members' information confidential and stored securely. You must also ensure your staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

Member record access

We have the right to access confidential medical records of Aetna members for the purpose of claims payment, assessing quality of care (including medical evaluations and audits), and performing utilization management functions. We may request medical records as a part of our participation in the Healthcare Effectiveness Data and Information Set (HEDIS®). HIPAA privacy regulations allow for sharing of protected health information (PHI) for purposes of making decisions around treatment, payment or health plan operations.

Privacy practices

Protecting our members' health information is one of our top priorities. Our members expect and rely on us to protect their protected health information (PHI). In turn, we expect our participating physicians, facilities, and office staff to safeguard our member's PHI, and treat it with the same care and consideration.

Our references to PHI include information that relates to:

- A patient's physical or mental health or condition
- The provision of health care to the patient
- Payment for the provision of health care to the patient

Our references to PHI do not include:

- Publicly available information
- Information that is available or reported in a summarized or aggregate fashion but does not identify the patient

We use PHI internally or share it with our affiliates when it is necessary or appropriate to do so. For example, in connection with a patient's care or treatment, the operation of our health plans, or other related activities. In these circumstances, we may disclose PHI to:

- Health care professionals
- Payers, including:
  - Health care provider organizations
  - Self-funded health plans
  - Others who may be financially responsible for payment for the services or benefits patients receive under their plans)
- Other insurers, third-party administrators, vendors, consultants, government authorities and their respective agents

The ways in which we use PHI include:

- Auditing and anti-fraud activities
- Claims payments
- Compliance with legal and regulatory requirements
- Coordination of care and benefits
- Coverage reviews
- Data and information systems management
- Disease and case management
- Due diligence activities in connection with the purchase
- Early detection
- Formulary management
- Health claims analysis and reporting
- Health services research
- Litigation proceedings
- Performance measurement and outcome assessments
- Preventive health
- Quality assessment and improvement activities

*For benefits plans that require the issuance of referrals for specialist care in southern New Jersey, Pennsylvania, Maryland, Virginia and the District of Columbia, the member should be directed to their PCP for referrals for laboratory and radiology services.

- Transfer of policies or contracts to and from other insurers, HMOs, and third-party administrators or sale of some or all of our business
- Underwriting activities
- Utilization reviews and management insurers, HMOs, and third-party administrators or sale of some or all of our business

Additional information about privacy and security practices at Aetna, including the following documents, are available at the **Aetna Privacy Center**:

- The Aetna Notice of Privacy Practices by plan type
- The Aetna Web and Mobile Privacy Statement

Like Aetna, participating providers are covered entities under HIPAA. They are required to keep PHI confidential, and to adhere to their obligations under the HIPAA Privacy Rule. All health care professionals and employed staff who have access to member records or confidential member information should be made aware of their legal, ethical, and moral obligations regarding member confidentiality.

The federal Department of Health and Human Services provides helpful information. This information includes, but is not limited to, information on the obligations of Covered Entities. You can access that information here: **HIPAA for Professionals**.

Referrals

Referral policies

In benefits plans that require the issuance of referrals for specialist care, the primary care physician is responsible for coordinating their patients' health care. If it's necessary for the patient to see a specialist, other than for direct-access services or emergency care, the primary care physician must issue a referral prior to the patient's visit to the specialist.* The referral must be for covered benefits under the plan.

To confirm covered benefits, you can submit an inquiry through the Eligibility and Benefits Inquiry transaction or call the number on your patient's member ID card.

Referrals should not be retroactive. We may adjust or deny payment for retroactive referrals. If your patient visits a specialist without a referral, depending on their plan type, the patient may be responsible for payment for all services rendered or for paying a deductible and coinsurance.

In addition to the requirement that primary care physicians review every referral issued by their practice, we recommend that the initial consultative referral be authorized for one visit, except when the patient is either known to have a predicted need for more visits or involved in an ongoing process of care.

This encourages communication from the specialist to the primary care physician.

After an initial consultation, additional referrals from the primary care physician are required in the following instances:

- If the specialist wishes to provide additional services not originally requested on the referral
- If the specialist refers their patient to a second specialist
- If the specialty visits will exceed the number of visits initially authorized by the primary care physician
- If the specialty visits require an extension beyond the referral expiration date

We require specialists communicate with the referring physician in a timely fashion. After receiving the consultation report from the specialist, the primary care physician can consider the appropriate course of treatment (for example, referrals for additional services and/or follow-up care, if needed).

*Referrals in Texas are only valid for 30 calendar days. After that time, another referral is needed.

Referrals may be authorized for consultation and treatment (C&T) using CPT code "99499." In most areas, C&T referrals do not need to specify the procedures to be performed by the specialist.* Specialists will be reimbursed for any associated covered procedure performed in an office setting, in accordance with current claims processing guidelines.

Referrals do not permit specialists to refer members to another specialist for care. If this is necessary, patients must get a referral from their primary care physician to see another specialist. This referral is not a guarantee of payment. Payment is subject to eligibility on the date of service, plan benefits, limitations and exclusions, pre-existing condition limitations, and patient liability under the plan.

No plans require a referral for emergency services. Some plans do not require the issuance of a referral. In those plans, a patient may self-refer to either participating or nonparticipating physicians or other health care professionals. The patient is responsible for paying any applicable copayment, deductible and/or coinsurance for self-referred benefits. See the Utilization Management section for rules regarding preauthorization for certain services.

In Aetna Open Access® plans, referrals also are not necessary. A patient may self-refer to any participating physician/health care professional.

We may terminate our agreement if you refer members to nonparticipating providers without one the following.

1. Sound clinical reasons.
2. Our advance approval.
3. Emergency services.
4. The member's request for referral to an out-of-network provider after notice and informed consent of the patient has been documented in writing.

Member's consent for nonparticipating providers' referrals

You may arrange services with a provider that doesn't participate with us if the member's plan allows it. In that event, you should acquire the member's written consent. The consent should state the member has been advised of the following.

1. The hospital, facility, or provider is not a participating provider.
2. The member's plan may provide reduced benefits.
3. The nonparticipating provider will not be restricted to seeking payment only from Aetna. The provider may bill the member for amounts other than deductibles, copayments, coinsurance, and medical services not covered under the plan.
4. The provider has an affiliation or financial ownership interest in or with the nonparticipating provider, if that is the case.

Referral processes

Electronic referrals should be issued for all plans that require referrals (see the "Aetna Benefits Products" section). For information on submitting electronic referrals, see the "Electronic Solutions" section.

For obstetric testing or infertility services, refer to the Women's Health Programs and Policy Manual, available at **Provider Manuals**.

Note: Providers who participate with us through an independent practice association (IPA) or physician hospital organization (PHO) should consult their IPA or PHO on plan policies and procedures. Some of these referral guidelines may not apply. (Upstate New York physicians and other health care professionals: Continue to work with Aetna and/or your respective IPA in your usual manner.)

*For these purposes, "coverage" means either of the following: The determination of whether or not the particular service or treatment is a covered benefit pursuant to the terms of the particular member's benefits plan. Or the determination of where a provider is required to comply with our utilization management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement.

Utilization management

Overview

Our Care Management model integrates available programs and services. This includes case management, disease management and specialty areas such as behavioral health. Our role is to help coordinate health care and to encourage members to be informed participants in health care decision-making.

Our care management activities for hospitalized members include:

- Focused discharge planning to help with the member's transition to the next level of care
- Targeted, concurrent review of the member's hospital course of treatment to evaluate the appropriate level of coverage* for medical services

Utilization management and standards

We use utilization review to promote adherence to accepted medical treatment standards. Additionally, utilization review encourages participating physicians to minimize unnecessary medical costs consistent with sound medical judgment. We expect participating providers to adhere to the following requirements.

- Participate, as requested, and collaborate with Aetna utilization review, care management and quality improvement programs and with all other related programs (as modified from time to time) and decisions with respect to all members.
- Regularly interact and cooperate with Aetna clinicians.
- Abide by Aetna participation criteria and procedures, including site visits and medical chart reviews, and to submit to these processes biannually, annually, or otherwise, when applicable.
- Cooperate to help us review and transition members hospitalized in a nonparticipating facility to a participating facility.
- Obtain advance authorization from Aetna prior to any nonemergency admission. In addition, when a member requires an emergency hospital admission, to notify us, according to our rules, policies and procedures in effect.
- To the extent medically appropriate and required by the plan's terms, refer or admit members only to participating providers for covered services. Provide these providers with complete information on treatment procedures and diagnostic tests performed prior to the referral or admission.
- Abide by CMS's Medicare Outpatient Observation Notice (MOON) requirement provided to members and related to observation services.

You may have an Aetna patient who requires services under an Aetna specialty program. If they do, we expect you to work with us to transfer the member's care to a specialty program provider.

How to contact us about utilization management issues

- Our staff, including medical directors, are available to receive provider and member inquiries about utilization management issues. You can call us during and after business hours via toll-free phone numbers.
- Health care providers may contact us during normal business hours (8 AM to 5 PM, Monday through Friday**) by calling the toll-free precertification number on the member ID card.
- When only a Member Services number is on the card, you'll be directed to the Precertification Unit through a phone prompt or a Member Services representative.
- Members and providers may access staff on weekends, company holidays, and after business hours through the same toll-free phone numbers.

**For all continental U.S. time zones; hours of operation may differ based on state regulations. Texas: 6 AM to 6 PM CT, Monday through Friday, and 9 AM to 12 noon CT on weekends and legal holidays. Phone recording systems are in use for all other times.

Utilization review policies

Summaries of **utilization review policies**, including precertification, concurrent review, discharge planning and retrospective review are located on our public website to determine:

- Whether or not the particular service or treatment is a covered benefit under the member's benefits plan
- When a provider is required to comply with Aetna utilization management programs
- Whether or not the particular service or treatment is payable under the terms of the provider agreement

How we determine coverage

Aetna Medical Directors make all coverage denial decisions that involve clinical issues. Only Aetna Medical Directors and licensed dentists, oral and maxillofacial surgeons, psychiatrists, psychologists, and pharmacists make denial decisions for reasons related to medical necessity. (Licensed dentists, pharmacists and psychologists review coverage requests as permitted by state regulations.) Where state law mandates, utilization review coverage denials are made, as applicable, by a physician or pharmacist licensed to practice in that state.

Patient Management staff use evidence-based clinical guidelines from nationally recognized authorities to guide utilization management decisions involving precertification, inpatient review, discharge planning and retrospective review. Staff use the following criteria as guides in making coverage determinations, which are based on information about the specific member's clinical condition:

- MCGTM guidelines (Seattle, WA: MCG Health, LLC)
- Clinical Policy Bulletins (CPBs) or Pharmacy Clinical Criteria — Clinical Policy Bulletins (PCPBs) (based on peer-reviewed, published medical literature)
- Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and the Medicare Benefit Policy Manual
- National Comprehensive Cancer Network (NCCN) Guidelines (Category 1 and 2A recommendations)
- **Level of Care Assessment Tool (LOCAT)**
- Applied Behavior Analysis (ABA) Medical Necessity Guide
- The American Society of Addiction Medicine (ASAM) Criteria: Treatment for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition.

This content is copyrighted. Contact the American Society of Addiction Medicine at **ASAMcriteria@asam.org** to information about how to purchase it.

The Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers (28TAC §§3.8001-3.8030) (formerly known as TCADA), are used in place of ASAM for chemical dependency treatment provided in Texas. And The Level of Care for Alcohol and Drug Treatment Referral (LOCADTR), is used in place of ASAM for chemical dependency treatment provided in New York.

Participating physicians may ask for a hard copy of the criteria that were used to make a determination by contacting our Provider Contact Center at **1-888-632-3862 (TTY: 711)**.

We base decisions on the appropriateness of care and service. We review coverage requests to determine if the requested service is a covered benefit under the terms of the member's plan and is being delivered consistent with established guidelines. 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 incorporates state, federal, CMS and NCQA requirements. If we deny a request for coverage, the member (or a physician acting on the member's behalf) may appeal this decision through the complaint and appeal process. Depending on the specific circumstances, the appeal may be made, as applicable to:

- A government agency
- The plan sponsor
- An external utilization review organization that uses independent physician reviewers

*Precertification may be the member's responsibility in certain plan types that offer out-of-network benefits. Per Medicare laws, rules and regulations, there is no penalty to Aetna Medicare Advantage plan members if they do not get precertification.

We do not reward physicians or other individuals who conduct utilization reviews for issuing denials of coverage or for creating barriers to care or service. Financial incentives for utilization management decision-makers do not encourage denials of coverage or service. Rather, we encourage the delivery of appropriate health care services. In addition, we train utilization review staff to focus on the risks of underutilization and overutilization of services. We do not encourage utilization-related decisions that result in underutilization.

Admissions protocol

In the case of referred care, the admitting physician must electronically submit or contact us for preadmission precertification.* In the case of self-referred care, the member must contact Aetna. Our precertification staff also takes calls from hospital admissions personnel. However, if the preadmission information isn't complete, we contact the admitting physician for clarification.

If the admission is precertified for surgical cases, we assign a recommended length of stay (RLOS). This determines when a review will start. For other cases, we give specific guidelines with the admission precertification. The RLOS determination is primarily based on Milliman Care Guidelines®.

Notify us of hospital admissions within one business day

We need notice of all inpatient admissions, including those through the emergency department, within one business day of the admission. If a patient is unable to provide coverage information, you must contact us as soon as you become aware of their Aetna coverage. You must also explain any extenuating situation. You may contact us by phone (call the number on the patient's member ID card) or through electronic data interchange (EDI) through our provider website.

All-products precertification list

Precertification* is the process of collecting information before inpatient admissions and certain ambulatory procedures and services.

The process includes:

- Confirmation of member eligibility
- Assessment of medical necessity
- Communicating a coverage decision to the treating practitioner and/or member before the procedure, service or supply
- Identifying members for pre-service discharge planning
- Identifying and registering members for covered Aetna specialty programs, such as case management and disease management, behavioral health, the National Medical Excellence Program and the Aetna Maternity Program

If we need to review the applicable medical records, we may provide you with, and you need to agree to accept, a precertification reference pending or tracking number. The reference number is not an approval. You will be notified once a coverage decision is made.

Medical records may be submitted using our provider website or another approved vendor.

You can find more information about our **precertification policy** on our website.

You can also access an updated **list of services requiring precertification** on our website.

Note: The term "precertification" means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets our clinical criteria for coverage. It does not mean precertification as defined by Texas law, as a reliable representation of payment of care or services to fully insured HMO and PPO members.

*Aetna Medicare members have access to a disease management program. It includes diabetes, coronary artery disease, cerebrovascular disease and stroke and congestive heart failure. The program offers information and tools to help these members better control their conditions. For information or to refer members, call the Member Services number on the Aetna member ID card.

Member programs and resources

We offer many programs that some of your Aetna patients may benefit from. If they qualify, there's no extra charge for them to join.

We review our member's records to see who might be a good candidate for some of these programs. If we feel a member would benefit from joining, we reach out to them directly. We inform them about the program and invite them to participate. These programs are not a substitute for regular visits to a physician. They are meant to support the member's physician. Through some of these programs, we work directly with the member. If that is the case, we apprise the physician of the member's health status as appropriate.

If you feel any of your Aetna patients would benefit from one of these programs, let us know by calling the Provider Contact Center. Your Aetna patients can also contact us about these programs by calling the number on their member ID cards.

Member programs

Care management

Our care management programs are designed to help our members achieve their optimal health. Program areas include:

- Disease management
- Case management
- End of life
- Transplant
- Women's health and maternity
- Integrated clinical programs for behavioral health, disability and pharmacy, as well as wellness programs

For more information, go to **Aetna Health and Wellness**.

Disease management

Our disease management program is designed to help your patients work with their doctors. The goal is to effectively manage ongoing health conditions and improve outcomes.

Participants have access to Aetna nurses, who are available to provide education and support. Participants may also have access to some or all of the following:

- The opportunity to work one-on-one with an Aetna nurse, who acts as their "personal health coach"
- Personalized information about their current health conditions and issues
- Educational information about multiple aspects of their medical condition(s), treatment options and medications
- Support in making lifestyle changes to achieve and maintain optimal health

Our disease management programs are included in many Aetna medical plans.* They're also available to self-funded plan sponsors that can include them in their benefits offering. For additional information or to refer your patients, call the Member Services number on the member's ID card. You can also find more information on **our public website**.

Aetna® Healthy Lifestyle Coaching program

The Aetna Healthy Lifestyle Coaching program is a comprehensive, motivational health coaching program. It offers a suite of one-on-one telephonic health coaching interventions, unlimited inbound calls and educational materials. The program is designed to help participants change one or more modifiable lifestyle behaviors, such as smoking and weight management.

*Unless state requirements are more stringent.
**State variations may exist.

Aetna® Lifestyle and Condition Coaching program
The Aetna Lifestyle and Condition Coaching program offers members a comprehensive health strategy. It provides lifestyle management, well-being and chronic condition support through one unified holistic member experience that blends personal and digital approaches to support the member. The program is designed to encourage sustained participation and help members:

- Form long-term healthy habits
- Reinforce and broaden existing healthy behaviors
- Improve lifestyle choices
- Successfully manage their chronic conditions

We deliver the program through a single-coach model with the support of a multidisciplinary team. The program engages members using diverse delivery channels and resources. This holistic, unified approach enables members to receive the right support they need, when and where they need it.

Fitness programs for Aetna Medicare Advantage members
For 2019, most individual Aetna Medicare Advantage plans offer fitness benefits through one of two programs:

- Silver&Fit® Exercise and Healthy Aging Program, administered by American Specialty Health, Inc. (ASH)
- SilverSneakers®, administered by Tivity Health

Neither program is available for two individual MA plans in Maryland.

For 2019, the fitness benefit is offered as a buy-up option for our group Aetna Medicare Advantage plans.

Medicare Members and providers can contact Member Services to determine if the fitness benefit is available and which program option is offered.

Women's health programs
Our **Women's Health Policies and Procedures Manual** explains Aetna gynecologic and obstetric programs and policies. It has information about our Aetna Maternity Program.

Member resources

Informed Health® Line
The Aetna Informed Health Line puts members in touch with registered nurses 24 hours a day, 7 days a week. The nurses can provide information on thousands of health issues, medical procedures and treatment options. They can also offer members suggestions for communicating more effectively with their doctors.

Institutes of Excellence™ network
Institutes of Excellence is our network of participating facilities for the following services:

- Infertility services
- Solid organ, blood and marrow transplants
- Transplant-related services, including evaluation and follow-up care
- Chimeric antigen receptor (CAR) T-cell therapy

Institutes of Quality® designation
Institutes of Quality is a designation facilities can achieve for certain clinical services (for example, bariatric surgery and selected orthopedic and cardiac procedures). We base this designation on our evaluation of their processes and outcomes (for example, readmission rates and mortality rates) for these procedures.

Behavioral health

On **Aetna.com**, check out information on the "Behavioral Health" page. There, you'll find:

- Our **Behavioral Health Provider Manual**
- Archived issues of our **Aetna Behavioral Health Insights™** newsletter for participating behavioral health professionals
- Aetna **Behavioral Health Programs** overview
- **Utilization Management** and how we determine coverage

*Unless state requirements are more stringent.
**State variations may exist.

Behavioral health access standards*

Service	Time frame
Non-life-threatening emergency needs	Within 6 hours
Urgent needs	Within 48 hours of request
Routine office visits	Within 10 days of request
Following inpatient hospital discharge for a behavioral health condition	Within 7 days of the inpatient discharge
After-hours care	• Behavioral health practitioners must have a reliable 24/7 live answering service or voice mail system. • MDs are required to have a notification system for call-backs or a designated practitioner backup. • Non-MDs must have a message system that provides 24-hour contact information to a licensed behavioral health care professional.

Aetna Depression in Primary Care Program

Depression often coexists with other serious medical illnesses, such as heart disease, stroke, cancer, HIV/AIDS, diabetes and Parkinson's disease. Most people do not seek treatment due to the perceived stigma associated with depression. Many of those treated don't receive appropriate or continued treatment.

Our Aetna Depression in Primary Care Program is designed to support the screening for and treatment of depression at the primary care level.

Our program offers your primary care practice:

- A tool to screen for depression as well as monitor response to treatment
- Reimbursement for depression screening and follow-up monitoring
- Patient health questionnaire (PHQ-9) — specifically developed for use in primary care
- PHQ-9 reimbursement**

To participate, you just need to be a participating primary care provider, use the PHQ-9 tool to screen your patients and submit claims with the following billing combination: CPT code "96127" (brief emotional/behavioral assessment) in conjunction with diagnosis code "Z13.89" (screening for depression). To learn more, visit our **Depression in Primary Care Program** homepage.

Screening, brief intervention and referral to treatment (SBIRT) practice

SBIRT is an evidence-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and illicit drugs. The Institute of Medicine recommendation encourages the SBIRT model, which calls for community-based screening for health risk behaviors, including substance use.

We'll reimburse you for screening patients for alcohol and substance use disorder, providing brief intervention and referring them to treatment. You can help increase the adoption of the SBIRT process in your practice. The patient must be 9 years of age or older and have Aetna medical benefits to be eligible.

The SBIRT practice supports health care professionals in all health care settings. Overall, our goal is to improve both the quality of care for patients with alcohol and substance abuse conditions, as well as outcomes for patients, families and communities. You can visit our **Screening, Brief Intervention and Referral to Treatment** page to get started.

Download the app
The SBIRT app is now available as a free download on the App Store for iOS devices. The app provides evidence-based questions to screen for alcohol, drug and tobacco use. If warranted, a screening tool is provided to further evaluate the specific substance use. The app also provides steps to complete a brief intervention and/or referral to treatment for the patient based on motivational interviewing.

Opioid Overdose Risk Screening program

In an effort to **address the rising opioid epidemic**, we've implemented a screening program to identify members at risk for opioid overdose. Our clinicians assess cases involving opioid dependence. When they do, they discuss the potential benefits of adding naloxone to the member's treatment plan as an intervention, in the event of a relapse or future overdose.

Consider naloxone as part of the treatment plan for patients at risk of an opioid overdose. Naloxone reverses the effects of an opioid overdose. Providing naloxone kits to laypeople reduces overdose deaths and is safe and cost effective. Other elements supporting this potentially life-saving intervention include telling patients and their family and support network about signs of overdose and about administering naloxone.

Coverage of naloxone varies by individual plans and can be verified by calling the number on the member ID card. We'll waive copays for the naloxone rescue medication Narcan® for fully insured commercial members.

Pharmacy management and drug formulary

Overview of the Pharmacy Plan Drug List (formulary)

Providers should prescribe medications according to the applicable drug formulary(ies). We may modify the drug formulary(ies) from time to time.

Commercial plans
Our pharmacy benefits plans use a **Pharmacy Plan Drug List** (formulary) to help maintain access to quality, affordable prescription drug benefits for patients. Many drugs, including drugs on the formulary, are subject to manufacturer rebate arrangements between Aetna and the manufacturers of those drugs.

Coverage is not limited to drugs on the list. In some benefits plans, certain non-preferred drugs are excluded from coverage, unless a medical exception is obtained. These drugs are on our **Formulary Exclusions List**.

Note: Not all members with Aetna medical benefits have Aetna pharmacy benefits.

Aetna Medicare Advantage plans
You can find the Medicare prescription drug formularies at the following links:

- **Individual MA-PD plan and PDP members**
- **Group MA-PD plan and PDP members**

CVS Caremark Mail Service Pharmacy™

CVS Caremark Mail Service Pharmacy is our mail-order pharmacy. It provides maintenance medications for chronic conditions, such as arthritis, asthma, diabetes, high cholesterol, heart conditions and others. CVS Caremark Mail Service Pharmacy can send members up to a three-month supply of these medications, with their physician's approval.

With this service, your patients will enjoy the benefits listed below.

- Convenience: Reorder only once every three months.
- Choice: Members can opt to receive order status alerts, and can track orders and more by phone, email or text message.
- Privacy: Prescriptions are discreetly packaged.
- Peace of mind: Pharmacists are available 24 hours a day, every day, to answer members' questions.
- Savings: Depending on the Aetna pharmacy benefits plan, members may save money by using CVS Caremark Mail Service Pharmacy. And standard shipping is always available at no additional cost.

How your patients can learn more
To learn more, encourage members to visit our **Aetna member website**. Once logged in, select "Aetna Pharmacy" at the top of the page.

Aetna Specialty Pharmacy® mail-order pharmacy

Aetna Specialty Pharmacy is our specialty medication pharmacy. It provides specialty medications including injectable, infused and select oral therapies.

Specialty medications are unique because they treat certain complex diseases. These conditions include anemia, hepatitis C, multiple sclerosis, cancer, rheumatoid arthritis and Crohn's disease, among many others. Specialty medications are often expensive and may not be readily available at retail pharmacies. They may also require refrigeration, special storage and handling, and fast delivery.

Helping patients manage their therapies
Specialty medications usually carry risk for side effects and risk that members may have trouble complying with their prescribed therapy schedule. For these reasons, the use of specialty medications must be consistently monitored.

With Aetna Specialty Pharmacy, your patients get personal care plans and ongoing support.

- Nurses and pharmacists who specialize in each patient's needs are on call 24 hours a day.
- Care coordinators work with your patients to help process orders quickly.
- Insurance and claims specialists help your patients maximize their benefits plans.
- Service representatives reach out to set up refills.

Aetna Specialty Pharmacy offers other helpful services, including:

- Free, secure delivery usually within 48 hours of confirming each order, or later if you request
- Delivery to the patient's home, your office or any other location needed
- Package tracking to ensure prompt delivery of each order
- Self-injection training and education to help your patient understand his or her condition and medication

Flexible payment options for out-of-pocket costs, when necessary
This pertains to free injection supplies, such as needles, syringes, alcohol swabs, adhesive bandages and sharps containers for needle waste, if needed.

Treating many complex diseases
Many of these specialty medications are available only through limited distribution networks. Aetna Specialty Pharmacy also works hard to monitor the FDA's pipeline to get access to new specialty therapies. If Aetna Specialty Pharmacy gets a prescription order for one of the few therapies they don't have access to, we respond without delay. We will forward the prescription to the appropriate contracted specialty pharmacy, along with a letter.

Ordering through Aetna Specialty Pharmacy is easy
- Print and complete a **Medication Request Form**.
- Fax it to: **1-866-FX-ASRX (1-866-329-2779)**.
- Or mail it to: Aetna Specialty Pharmacy, 503 Sunport Lane, Orlando, FL 32809.

Electronic prescribing
Physicians use e-prescribing technology to input prescriptions through an electronic medical record (EMR) using a tablet, smartphone or desktop computer. Physicians can send orders electronically to the patient's pharmacy, eliminating the need for patients to physically take the prescription to their pharmacy. Electronic prescribing also helps:

- Reduce paperwork and result in faster, more accurate information
- Simplify the prescribing process for physicians and patients
- Reduce medication errors resulting from unreadable, handwritten prescriptions

Aetna Pharmacy Management tries to integrate our pharmacy information with our clinical support tools.

Our goal is to make insightful connections that can help us identify and act on opportunities to help improve member health. Care Consideration℠ alerts are just one example. Through personalized outreach, we share recommendations to encourage members to get the right care at the right time. This service is confidential, and is included free of additional charge as part of our Aetna pharmacy benefits plan coverage.

Learn more about **e-prescribing products and services**.

Pharmacy clinical policy bulletins

The Aetna **Pharmacy Clinical Policy Bulletins** (PCPBs) are used as a guide when determining coverage for members with benefits plans that cover outpatient prescription drugs. They also describe the medical exception clinical coverage criteria for drugs on our:

- Formulary Exclusions List
- Precertification List
- Step-Therapy List
- Quantity Limits List

Precertification, step therapy and quantity limits

Precertification

Most members with Aetna pharmacy benefits may have a plan that includes precertification. These drugs require an extra coverage review before they are covered.

Precertification is based on current medical findings, FDA-approved manufacturer labeling information and guidelines, and cost and manufacturer rebate arrangements.

Visit our website to determine which medications may require precertification. If you have questions, call us at **1-800-Aetna Rx (TTY: 711)** or **1-800-238-6279 (TTY: 711)**.

Step therapy

Some members may have a plan that includes step therapy. With step therapy, certain drugs are not covered unless members try one or more preferred alternatives first. Step therapy is based on:

- Current medical findings
- U.S. Department of Food and Drug Administration (FDA)-approved manufacturer labeling information
- FDA guidelines
- Cost and manufacturer rebate arrangements

If it's medically necessary, a member can get coverage of a step-therapy drug without trying a preferred alternative first. In this case, a physician, patient or a person appointed to manage the patient's care must request coverage for a step-therapy drug as a medical exception. The drugs requiring step therapy are subject to change. You'll find current step-therapy requirements on our **website**. If you have questions, call us at **1-800-Aetna Rx (TTY: 711)** or **1-800-238-6279 (TTY: 711)**.

Quantity limits

We also limit coverage on the quantity of certain drugs. Quantity limits are established using medical guidelines and FDA-approved recommendations from drug manufacturers. The quantity limits include the following.

- Dose efficiency edits: Limits coverage of prescriptions to one dose per day for drugs that are approved for once-daily dosing.
- Maximum daily dose: A message is sent to the pharmacy if a prescription is less than the minimum or higher than the maximum allowed dose.
- Quantity limits over time: Limits coverage of prescriptions to a specific number of units in a defined amount of time.

You, your patient or the person appointed to manage the patient's care may request a medical exception for coverage of amounts over the allowed quantity. Contact the Aetna Pharmacy Management Precertification Unit. Refer to the Medical Exception and Precertification information on how to access this unit.

Generic drugs

- Under Aetna commercial closed formulary plans, generic drugs are generally covered. Those that aren't covered are on the Formulary Exclusions List.
- Many commercial formulary plans have a lower copay for covered generic drugs. However, several generics are considered nonpreferred and may be subject to a higher, nonpreferred copay in some plans.
- To control health care costs, consider prescribing preferred generic drugs when appropriate.
- In some plans, if the member or their physician requests a brand-name drug when a generic drug is available, the member may have to pay more. They have to pay the difference in cost between the brand-name drug and the generic drug, in addition to their copay.
- Many state laws encourage or require the pharmacy to dispense generic drugs, if the prescriber permits.

Medical exception and precertification

You can ask for a medical exception for coverage of drugs on the Formulary Exclusions List or the Step-Therapy List or request prior authorization or exceptions to quantity limits. Physicians, patients or a person appointed to manage the patient's care can contact the Aetna Pharmacy Management Precertification Unit.

To contact us, see the options below.

	Phone	Fax	Online
Commercial	**1-855-240-0535 (TTY: 711)**	**1-877-269-9916**	**—**
Medicare part B	**1-866-503-0857 (TTY: 711)**	**1-844-268-7263**	**—**
Medicare part D	**1-800-414-2386 (TTY: 711)**	**1-800-408-2386**	On **Aetna.com**, see the "**Forms**" section.
Precertification for specialty drugs on the Aetna National Precertification List	**1-866-503-0857 (TTY: 711)**	**1-888-267-3277**	Go to **Availity.com** to access this information.

Performance programs

We use practitioner and provider performance data to help improve the quality of service and clinical care our members receive, if certain thresholds are met. Accrediting agencies require that you let us use your performance data for this purpose.

Quality, accreditation, review and reporting activities

We expect providers to cooperate with any of our quality activities, or any review of Aetna, a payer or a plan by:

- The National Committee for Quality Assurance (NCQA)
- The Utilization Review Accreditation Commission (URAC) or other applicable accrediting organizations
- A state or federal agency with authority over Aetna and/or a plan, as applicable

We expect our network providers to comply with our reporting requirements. These include Healthcare Effectiveness Data Information Set (HEDIS) and similar data collection and reporting requirements.

Aexcel® network of specialist doctors

Aexcel is a designation within the Aetna Performance Network. Aexcel designation helps distinguish physicians in 12 specialty categories who have met certain clinical performance and efficiency standards. Aexcel providers are identified by a blue star.

We evaluate participating specialists in the 12 specialty categories at least once every 2 years for Aexcel designation. The evaluation process is made up of 4 key components:

1. Case volume
2. Clinical performance
3. Efficiency
4. Network adequacy

To find Aexcel physicians online, look for a blue star next to their names. To learn more, log in to our **provider website**. Once on the site, go to Aetna Support Center > Doing Business > Aexcel Designation.

Patient-centered medical home (PCMH)

PCP practices can participate as a PCMH in two ways:

1. Direct contract via an amendment to a physician or group agreement
2. Via the Aetna external PCMH recognition program

Each arrangement has its unique parts, but they all generally include these two requirements:

1. NCQA or other accepted organization's PCMH recognition, preferably Level 3 with a fully implemented electronic medical record (EMR) process
2. Adherence to the seven principles of PCMH (as promoted by the PCPCC)

These two requirements cover many terms and standards, such as:

- Case management
- Enhanced access for patients
- ePrescribing
- Measures tracking
- Patient registries

The purposes of our PCMH Recognition Plan are:

- Meet the triple aim of improved efficiencies, clinical outcomes and patient satisfaction.
- Help establish a sufficient amount of PCMH sites to enable us to offer the advantages of a benefits plan featuring PCMHs to plan sponsors. Under this type of plan, members would choose a PCMH PCP practice for their primary care services.

A direct contract is available in all markets to all providers that include PCPs and is executed via a signed amendment to their current participation agreement. The external PCMH recognition program is only available in markets that Aetna decides to implement. These are currently:

- The states of Arizona, Colorado, Connecticut, Delaware, Maryland, Massachusetts, New Jersey, New York, Virginia, Washington and West Virginia
- The city of Tampa, Florida
- The cities of Cleveland and Columbus, Ohio

Physician pay for performance (P4P)
Participation is through a direct contract. It's available in all markets to all providers that include PCPs. It's executed via a signed amendment to their current participation agreement.

Our nationally available Physician Performance Incentive programs apply the strengths of our data aggregation and national data repository resources to local-market initiatives. This allows for customized measures and goals. Annual goals are:

- Negotiated agreements between the provider group and Aetna
- Based on market position and previous-year measurements

We provide detailed information on each individual physician's results on each measure.

Our physician performance incentive programs identify and target areas of opportunity for quality improvement. The objective is to help improve the overall quality, safety and cost efficiency of health care. These programs set targets for improvements and deliver performance measurement results for:

- Independent practice associations (IPAs)
- Physician-hospital organizations (PHOs)
- Physician groups

We incorporate group and physician-level data into our online and other tools. This provides actionable, patient-level information to physicians. Physicians earn reward payments only when they either improve toward their targeted performance results or maintain their high-performing levels of achievement.

We annually reset target goals and, in some cases, add and/or drop measures. In most programs, physicians are not paid for this component of their compensation until we have measured and compared their performance to targets. As a result, performance payments are not included in initial claims payments.

More broadly, we believe that performance incentive program success requires:

- A clear and specific understanding between payers and providers on the parameters of the program's measurements, incentive opportunities and targets
- National, consensus measures
- A focus on continuous quality improvement
- A commitment to retire measures after there have been several periods of top-level performance (for example, 95% and above) and replace them with new measures that have new opportunities for improvement
- Collaboration to identify new sources of actionable information, and creative ways to encourage and engage with physicians and physician groups effectively
- A commitment across all commercial payers to include performance incentives in the overall reimbursement strategy. We recognize that when physicians improve their practices, all patients benefit.

Clinical medical management

Clinical practice and preventive service guidelines

Evidence-based clinical practice and preventive services guidelines from nationally recognized sources promote consistent application of evidence-based treatment methodologies. This helps to provide the right care at the right time. For this reason, we make them available to our network providers to help improve health care.

They are provided for informational purposes only. They aren't meant to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines don't dictate or control a provider's clinical judgment regarding the appropriate treatment of a patient in any given case.

Evidence-based guidelines can be found on various nationally recognized sources. Here are links to some of those sources.

*State variations may exist.

Clinical practice guidelines

- **Agency for Healthcare Research and Quality**
- **American College of Cardiology/American Heart Association**
- **American Diabetes Association**
- **American Psychiatric Association**
- **National Heart, Lung and Blood Institute**

Behavioral health clinical practice guidelines

- **American Academy of Pediatrics (AAP) Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents**
- **American Psychiatric Association (APA) Guideline for the Treatment of Patients with Major Depressive Disorder**
- **National Institute on Alcohol Abuse and Alcoholism (NIAAA) Helping Patients Who Drink Too Much Guideline**
- **Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain**

Preventive services guidelines

- **Centers for Disease Control and Prevention Immunization Schedules**
- **U.S. Preventive Services Task Force**

Case management

Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes.* Case management is a standard component of most Aetna medical plans.

The basis of the case management program is evidence-based medical literature and clinical practice guidelines. There are both automated and manual processes to identify members for case management through a variety of methods.

Our case managers review and coordinate services for members with multiple and complex needs (for example, cardiac care, complex pediatric care, complex behavioral health care, medical psychiatric coordination, oncology) and for members who are at risk for high cost or high utilization. We welcome referrals from treating physicians to our case management program. You can submit a referral through the toll-free phone number on the member ID card.

Once we decide that a member is right for case management and the member or caregiver agrees to it, we make an individualized plan.

We work with the member, the member's family, physician(s), and other health care professional(s).

The assessment process leads to the development of a case management plan that meets the member's specific needs. The plan includes member-specific deficits, goals and objectives. There are targeted activities to meet these goals and objectives. The case manager helps the member achieve their health goals and works to resolve any identified issues or barriers.

We regularly reassess the plan to determine the member's progress in meeting the goals and objectives. As the member's condition progresses or regresses, we modify the plan accordingly.

Once the stated goals and objectives are met, the member is discharged from case management. This is usually within an average of 30 to 180 days.

Coordination of care

Importance of collaboration

We monitor and try to improve coordination and collaboration between treating providers of care. Results from our annual Physician Practice surveys have shown that physicians continue to be concerned that they do not regularly receive reports about their patients' ongoing evaluation and care from other practitioners and facilities. These include medical specialists, behavioral health practitioners, skilled nursing facilities, home health agencies, surgical centers or hospitals. The increased focus on patient safety in the medical community also highlights the critical nature of improving collaboration between treatment providers.

Sharing patient information

Increased treatment compliance and improved outcomes have been attributed, in part, to collaboration between providers.[1] In addition, the quality of communication is rated as an important factor considered by primary care physicians when choosing a specialist to whom they can refer their patients.[2]

To this end, we strongly encourage you to send progress notes and discharge summaries to your patients' other treating practitioners.[2] Forms are available on our **public website at Aetna.com** and include the following:

- The **Physician Communication Form** and the **Specialist Consultant Report.** These can be used to share information between a primary care physician and specialty care physicians in order to document a patient's diagnosis, medications, procedures and status.
- The **Behavioral Health/Medical Provider Communication Form**. This helps behavioral health providers share information about a patient's treatment plan with primary care physicians. Providers can use the form to pass on detailed information about a patient's diagnosis, medications, risks and concerns.

Accessing communication forms

You can access these forms on our **public website**.

We appreciate your efforts to close the communication gap between specialists, facilities and primary care physicians and promote improved patient care and safety.

Transition of care

Transition of care provides a temporary bridge for members at the time of plan enrollment or renewal. Members in an active course of covered treatment that meets clinical coverage criteria/guidelines with a treating provider may be eligible for transition of care coverage consideration. The treating provider must fall under one of these categories:

- Is not a contracted provider in the member's plan
- Is not a practitioner designated for inclusion within a tiered network (Aetna Performance Network) or Aexcel® specialty categories when a specific practitioner or provider network is applicable to the member's plan
- Is not included within a plan sponsor-specific network

Additionally, the treating provider must be an individual practitioner (for example, a specialist, physical therapist, speech therapist) or home care agency in order to be eligible for the transition-of-care process

Transition of care does not apply to nonparticipating durable medical equipment (DME) vendors or pharmacy vendors. Transition of care does not apply to nonparticipating facilities, with the exception of facilities in which:

- The Aetna contract has terminated (for reasons other than quality issues)
- A treating participating practitioner temporarily has privileges only at the nonparticipating facility

[1]Grey N, Maljanian R, Staff I, Cruzmarino de Aponte M. Improving care of diabetic patients through a collaborative care model. Conn Med. Jan 2002;66(1), 7-11. Felker BL, Chaney E, Rubenstein LV, Bonner LM, Yano EM, Parker LE, Worley LL, Sherman SE, Ober S. Developing effective collaboration between primary care and mental health providers. Prim Care Companion J Clin Psychiatry. 2006;8(1), 12-16. Dawson S. Interprofessional working: communication, collaboration ... perspiration! Int J Palliat Nurs. Oct. 2007;13(10), 502-5.

[2]Kinchen KS, Cooper LA, Levine D, Wang NY, Powe NR. Referral of patients to specialists: factors affecting choice of specialist by primary care physicians. Annuals of Family Medicine. May/June 2004;2(3), 245-252.

The transition-of-care process applies to all benefits plans except Traditional Choice® and Aetna Medicare Advantage PPO ESA (Extended Service Area) plans. It is also limited to a fixed period of time. Transition of care also applies to members who are in an active course of covered treatment when a physician or other health care professional terminates participation in the Aetna network.

An "active course of treatment" is defined* as a program of planned services that:

- Starts on the date a physician or other health care professional first renders a service to correct or treat the diagnosed condition
- Covers a defined number of services or period of treatment
- Includes a qualifying situation (for example, a surgical follow up)

Procedures for requesting transition of care

1. The member asks for a Transition Coverage Request Form from Member Services or their employer. The member completes the form with help, as needed, from the nonparticipating treating physician.
2. The member or nonparticipating treating physician faxes the completed form to the Aetna fax number on the form.
3. We review the information. When necessary, an Aetna Medical Director evaluates the treatment program. The director may also contact the treating physician or health care professional.
4. We send a letter about the coverage decision to the member and the nonparticipating treating physician or health care professional. If coverage is approved, the letter also includes the length of time the transition benefits apply. We also send a letter to the member's primary care physician, as applicable.

Complaints and appeals

We have a formal complaint and appeal policy* for physicians, health care professionals and facilities. The complaint and appeal process has **one level of appeal**.

Physician, health care professional and facility appeals involve payment decisions (claims). A provider may also appeal pre-service or concurrent medical-necessity decisions. However, those appeals will be handled through the **member appeal process**.

Note: The process may vary due to state-specific requirements. For more information on complaints or appeals, contact your local Aetna office.

Physician and health care professional post-service appeals may either be on the provider's behalf or on the member's behalf. An appeal is not considered on behalf of the member unless it includes both of the following:

1. An appeal that explicitly states "on behalf of the member"
2. Specific written authorization from the member that was submitted by the physician or health professional

For more information, visit our **disputes and appeal process**.

In accordance with CMS requirements, we have a formal process for Aetna Medicare Advantage** plan provider **dispute resolution for non-contracted providers**.

*State variations may exist.

**Aetna Medicare Advantage plans must comply with CMS requirements and time frames when processing appeals and grievances received from Aetna Medicare Advantage plan members. Refer to the Medicare section of this manual for further information.

Medicare

Aetna Medicare plans

Below is a summary of how our Aetna Medicare Advantage plans work with primary care physician (PCP) selection, referrals and out-of-network benefits.

Aetna Medicare℠ Plan (HMO) and Aetna Medicare Prime Plan (HMO)
Patients *must* choose and use a participating PCP.

Patients *must* get referrals from their PCP before getting nonemergency care from other participating providers. Exception: Behavioral health routine outpatient visits.

Services received outside of the Aetna participating provider network are not covered, except emergency, out-of-area urgent care or out-of-area renal dialysis — unless approved by Aetna in advance of receiving services.

Aetna Medicare℠ Plan (HMO) Open Access
Patients are encouraged, but not required, to choose and use a participating PCP.

PCP referrals are not required.

Services received outside of the Aetna participating provider network are not covered — except for emergency, out-of-area urgent care or out-of-area renal dialysis — unless approved by Aetna in advance of receiving services.

Aetna Medicare℠ Plan (PPO) and Aetna Medicare Prime Plan (PPO)
Patients are encouraged, but not required, to choose and use a participating PCP.

PCP referrals are not required.

Patients receiving covered services from a nonparticipating provider are subject to out-of-network deductibles, coinsurance, and potential balance billing.

Aetna Medicare Advantage plans (HMO and PPO)
Aetna contracts with the Centers for Medicare & Medicaid Services (CMS) to offer Aetna Medicare Advantage plans. As such, we're considered a Medicare Advantage organization (MAO). All MA plans are required to offer Medicare Parts A and B medical benefits and to follow CMS' national and local coverage decisions. MA plans may also offer Medicare Part D benefits (MA-PD). We offer both individual and employer group-sponsored MA products. The **Aetna Medicare Advantage HMO plans** are available in select counties and states throughout the country. **Aetna Medicare Advantage PPO plans** are available to individuals in select counties and states throughout the country and for employer groups in all 50 states, plus the District of Columbia.

Go the Medicare page on **Aetna.com** for specific Aetna Medicare Advantage plan information.

Individuals may choose from several Aetna Medicare Advantage plans, depending on their location, budget and needs. Go to **AetnaMedicare.com** to see the plans available within a specific geographic area.

Aetna Medicare Advantage HMO plan members are required to receive all covered services, with the exception of emergent or urgently needed services and out-of-area renal dialysis, through Aetna Medicare Advantage network providers. The Aetna Medicare Advantage Plan (HMO) requires members to select a participating PCP and, except for those benefits described in the member's plan documents as direct-access benefits and emergency or urgent care, members must have a referral from their PCP to obtain covered specialty services or care in a facility.

In select service areas, the individual Aetna Medicare Advantage Plan (HMO) includes an open-access feature that does not require PCP selection or referrals for in-network covered services. Some employer group plans may also offer this feature.

Aetna Medicare Advantage PPO plan members are not required to select a PCP or obtain a referral in order to obtain services from participating providers. Generally, members who select a PCP are responsible to pay the PCP copayment for covered services received from their designated PCP. Aetna Medicare Advantage Plan (PPO) members also have the option to receive covered services from any nonparticipating provider for covered services without a referral. If exercising this option, the member is responsible for the cost of his or her out-of-network medical expenses in accordance with their plan.

In addition, CMS provides an Employee Group Waiver Plan that permits an MAO to extend enrollment to all retirees of an employer group. This is permitted even if some of the retirees reside in a service area where Aetna does not offer a provider network that meets CMS network requirements ("Extended Service Area").

To use this waiver, at least 51% of members enrolled in the employer group Medicare Advantage (MA) plan must reside in a service area where Aetna offers a provider network that meets CMS requirements. And members who reside in an Extended Service Area must be permitted to obtain all covered services from nonparticipating providers at the in-network level of cost sharing.

Home assessment program
As part of our ongoing quality improvement efforts, we periodically offer in-home health assessments to our Aetna Medicare Advantage members. It's possible your patients may be asked to participate in this no-additional-cost, comprehensive assessment. It is voluntary and is performed in the patient's home by a licensed provider. If one of your patients is selected to participate in this program, a summary of the completed assessment will be mailed to you.

We'll use information from the assessment to identify care management programs which may benefit the member. If you have questions about the home assessment program, contact your local provider relations representative for more information.

Quality improvement program
An annual Chronic Care Improvement Program (CCIP) is implemented in accordance with CMS requirements. It is designed and conducted to coordinate care, promote quality and help improve member satisfaction.

The goal of the CCIP is to promote effective management of chronic disease and improve health outcomes and quality of care. Programs are available to support your patients and to help them make healthy lifestyle choices.

Medicare prescription drug plan
We administer a stand-alone prescription drug plan (PDP) portfolio of products referred to as the Aetna Medicare Rx® (PDP) plan. There are three different PDP plan options available to individuals on a national basis. Medicare prescription drug benefits are also offered to individuals through our MA plans that include Medicare prescription drug coverage (MA-PD plans) in select service areas. In addition, we offer Medicare prescription drug coverage through PDPs and MA-PD plans to employer groups nationwide.

MA-PD plans and PDPs must meet applicable benefits requirements under the Medicare Part D program and, as of 2019, at a minimum, these plans must contain the following provisions.

- Deductible: Not to exceed $415 for 2019.
- Coverage gap: Once a member reaches $3,820 in covered Medicare Part D drug expenses, he or she will pay no more than 37% for covered generics and 25% for covered brand drugs, including a manufacturer discount of up to 70% off covered-brand drug costs until reaching the True Out-of-Pocket (TrOOP) threshold of $5,100. Most individual and group PDP and MA-PD plans provide supplemental gap coverage.

Note: The previous description is not applicable to members who qualify for Low-Income Subsidy assistance.

- Catastrophic coverage level: For 2019, once a member reaches $5,100 in TrOOP costs for covered Part D drugs, the member's maximum cost sharing for covered Part D drugs will be the greater of 5% or $3.40 for generic drugs (or those prescription drugs treated like generic), or $8.50 for all other prescription drugs.
- Quantity limits, step therapy and precertification requirements apply to certain prescription drugs.

Formulary: The Aetna Medicare prescription drug formularies (also known as the "Aetna Medicare Preferred Drug List") differ from the formularies applicable to Aetna commercial pharmacy plans. Go to **AetnaMedicare.com/formulary** to see a list Medicare prescription drug formularies.

Group MA-PD Plan and PDP members: Visit our retiree plans website at **AetnaRetireePlans.com**, then select "Manage your prescription drugs."

Note: All formularies applicable to MA-PD plans and PDPs are reviewed and approved by CMS.

Transition-of-coverage (TOC) policy
CMS requires Part D plan sponsors, like Aetna, to have an appropriate TOC process. Members who are taking Part D drugs that are not on the plan's formulary or that are subject to utilization management requirements can get a transition supply of their drug in certain circumstances. This gives members the opportunity to work with their doctors to complete a successful transition and avoid disruption in their respective treatments.

Aetna Medicare has established a TOC process in accordance with CMS requirements that applies to new members as well as current members who remain enrolled in their Aetna Medicare plan from one plan year to the next.

The following is a summary of the key features of Aetna Medicare's TOC process.

Newly enrolled members who are taking a Part D drug that is not on the Aetna Medicare formulary, or is subject to a utilization management requirement or limitation (such as step therapy, preauthorization or a quantity limit), are entitled to receive a maximum of a 30-day supply of the Part D drug within the first 90 days of their enrollment. (The period of time in which they are entitled to receive the transition supply is called their "transition period.")

Existing members who renew their Aetna Medicare coverage and are taking a Part D drug that is removed from the formulary, or is subject to a new utilization requirement or limitation at the beginning of the new plan year, are entitled to receive a maximum 30-day supply during their transition period. For existing members who renew their Aetna Medicare coverage from one year to the next, their transition period is the first 90 days of the new plan year.

Whether an individual is a new or renewing member, if the member's initial prescription is for less than the full transition amount (30 days), the member can get multiple fills up to the 30-day supply. If a member lives in a long-term care facility and is entitled to a transition supply, Aetna will cover a 31-day supply (unless the prescription is for fewer days).

Members may also be entitled to receive a transition fill outside of their transition period in certain circumstances. We send a TOC notice to members via first-class mail within 3 business days from the date the transition fill claim is processed. The letter:

- Notifies members that the transition fill was a temporary supply
- Describes the options available to the member if the drug for which they received the transition fill is not on the formulary or is subject to a utilization management requirement or restriction (including changing to a therapeutic alternative, or seeking an exception or prior authorization, as appropriate)
- Describes the procedures for requesting an exception or prior authorization
- Encourages members to work with their respective doctors to achieve a successful transition so they can continue to receive coverage for the drugs they need

A duplicate copy of the notice is sent to the prescribing physician.

You can view Transition rules for our Medicare Prescription Drug process. At **AetnaMedicare.com**, go to Aetna Medicare Plans > Aetna Medicare Rx (PDP) > Find Prescriptions > Please select a plan year > Public notice. There you'll find PDFs describing the process.

Additional prescription drug plan information

- **Days supply:** Generally, a 1-month prescription may be filled for up to a 30-day supply. A member may obtain up to a 3-month (90-day) supply of maintenance medications from either a participating retail pharmacy or through a participating mail-order vendor.
- **Mail-order drug option:** A member may obtain up to a 90-day supply of maintenance medications from our preferred CVS Caremark Mail Service Pharmacy mail-order pharmacy.

Specialty pharmacies fill high-cost specialty medications that require special handling. Although specialty pharmacies may deliver covered medications through the mail, they are not considered "mail-order pharmacies." Therefore, most specialty drugs are not available at the mail-order cost share. In 2014, CMS instituted a feature that allows PDP and MA-PD plan members in some instances to pay prorated cost sharing for prescriptions written for less than a 30-day supply. For example, prorated cost sharing may apply when an initial prescription is written for a short supply to assure the member can tolerate the drug, or when a member wishes to synchronize their prescriptions to fill on the same day. However, limitations apply to this plan feature. For example, prepackaged drugs cannot be broken, and this plan feature does not apply to antibiotics and some other drugs.

Preferred pharmacies

Most of our plans give members access to our preferred pharmacy network.

Our members generally pay less when they fill their prescription at one of our preferred pharmacies.

All of our network pharmacies must meet strict discount standards. But preferred pharmacies offer us even bigger discounts. And we pass those discounts on to our members, in the form of lower-cost sharing.

Preferred pharmacies are identified with a circled "P" in our directories.

Part D drug rules

Here are three general rules that apply to prescription drug coverage under Medicare Part D.

1. Medicare Part D cannot provide coverage for a drug that would be covered under Medicare Part A or Part B.
2. Medicare Part D cannot provide coverage for a drug that is purchased and/or consumed outside the United States and its territories.
3. Medicare Part D usually cannot provide coverage for "off-label use." Generally, coverage for "off-label use" is allowed under Medicare Part D only when the use is supported by the following reference books:
   - The American Hospital Formulary Service Drug Information
   - The DRUGDEX Information System
   - The United States Pharmacopeia-Drug Information (USP DI) or its successor

Also, by law, the following categories of drugs are not covered by Medicare Part D unless enhanced drug coverage is included or offered under a particular Medicare Part D plan or benefit:

- Nonprescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra and Caverject
- Drugs when used for treatment of anorexia, weight loss or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

The amount a member with Medicare Part D coverage pays when filling prescriptions for these drugs does not count towards the plan deductible, initial coverage limit or qualifying for the Catastrophic Coverage Stage. Also, those eligible for the Low-Income Subsidy will not receive subsidized cost sharing.

Note: Most injectable medications and oral drugs not covered under Medicare Part B will be considered Medicare Part D drugs, but coverage will be determined by the formulary. Precertification is required for Medicare Part B situational drugs. If you have questions regarding whether a medication is covered under Medicare Part B versus Medicare Part D, contact the Aetna Pharmacy Management Precertification unit at **1-800-414-2386 (TTY: 711)** for assistance.

Home infusion

The following provisions only apply to providers who dispense home infusion drugs that are covered under Medicare Part D to Medicare members (and the Medicare member has MA-PD coverage):

- Provider will be paid clean claims within 30 days, and provider will be reimbursed at the rates agreed to by provider and Aetna.
- Updates to prescription drug pricing used for payment will occur no less frequently than once every seven days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the home infusion drug.
- Provider will submit claims for home infusion drugs whenever the Medicare member's ID card is presented or is on file, unless the Medicare member expressly requests otherwise.
- Provider must submit claims for home infusion drugs by means of a point-of-service claims adjudication system.
- Provider must provide Medicare members with access to the negotiated prices.
- Provider must apply the correct cost-sharing amount to the Medicare member, as indicated by Aetna.
- Provider must inform the Medicare member of any difference between the price of the home infusion drug being dispensed and the price of the lowest-priced generic version, unless the home infusion drug being dispensed is the lowest-priced generic version.

- Before dispensing, provider must ensure that the professional services and ancillary supplies necessary for home infusion drugs are in place.
- Provider must provide delivery of home infusion drugs within 24 hours of Medicare member's discharge from an acute setting, unless prescribed later.
- Provider must submit claims for equipment, supplies and professional services associated with dispensed home infusion drugs for Medicare members covered by Medicare Part C.

Additional Aetna Medicare Advantage information

As outlined in Medicare laws, rules and regulations, physicians and health care professionals (and their employees, independent contractors and subcontractors) contracted with an Aetna Medicare Advantage organization ("contracted providers") must comply with various requirements. Refer to your Aetna contract for further information regarding these Medicare contractual requirements. What follows is a general summary of some Medicare requirements that apply to contracted providers.

Demographic data quarterly attestation

The Centers for Medicare & Medicaid Services (CMS) requires every Medicare Advantage Organization (MAO) to perform quarterly outreach to every MAO-contracted provider and request validation of their demographic information listed in our search tool. We use vendors (currently the Council for Affordable Quality Healthcare® and Availity®) to make this outreach each quarter, and you are obligated, as an Aetna Medicare Advantage provider, to comply with this validation.

Failure to respond and validate your information will result in us suppressing your information in our search tool. Suppressing your information means patients and other providers will not see you listed as a participating provider in the Aetna search tool. This could result in your practice losing patients and revenue.

If you move your office or change your phone number or other demographic information, you should go to the website for our vendor and update your profile within seven days of the change. Do not wait for the quarterly attestation process, and do not call or fax the information to Aetna. We will get the update from the vendor and process it accordingly.

It's important that you cooperate fully with the validation/attestation requests from our vendors within the allotted time frame. To do so, just sign in to their website and complete the attestation questions about your demographic information. We take this compliance obligation very seriously and will take action against providers who refuse to cooperate. This action can include the suppression and, ultimately, the termination of participation in our Aetna Medicare Advantage plans.

Collecting all Aetna Medicare Advantage plan member cost sharing

CMS reviews and approves all Medicare Advantage (MA) benefits packages. The statutes, regulations, policy guidelines and requirements in the Medicare Managed Care Manual and other CMS instructions are the basis for these reviews and approvals. To comply, MA organizations must be sure that their MA plans do not discriminate in the delivery of health care services, including source of payment.

The rules regarding collection of Medicare beneficiary cost-share amounts applicable in traditional Medicare apply to Aetna Medicare Advantage as well. Therefore, providers must collect all applicable cost-share amounts from Aetna Medicare Advantage plan members. To waive the cost share is a direct violation of federal laws and regulations. This action puts Aetna and your compliance at risk.

Access to facilities and records

Medicare laws, rules and regulations require that contracted providers retain and make available all records pertaining to any aspect of services furnished to MA plan members or their contract with the MAO for inspection, evaluation and audit. Providers are required to hold these records for whichever of the following time periods is longest:

1. A period of 10 years from the end of the contract period of any Aetna Medicare contract.
2. The date the Department of Health and Human Services or the Comptroller General or their designees complete an audit.
3. The period required under applicable laws, rules and regulations.

Access to services
We have established programs and procedures to:

- Identify members with complex or serious medical conditions
- Work in conjunction with the member's physician, who is responsible for directing and managing his or her patients' care, assessing those conditions, and using medical procedures to diagnose and monitor patients on an ongoing basis
- Establish a treatment plan with an adequate number of direct-access visits to specialists (that is, no prior authorization required) to implement the treatment plan

In addition, as provided in applicable laws, rules and regulations, contracted providers are prohibited from discriminating against any Medicare member based on health status. Therefore, providers contracted with us are required to make services available in a culturally competent manner to all MA plan members. This includes those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities. In turn, we maintain procedures to inform members with specific health care needs of follow-up care and provide training in self-care, as necessary.

Medicare Outpatient Observation Notice (MOON) requirement
All participating hospitals and critical access hospitals (CAHs) must adhere to the provisions of the MOON Notice Act developed by CMS. Under this act, hospitals and CAHs must deliver a MOON to any member, including Medicare Advantage members, who receives observation services as an outpatient for more than 24 hours. The MOON must be provided to members no later than 36 hours after services begin. The notice and accompanying instructions may be found online at **CMS.gov/Medicare/Medicare-General-Information/BNI/Index**.

Medicare Medical Loss Ratio (MLR) requirements
Congress, under the Affordable Care Act, amended the MA program provisions in the Social Security Act to require MAOs to achieve an 85% MLR, beginning with contract year 2014. CMS issued regulations to implement these MLR requirements that include new maintenance and access to records obligations.

These new requirements apply to any provider that:

- Is contracted with an MAO to participate in their Medicare network
- Retains medical/drug cost data that the MAO uses to calculate Medicare MLRs for which the MAO does not have independent access

Under these new regulations, MAOs "are required to maintain evidence of the amounts reported to CMS and to validate all data necessary to calculate MLRs." This requirement exists for 10 years from the date such calculations were reported to CMS.

Additionally, the MAO "must require any third-party vendor supplying drug or medical cost contracting and claim adjudication services" to provide the MAO with "all underlying data associated with MLR reporting … regardless of current contractual limitations." If this MA regulation is applicable to a participating provider, the provider is required to do both of the following.

1. Ensure that they are retaining such data for the requisite time period (11 years from the **CMS MLR reporting date**, not the termination of the CMS contract, as referenced in existing MA regulations).
2. Preserve the MAO's and government's ability to obtain data and records, as necessary, to satisfy any government information request during the 11-year period.

Advance directives
Our contracted providers must document in a prominent place in an MA plan member's medical record whether the member has executed an advance directive. Refer to the "Member Rights and Responsibilities" section for more information on advance directives.

MA Organization Determination (OD) process
Medicare beneficiaries enrolled in MA plans are entitled to request an OD, which is a decision or determination concerning the rights of the member with regard to services covered by Medicare and/or Aetna, and any decision/determination concerning the following items.

- Reimbursement for coverage of emergency, urgently needed services or post-stabilization care.
- Payment for any other health services furnished by a provider or supplier other than the organization that the member believes are Medicare covered. Or, if not covered by Original Medicare, should have been furnished, arranged for or reimbursed by the organization.
- Denial of coverage of an item or service the member has not received but believes should be covered.
- Discontinuation of coverage of a service, if the member disagrees with the determination that the coverage is no longer medically necessary.

Members can request an expedited or standard organization determination decision. We will review and process the request in accordance with the CMS requirements and time frames. If the member's request is denied, the member may exercise his or her appeal rights.

Ban of Advance Beneficiary Notice of Noncoverage (ABN) for Medicare Advantage (MA)

Provider organizations should be aware that an ABN is not a valid form of denial notification for a MA member. ABNs, sometimes referred to as "waivers," are used in the Original Medicare program. CMS prohibits use of ABNs for members enrolled in a Medicare Advantage plan. Therefore, ABNs cannot be used for patients enrolled in Aetna Medicare Advantage plans.

As a provider who has elected to participate in the Medicare program, you should understand which services are covered by original Medicare and which are not. Aetna Medicare Advantage 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 is covered under Original Medicare.

As an Aetna Medicare Advantage contracted provider, you are expected to understand what is covered under Aetna Medicare Advantage plans. CMS mandates that providers who are contracted with a Medicare Advantage plan, such as Aetna, are not permitted to hold a Medicare Advantage member financially responsible for payment of a service not covered under the member's Medicare Advantage plan unless that member has received a pre-service OD notice of denial from Aetna before such services are rendered.

If the member does not have a pre-service OD notice of denial from Aetna on file, you must hold the member harmless for the noncovered services. You cannot charge the member any amount beyond the normal cost-sharing amounts (such as copayments, coinsurance and/or deductibles).

However, if a service is never covered under Original Medicare or is listed as a clear exclusion in the member's plan materials, you can hold the member financially liable without a pre-service OD. However, you cannot hold a member financially liable for services or supplies that are only covered when medically necessary unless you go through the OD process. Members cannot be expected to know when a service is medically necessary and when it is not.

Providers and members can initiate pre-service ODs. You must go through this process to determine if the requested or ordered service is covered prior to a member receiving it, or prior to scheduling a service such as a lab test, diagnostic test or procedure. The procedure to request a pre-service OD is similar to the procedure to request a prior authorization. Call the number on the member's ID card and ask for a pre-service OD to determine if the service will be covered for the member.

Once we make a determination, the member will be notified of the decision. You will only be able to charge the member for the service if the member has already received the decision from us before you render the services in question to the member.

Medicare prescription drug plan (PDP) coverage determinations and exceptions process

Medicare beneficiaries enrolled in PDPs have the right to request a coverage determination concerning the prescription drug coverage they're entitled to receive under their plan, including:

- Basic prescription drug coverage and supplemental benefits
- The amount, including cost sharing, if any, that the member is required to pay for a drug

An adverse coverage determination constitutes any unfavorable decision made by or on behalf of Aetna regarding coverage or payment for prescription drug benefits a member believes they are entitled to receive.

The following actions are considered coverage determinations.

- A decision not to provide or pay for a prescription drug that the member believes should be covered by the plan. (This includes a decision not to pay because the drug is not on the plan's formulary, is determined to not be medically necessary, is furnished by an out-of-network pharmacy, or we determine is otherwise excluded under section 1862(a) of the Social Security Act, if applied to Medicare Part D.)
- The failure to provide a coverage determination in a timely manner when a delay would adversely affect the health of the member.
- A decision concerning an exceptions request for a plan's tiered cost-sharing structure.

- A decision concerning an exceptions request involving a nonformulary drug.
- A decision on the amount of cost sharing for a drug.

We have both standard and expedited procedures in place for making coverage determinations.

Exceptions process
The exceptions process can be initiated for:

- Requests for exceptions involving a nonformulary Part D drug
- Requests for exceptions to a plan's tiered cost-sharing structure

A decision by a Part D plan sponsor concerning an exceptions request **constitutes a coverage determination**. Therefore, all of the applicable coverage determination requirements and time frames apply.

The member, their appointed representative or the prescribing physician can submit an exceptions request either orally or in writing, via phone or fax.

- Phone: **1-800-414-2386 (TTY: 711)**
- Fax: **1-800-408-2386**

Medicare coverage determinations and exception requests have a strict turnaround time for completion. It is critical that you send your requests to the correct areas of Aetna Medicare so we may handle them appropriately for our members. Send all Medicare prescription drug requests via phone or fax.

- Phone: **1-800-414-2386 (TTY: 711)**
- Fax: **1-800-408-2386**

A complete description of our coverage determination and exceptions process, and how to contact us if you are assisting a member with this process, is available on our Aetna Medicare Plans website.

Medicare Advantage (MA) and Medicare PDP member grievance and appeal rights
Medicare beneficiaries enrolled in MA plans and PDPs are entitled to specific CMS-mandated appeal and grievance rights. We have a dedicated Medicare Grievance and Appeal unit to process all member appeal and grievance requests.

Appeals and grievances are processed in accordance with the standard and expedited requirements and time frames established by CMS. MA plan and PDP members have the right to appeal any decision about the plan's failure to pay or provide coverage for what the member believes are covered benefits and services (including non-Medicare covered benefits).

We may require the cooperation and/or participation of contracted providers in our internal and external review of procedures relating to the processing of Medicare member appeals and grievances. If necessary, contracted providers should:

- Instruct the member to contact us for their MA plan appeal rights
- Inform the member of their right to receive, upon request, a detailed written notice from us regarding coverage for services

Members should be directed to contact Member Services using the phone number listed on their Aetna member ID card.

When a Medicare member appeals a denied service or a denial of a service they believe they are entitled to, we may need clinical records from you. We require all requests for clinical records to be handled by you as promptly as possible.

There are instances where we have less than 48 hours to respond to an appeal and your clinical information is imperative to making an accurate and timely decision.

For a complete description of our MA and Medicare PDP appeal and grievance procedures and time frames, and how to contact Aetna if you are assisting a member with this process, refer to the following links:

- **Aetna Medicare Rx Plan (PDP): Exceptions, Appeals and Grievances**
- **Aetna Medicare Advantage: Appeals and Grievances**

Obligation to respond to requests for records
We are required to ask our network providers to give us clinical documentation to help make coverage decisions for pharmacy or medical services. Under our contract with you, you're obligated to provide this information to us promptly upon request. Our clinical staff will contact your office by phone or fax when we need documentation.

The timelines for making coverage decisions are short and highly regulated, so it is critical that you provide us with the requested clinical information on a timely basis. If you don't, it adversely impacts your patients' access to care and results in unnecessary coverage denials. Please make sure your staff knows they must respond quickly to medical record requests. Failure to respond may impact your future participation status.

Confidentiality and accuracy of member records
Contracted providers must safeguard the privacy and confidentiality of, and ensure the accuracy of, any information that identifies an MA plan member. Original medical records must be released only in accordance with federal or state laws, court orders or subpoenas.

Specifically, our contracted providers must:

- Maintain accurate medical records and other health information
- Help ensure timely access by members to their medical records and other health information
- Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information and member information
- Provide staff with periodic training in member information confidentiality

Refer to the "Privacy Practices" section for further information.

Coverage of renal dialysis services for Medicare members who are temporarily out-of-area
An Aetna Medicare Advantage plan member may be temporarily out of the service area for up to six months. MAOs must pay for renal dialysis services obtained by an MA plan member while the member is temporarily out of their Medicare Advantage plan's service area. These services can be from a contracted or noncontracted Medicare-certified physician or health care professional.

Direct access to in-network women's health specialists
Without a referral, MA plan members have direct access to mammography screening services at a contracted radiology facility. They also have direct access to in-network women's health specialists for routine and preventive services.

Direct-access immunizations
Without a referral, MA members may receive influenza, hepatitis B and pneumococcal vaccines from any network provider. There is no cost to the member if any of these vaccinations are the only service provided at that visit. A PCP copayment will apply for all other immunizations that are medically necessary, in addition to the cost of the drug.

Emergency services
Refer to the Your Rights section of the Aetna website for more information on emergency services.

Health-risk assessment
We perform an initial health-risk assessment of each new MA plan member within 90 days of their enrollment in an Aetna MA plan. This health-risk assessment is completed by telephone for all new MA plan members.

The information obtained through the survey is sent to the member's primary care physician.

Receipt of federal funds, compliance with federal laws and prohibition on discrimination
Payments received by contracted providers from MAOs for services rendered to MA plan members include federal funds. Therefore, a MAO's contracted providers are subject to all laws applicable to recipients of federal funds. These include, without limitation:

1. Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45CFR part 84
2. The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91
3. The Rehabilitation Act of 1973
4. The Americans with Disabilities Act
5. Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law
6. The False Claims Act (31 U.S.C. §§ 3729 et. seq.
7. The anti-kickback statute (section 1128B(b) of the Social Security Act)
8. Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR parts 160, 162 and 164

In addition, our contracted providers must comply with all applicable Medicare laws, rules and regulations. And, as provided in applicable laws, rules and regulations, contracted providers are prohibited from discriminating against any MA plan member on the basis of health status.

Provider terminations
When a provider's participation in the Aetna Medicare network is terminated, CMS requires that we make a good-faith effort to provide written notice of the termination. This notice must be at least 30 calendar days prior to the termination effective date to all MA plan members who are patients seen on a regular basis by the provider.

However, note that when a PCP is terminated from the Aetna Medicare network, all members who are patients of that PCP must be notified of the PCP's termination at least 30 days prior to the termination effective date. According to your contract, you must give advanced notice to us prior to terminating your Aetna Agreement. For example, 90–120 days prior to terminating (or based on your contractual language).

Financial liability for payment for services
In no event should an MAO's contracted provider bill an MA plan member (or a person acting on behalf of an MA plan member) for payment of fees that are the legal obligation of the MAO. However, a contracted provider may collect deductibles, coinsurance or copayments from MA plan members in accordance with the terms of the member's Evidence of Coverage.

Note: CMS issued a memo to MAOs dated September 17, 2008, ("CMS Guidance") providing guidance regarding balance billing by providers of certain individuals enrolled in both Medicare Advantage plans and a State Medicaid plan ("Dual Eligible beneficiaries"). More specifically, this CMS Guidance states that providers are prohibited from balance billing Dual-Eligible beneficiaries who are classified as Qualified Medicare Beneficiaries (QMB) for Medicare Parts A and B cost-sharing amounts.

The CMS Guidance explains that providers must accept Medicare and Medicaid payment(s), if any, as payment in full. A QMB has no legal liability to make payment to a provider or MA plan for Medicare Part A or B cost sharing, and a provider may not treat a QMB as a "private pay patient" in order to bill a QMB patient directly. In addition, the CMS Guidance states that federal regulations require a provider treating an individual enrolled in a State Medicaid plan, including QMBs, to accept Medicare assignment.

Providers participating in Aetna Medicare networks are required to provide covered services to Aetna Medicare Dual-Eligible beneficiaries enrolled in Aetna Medicare Advantage plans ("Dual-Eligible members") and comply with all of the requirements set forth in this CMS Guidance. Participating providers must accept Aetna payment as payment in full or bill Medicaid for the Dual Eligible member's copayment.

Medicare Compliance Program requirements
CMS requires that Aetna first tier, downstream and related entities (FDRs) fulfill Medicare Compliance Program requirements. If you are contracted to provide health care and/or administrative services for any of our Medicare plans, you are an FDR.

Our Medicare plans include:

- Medicare Advantage (MA or MAPD)
- Medicare-Medicaid Plans (MMPs)
- Dual-Eligible Special Needs Plans (D-SNPs)

We describe all of CMS' compliance program requirements in our **First Tier, Downstream and Related Entities (FDR) Medicare Compliance Program Guide (FDR Guide)**. Go to **Aetna.com/medicare** to find the **FDR Guide**.

Be sure to review the **FDR Guide** and make sure you are complying with all of the requirements.

Standards of Conduct and Compliance policies
Your organization should distribute Standards of Conduct and Compliance Policies that explain your:

- Commitment to comply with federal and state laws
- Ethical behavior
- Compliance program operations

They should be distributed within 90 days of hire, when revised, and annually thereafter.

If you don't have your own documents, you can use our **Code of Conduct** and **Compliance Policies**.

Exclusion list screening
Your organization should not employ or contract with an individual or entity that is excluded from participating in federally funded health care programs. Prior to contracting

*Twelve months for members enrolled in a stand-alone Medicare prescription drug plan (PDP).

and monthly thereafter, you must screen employees and downstream entities against the following lists:

- **Office of Inspector General (OIG) List of Excluded Individuals and Entities**
- **General Services Administration (GSA) System for Award Management (SAM)**

If an excluded individual or entity is identified, you must notify us and immediately remove them from working on our Medicare business.

Patient Protection and Affordable Care Act (PPACA)
We refer to PPACA as the Affordable Care Act (ACA). As part of the ACA, Congress enacted a broad new law — ACA Section 1557 — that generally prohibits most health insurers, including Aetna, from discriminating on the basis of race, color, national origin, sex, disability or age. A central element of the ACA Section 1557 rules is a requirement that covered entities, including health care providers such as hospitals or doctors, provide special aids to persons with communication disabilities, such as the deaf and hard of hearing, so they can equally access and benefit from their services. Aetna expects providers to comply with ACA Section 1557.

The "effective communication" baseline rule
As an Aetna Provider, you are obligated to do both of the following.

1. Ensure all communications with the deaf and hard of hearing are as effective as those with other persons.
2. Provide appropriate auxiliary supports and services to the deaf and hard of hearing, whenever necessary, to afford them an equal opportunity to benefit from their services.

   When deciding whether a particular aid should be provided, keep in mind that the general goal is to ensure all communications with individuals who are deaf or hard of hearing are effective.

Individuals qualifying for auxiliary supports and services
Individuals qualify for auxiliary supports and services if either of the following apply.

1. They are deaf or hard of hearing.
2. They are in one of the classes of people covered by the regulations.

The term "deaf" includes individuals who do not hear well enough to rely on their hearing to process speech and language. The term "hard of hearing" includes individuals with conditions that affect the frequency or intensity of their hearing. A deaf or hard of hearing person would be covered by ACA Section 1557 if they are substantially limited in hearing or substantially limited in some other major life activity because of hearing loss. An individual may be considered deaf or hard of hearing even if their hearing loss is eased by the use of a hearing aid or cochlear implant.

Auxiliary support and service options
The regulations include a long, but nonexhaustive list of auxiliary supports and services that may be provided in a particular instance. The list includes (among other possibilities):

- Qualified interpreters, who can provide services in person and on-site or remotely through technology, such as video remote interpreting (VRI)
- Use of written materials and exchange of written notes
- Voice-, text- and video-based telecommunications products, such as video relay service (VRS)
- Text telephones, called "teletypewriters" (TTYs)

There are many other options, though all must be provided free of charge to people who are deaf or hard of hearing. Any special technology such as VRI or VRS must meet technical and operational standards and users must be properly trained. The appropriate aid to use will depend on the individual with the disability, the type of communication and the context. When deciding which aid to provide, primary consideration should be given to the person with a disability who is requesting the service. Aids should also be provided in a timely manner and in such a way that protects the privacy and independence of the individual.

Persons qualified to act as interpreters
Interpreters used by covered entities (whether interpreting in-person or via VRI) should be qualified. A qualified interpreter may use one of several methodologies, but must:

1. Adhere to generally accepted interpreter ethics principles, including client confidentiality
2. Be able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology

You must not require a person who is deaf or hard of hearing to bring someone with him or her to interpret, nor should you rely on an adult companion or child to interpret, unless:

1. There is an emergency involving an imminent threat to the safety or welfare of the individual or the public and no other interpreter is available
2. The person requests interpretation from their companion and reliance on the companion is determined to be appropriate

For more from the Office of Civil Rights on effective communications for persons who are hard of hearing, go to the U.S. Department of Health and Human Services website.

Oversight of your subcontractors
If your subcontractors provide health care and/or administrative services for the Aetna Medicare business, they are a downstream entity.

You must ensure that your downstream entities abide by all laws, rules and regulations. This includes ensuring your:

- Contractual Agreements contain all CMS-required provisions
- Downstream Entities comply with applicable Medicare requirements, including operational and compliance program requirements

What may happen if you don't comply
If our FDRs fail to meet these CMS Medicare compliance program requirements, it may lead to:

- Development of a corrective action plan
- Retraining
- Termination of your contract and relationship with Aetna

Making sure you maintain documentation
You are required to maintain evidence of your compliance with the requirements for 10 years. Aetna or CMS may request that you provide documentation of your compliance with these requirements.

Annual attestation
Each year, on behalf of your organization, an authorized representative is required to review the **FDR Guide** and go to **Aetna.com/medicare** to complete the Aetna Medicare Compliance Attestation. In addition to completing an attestation, we and/or CMS may request that you provide evidence of your compliance with these Medicare Compliance Program requirements.

Report concerns or questions
If you identify noncompliance or fraud, waste and abuse, you can report it to us by using the mechanisms outlined in our **Code of Conduct**. We prohibit retaliation for good-faith reporting of concerns.

If you have questions about the requirements that apply to FDRs or if you have difficulty finding our **FDR Guide**, contact the Provider Contact Center.

Medicare Access and CHIP Reauthorization Act (MACRA) reimbursement policy
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015. MACRA created the Quality Payment Program (QPP), which repeals the Sustainable Growth Rate (SGR) formula. It changes the way Medicare rewards physicians for value versus volume over time.

Our MACRA reimbursement policy applies to both of the payment tracks below.

1. Advanced Alternative Payment Model (AAPM): Our value-based contracting reimbursement programs are known as "CPC+" or "Medicare Collaboration Premier" or "Medicare Collaboration Enhanced." They offer providers CMS-approved options to qualify for this track as an Other Payer AAPM as long as the AAPM criteria are met within your specific contract terms. However, our provider reimbursements do not adjust to include reciprocal AAPM bonuses. AAPM bonuses are based on CMS Fee-For-Service membership, not your Aetna-specific membership.
2. Merit-Based Incentive Payment System (MIPS): Our provider reimbursements do not adjust to include performance-based incentive payments made under traditional Medicare as the result of MACRA. Incentive payments are based on CMS Fee-For-Service membership, not your Aetna-specific membership.

Temporary move out of the service area
CMS defines a temporary move as:

1. An absence from the service area (where the member is enrolled in an MA plan) of six months* or less

2. Maintaining a permanent address/residence in the service area

An MA plan member is covered while temporarily out of the service area for emergent, urgent and out-of-area dialysis services. If a member permanently moves out of the MA plan service area or is absent for more than six months,* the MAO must disenroll the member from the MA plan.

Travel programs — when members are away from home for an extended period

Under travel programs, we let members travel out of their home service area for an additional 6 months for a total of 12 months in a row. Members travelling can get services from providers in our Medicare network for the service area they're visiting. Plan coverage rules still apply. For example, they may need referrals for some services. Our Medicare network isn't in all locations, so it is important members check for participating providers in the area they're visiting.

We offer two Medicare Advantage visitor/traveler programs:

- Travel Advantage (HMO plans)
- Travel Explorer (PPO plans)

Travel Advantage (HMO plans)

Travel Advantage is offered on *some* **Individual** and **Group** Medicare Advantage HMOs. It's not available to California (CA) or Florida (FL) members or those members enrolled in our Medicare Advantage Prime Plan.

- **Visitor Traveler:** Allows members to remain in their plans for an extra six months when out of the plan's service area.
- **Seamless network:** Multi-state network allows HMO members to get routine services at an in-network cost share when they see a contracted Aetna HMO provider throughout the United States. An HMO member cannot see a PPO-contracted provider.
- **Medicare Advantage Open Access HMO:** Members don't choose PCPs. When enrolled in Travel Advantage, members can continue using any Aetna Medicare Advantage HMO provider without a referral.
- **Medicare Advantage non-Open Access HMO:** Members whose plans need referrals and PCP choices have to change their PCP to another PCP in the service area they're visiting. The new PCP renders primary care services and refers members to other providers in the service area they're visiting.

Travel Explorer (PPO plans)

Travel Explorer is offered on *some* **Individual** Medicare Advantage PPO plans and includes "Travel Pass." For 2019, the Explorer travel program is available on some Individual Medicare Advantage PPO plans in the states listed below.

Alabama (AL)
Arizona (AZ)
California (CA)
Colorado (CO)
Connecticut (CT)
Delaware (DE)
Florida (FL)
Georgia (GA)
Illinois (IL)
Indiana (IN)
Kentucky (KY)
Louisiana (LA)
Maine (ME)
Massachusetts (MA)
Michigan (MI)
Mississippi (MS)
Nevada (NV)
New Jersey (NJ)
New York (NY)
North Carolina (NC)
Ohio (OH)
Pennsylvania (PA)
South Carolina (SC)
Tennessee (TN)
Utah (UT)
Virginia (VA)
Washington (WA)
Wisconsin (WI)
Wyoming (WY)

- **Visitor Traveler:** Allows members to stay in their plans for an extra six months when out of the plan's service area.
- **Seamless network:** Multi-state network allows PPO members to get routine services at an in-network cost share when they see a contracted Aetna PPO-provider throughout the United States.
- **Travel Pass:** Gives a snapshot of key health care elements such as your primary care provider, medication history, vaccine history and other information — all of which can help members direct their care while traveling.

Plans rules and requirements must be followed:

- Members may only change to PCP in another Medicare Aetna plan service area.
- If a plan requires a PCP, members must change their PCP. If they don't, their claims will be denied.
- Members must get PCP referrals in accordance with plan rules.

Urgently needed services

Urgently needed services are covered services provided to a member that are both of the following:

- Nonpreventive or nonroutine
- Needed to prevent the serious deterioration of a member's health following an unforeseen illness, injury or condition

*Twelve months for members enrolled in a stand-alone Medicare prescription drug plan (PDP).

Urgently needed services include conditions that cannot be adequately managed without immediate care or treatment, but do not require the level of care provided in the emergency room.

Physicians and other health care professionals and marketing of Aetna Medicare Advantage plans
MAOs and their contracted providers must adhere to all applicable Medicare laws, rules and regulations relating to marketing. Per Medicare regulations, "marketing materials" include, but are not limited to, promoting an MAO or a particular MA plan, informing Medicare beneficiaries that they may enroll or remain enrolled in an MA plan offered by an MAO, explaining the benefits of enrollment in an MA plan or rules that apply to members, or explaining how Medicare services are covered under an MAO plan.

Regulations prevent MAOs from conducting sales activities in health care settings except in common areas. MAOs are prohibited from conducting sales presentations and distributing and/or accepting enrollment applications in areas where patients primarily intend to receive health care services. MAOs are permitted to schedule appointments with beneficiaries residing in long-term care facilities, only if the beneficiary requests it.

Physicians and other health care professionals may discuss, in response to an individual patient's inquiry, the various benefits of MA plans. They shall remain neutral when assisting Medicare beneficiaries with enrollment decisions. Physicians are encouraged to display plan materials for all plans in which they participate.

For additional information, physicians and health care professionals can also refer their patients to:

- **1-800-624-0756 (TTY: 711)**
- The State Health Insurance Assistance Program
- The specific MAO marketing representatives
- CMS' website at **Medicare.gov**

Physicians and other health care professionals cannot accept MA plan enrollment forms.

We follow the federal anti-kickback statute and CMS marketing requirements associated with Medicare marketing activities conducted by providers and related to Aetna Medicare plans. Payments that we make to providers for covered items and/or services will:

- Be fair market value
- Be consistent with an arm's length transaction
- Be for bona fide (genuine) and necessary services
- Comply with relevant laws and requirements, including the federal anti-kickback statute

For a complete description of laws, rules, regulations, guidelines and other requirements applicable to Medicare marketing activities conducted by providers, refer to Chapter 3 of the Medicare Managed Care Manual, and the **Medicare Communications and Marketing Guidelines** contained therein, which can be found on the CMS website.

Annual notice of change
MA plan benefits are subject to change annually. Members are provided with written notice regarding the annual changes by the date specified by CMS. The CMS Annual Election Period typically runs from October 15 through December 7 for the upcoming calendar year for beneficiaries enrolled in individual MA-PD and PDP plans. Elections made during the Annual Election Period are effective January 1 of each year. Providers can access the **Aetna Medicare website** for information on the individual plans and benefits that will be available within their service area for the following calendar year.

Services received under private contract
As specified by Medicare laws, rules and regulations, physicians may "opt out" of participating in the Medicare program and enter into private contracts with Medicare beneficiaries. If a physician chooses to opt out of Medicare due to private contracting, no payment can be made to that physician directly or on a capitated basis for Medicare-covered services. The physician cannot choose to opt out of Medicare for some Medicare beneficiaries but not others, or for some services but not others.

The MAO is not allowed to make payment for services rendered to MA members to any physician or health care professional who has opted out of Medicare due to private contracting, unless the beneficiary was provided with urgent or emergent care.

Claims and billing requirements
Physicians and other health care professionals must use the current revision of the International Classification of Diseases, Clinical Modification (ICD-10-CM) codes and adhere to all conventions and guidelines specified in the ICD-10-CM Official Guidelines for Coding and Reporting. Complete, accurately use both the CMS Healthcare Common Procedure Coding System (HCPCS Level II) and the required procedural codes of the American Medical Association's (AMA's) Current Procedural Terminology (CPT), current edition.

Hospitals and physicians using the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, (DSMV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk-Adjustment Processing System.

- The ICD-10 CM codes must be to the highest level of specificity: A code is invalid if it does not contain the full number of required characters detailed in the tabular list. Valid codes may contain three to seven characters.
- Report all secondary diagnoses that impact clinical evaluation, management and/or treatment.
- Report all relevant status codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Again, failure to use current coding guidelines may result in a delay in payment and/or rejection of a claim.

Submitting Medicare claims and encounter data for risk adjustment

Risk adjustment is used to fairly and accurately adjust payments made to MAOs by CMS based on the health status and demographic characteristics of an enrollee. CMS requires MAOs to submit diagnosis data regarding physician, inpatient and outpatient hospital encounters on a quarterly basis, at minimum.

CMS uses the Hierarchical Condition Category payment model referred to as CMS-HCC model. This model uses the ICD-10 CM as the official diagnosis code set in determining the risk-adjustment factors for each member. The risk factors based on HCCs are additive and are based on predicted expenditures for each disease category. For risk-adjustment purposes, CMS classifies the ICD-10 CM codes by disease groups known as HCCs.

Providers are required to submit accurate, complete and truthful risk-adjustment data to the MAO. Failure to submit complete and accurate risk-adjustment data to CMS may affect payments made to the MAO and payments made by the MAO to the physician or health care professional organizations delegated for claims processing.

Risk adjustment medical record validation

CMS conducts medical record reviews to validate the accuracy of the risk-adjustment data submitted by the MAO. Medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient and physician diagnoses submitted by the provider to the MAO. In addition, Medicare Advantage regulations require that providers submit samples of medical records for validation of risk-adjustment data and the diagnoses reported by Aetna to CMS, as required by CMS.

Therefore, providers must give access to and maintain medical records in accordance with Medicare laws, rules and regulations. (Refer to the "Access to Facilities and Records" section in this manual.) CMS may adjust payments to the MAO based on the outcome of the medical record review.

Providers of hospice-related services

Aetna Medicare Advantage members may elect to use the hospice benefit in the Original Medicare program instead of their MA HMO and PPO coverage. Prior to initiating hospice care, the member or their representative must sign the "Election of Benefits" waiver. When this election is documented, the enrollee should be referred to the Original Medicare hospice provider.

Original Medicare will assume financial responsibility on the date the waiver is signed, and reimbursement will be made by Original Medicare directly to the agency. Durable medical equipment (DME) will be the responsibility of the hospice provider. The MA plan remains responsible for payment of those medical services not related to the terminal illness and additional benefits not covered by Medicare. An example of an additional benefit is the eyeglasses reimbursement.

For services not related to the terminal illness, inpatient services should be billed to the Medicare Fiscal Intermediary using the condition code "07." For physician services and ancillary services not related to the terminal illness, the physician or other health care professional should bill the Medicare carrier (as is done for Medicare FFS patients) and use the modifier "GW."

Attending physician services are billed to the Medicare carrier with the "GV" modifier, provided they were not furnished under a payment arrangement with the hospice. If another physician covers for the designated attending physician, the services of the substituting physician are billed by the designated attending physician under the reciprocal or locum tenens billing instructions. In such instances, the attending physician bills using the "GV" modifier in conjunction with either a "Q5" or "Q6" modifier.

Centers for Medicare & Medicaid Services (CMS) physician incentive plan: general requirements

Aetna Medicare Advantage regulations require that MAOs and their participating providers meet certain CMS monitoring and disclosure requirements that apply to "physician incentive plans." As outlined in 42 C.F.R § 422.208(a), a "physician incentive plan" means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any MA plan enrollee.

The physician incentive plan requirements apply to an MAO and any of its first-tier and downstream provider arrangements that utilize a physician incentive plan in their payment arrangements with individual physicians or physician groups. Provider downstream arrangements may include an intermediate first-tier entity. This includes, but is not limited to, an independent practice association (IPA) that contracts with one or more physician groups or any other organized group that provides administrative and/or health care services to MA members through downstream providers.

CMS imposes the following requirements on MAOs and their participating providers regarding physician incentive plan arrangements.

- MAOs and their participating providers cannot make a specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular MA enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.
- If the physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, the MAO or participating provider must ensure that all physicians and physician groups at substantial financial risk (as described in 42 C.F.R §422.208(a) & (d)) have either aggregate or per-patient stop loss protection (as described in 42 C.F.R §422.208(f)). In addition, MAOs and participating providers must conduct periodic Aetna MA member surveys in accordance with MA regulations.
- For all physician incentive plans, the MAO must provide CMS with assurances that applicable physician incentive plan requirements are met and information concerning physician incentive plans, as requested. To meet this CMS requirement, any participating provider with a physician incentive plan arrangement must annually provide Aetna with the following information for each physician incentive plan arrangement:
  - Whether referral services are covered by the physician incentive plan
  - The type of physician incentive plan arrangement (that is, withhold, bonus, capitation)
  - The percent of total income at risk for referrals
  - The patient panel size
  - The amount and type of stop loss protection

We will disclose any physician incentive plan arrangements maintained by participating providers, if required to do so, under applicable laws and regulations.

CMS physician incentive plan: substantial financial risk

As more fully described in 42 C.F.R. § 422.208 (a) and (d), substantial financial risk occurs when risk is based on the use or costs of referral services and that risk exceeds a risk threshold of 25% of potential payments. (Payments based on other factors, such as quality of care furnished, are not considered in this determination.) Refer to 42 C.F.R. § 422.208 for additional information.

CMS physician incentive plan: stop loss protection requirements

In addition, as more fully described in 42 C.F.R. §422.208(f), MAOs and their participating providers must ensure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop loss protection in accordance with the following requirements:

- Aggregate stop loss protection must cover 90% of the costs of referral services that exceed 25% of potential payments.
- For per-patient stop loss protection, if the stop loss protection provided is on a per-patient basis, the stop loss limit (deductible) per patient must be determined based on the size of the patient panel. It may be a combined policy or consist of separate policies for professional services and institutional services. In determining patient panel size, the patients may be pooled, as described in 42 C.F.R. § 422.208(g).
- Stop loss protection must cover 90% of the costs of referral services that exceed the per-patient deductible limit. The per-patient stop loss deductible limits are set forth in 42 C.F.R. § 422.208(f).

Participating providers with physician incentive plan arrangements must maintain, at their sole expense, any stop loss coverage they are required to maintain

under applicable laws and regulations. They must also provide evidence of such coverage to us upon request.

Aetna Medicare Advantage organization (MAO) obligations

The MAO is prohibited from restricting a physician or health care professional from advising his or her patients about:

- Their health status
- Their treatment options
- The risks and benefits of their treatment options
- The opportunity to refuse treatment and/or express preferences about future treatment decisions

CMS: CY 2019 Medicare Communications and Marketing Guidelines (MCMG)

In July 2018, CMS released new guidelines, titled **CY 2019 Medicare Communications and Marketing Guidelines (MCMG)**. Review **Section 60 — Activities in a Healthcare Setting** for complete details.

Provider-initiated activities are those conducted by a health care professional at the request of the patient or as a matter of a course of treatment, when meeting with the patient as part of the professional relationship.

Permissible activities

- Distributing unaltered, printed materials created by CMS
- Providing the names of plans with which they participate
- Answering questions or discussing the merits of a plan or plans, including cost sharing and benefits information (these discussions may occur in areas where care is delivered)
- Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP), plan marketing representatives, their state Medicaid or Social Security office, or Medicare via **Medicare.gov** or **1-800-Medicare (1-800-633-42273)**
- Referring patients to plan marketing materials available in common areas
- Providing information and help applying for the low-income subsidy (LIS)

What contracted providers may do

- Make communication materials available, including in areas where care is delivered
- Make plan marketing materials and enrollment forms available outside of the areas where care is delivered (such as common entryways or conference rooms)

Distributing or making plan marketing materials available is allowed as long as the provider does this for **all** plans in which they participate. **Providers must remain neutral when helping beneficiaries with enrollment decisions.**

Coventry workers' compensation and Coventry Auto Solutions

About Coventry

Coventry offers workers' compensation, auto and disability care and cost management solutions for employers, insurance carriers and third-party administrators. With roots in both clinical and network services, we leverage 30+ years of industry experience, knowledge and data analytics. As part of the specialty division of Aetna, our mission is returning people to work, to play and to life.

Workers' compensation

As a provider in the Coventry workers' compensation network, known as the Coventry Integrated Network℠ you participate in the largest national network in the workers' compensation industry. Coventry Workers' Comp Services actively markets your practice to insurance carriers, resellers, managed care organizations, third-party administrators and employers within your area.

Additionally, Coventry Workers' Comp Services provides Managed Care Organization (MCO) services in a number of states where MCO programs are supported by statute. Our MCOs are designed to manage medical costs and return-to-work outcomes without compromising quality of care. In addition, Coventry monitors legislative and regulatory changes in these states in order to ensure continued compliance and to identify opportunities to improve outcomes.

To help support the network, Coventry Workers' Comp Services offers workers' compensation payers and employers access to online directories and worksite posters. These directories and posters can help direct injured workers to identify participating network providers via our website at **CoventryWCS.com**.

Contact information and links

Coventry Workers' Comp services:
1-800-937-6824
CoventryAutoSolutions.com

Payer contact information:
DirectProvider.com

Workers' compensation tool

You can use **DirectProvider.com** to easily complete some of your daily tasks, including these related to workers' compensation:

- View bills, explanation of review (EOR) or pricing sheets
- Visit the Jopari Portal
- Refer a patient to a workers' compensation provider
- Locate provider resources specific to workers' compensation products

Just log in to **DirectProvider.com**, our provider website.

Injured worker and client identification

Coventry is dedicated to providing information important to our network doctors and hospitals. To this end, Coventry Workers' Comp Services makes available a detailed list with payer contact information. The list includes Coventry Workers' Comp Services clients and payers who access the Coventry Network for workers' compensation:

You can find the list online under the provider tool section of the workers' compensation website at **CoventryAutoSolutions.com**. Or you can access it directly by visiting **DirectProvider.com**.

Referral process

As a Participating Provider in Coventry Integrated Network, we appreciate your efforts to refer injured workers to other participating providers. Use of our network providers helps injured workers maximize their medical benefits and reduce their related out of pocket expense.

To determine who to refer to in network, go to **DirectProvider.com** and visit the "Refer a Patient" section. Or call **1-800-937-6824 (TTY: 711)**.

With this tool, you can quickly:

- Search for a provider by name
- Search by address
- Search by region
- View the Directory Library for pregenerated statewide and regional directories

Claims administration information

- **Verification of compensability**
  Verify the injured worker's compensability status by calling the injured worker's payer or clams administrator.
- **Utilization management and precertification**
  Utilization management requirements for workers' compensation patients vary from state to state. Contact the payer or claims administrator to verify utilization management or precertification requirements.
- **Billing, payment and claims**
  Provider/clinic claims for patients are typically billed electronically or on the CMS-1500 and UB-04 (or successor) forms and submitted by the provider's office. Incomplete forms or claims sent to the incorrect address may cause delays in payment.
- **Contracted amounts and allowable PPO**
  In accordance with state workers' compensation laws, the injured worker should not be balance-billed for the difference between the contracted amount and the total billed charges.
- **Guarantees of payment, prepayment agreements and separate fee arrangements**
  Providers should not enter into separate contracted-amount agreements with Coventry clients.
- **Covered services not medically necessary**
  Injured workers will not be billed for services that are determined to be "not medically necessary."
- **Billing follow up**
  Initial billing follow-up calls should be made to the payer or its administrator.
- **Explanation of review (EOR)**
  - Varies from payer to payer
  - For Workers' Comp questions related to an EOR, call the Customer Service telephone number located on the specific EOR

Provider responsibilities

Responsibilities of providers depends largely on the state in which the provider operates. Go to **CoventryWCS.com** to find information about state-specific requirements.

Under this section you'll be able to access information required by specific states by using the state drop-down box located on the right-hand side of the page.

Participants in the Coventry Integrated Network

As a participant in the Coventry Integrated Network, you need to do the following:

- See referred workers' compensation patients as soon as possible.
- Obtain prior authorization when required by applicable laws from the workers' compensation payer for proposed services.
- Communicate treatment plans to injured workers clearly.
- Respond promptly to requests for injured worker status and medical records.
- Familiarize yourself with the workers' compensation payers and accept PPO contract allowable as payment in full (to avoid balance billing).
- Help Coventry Workers' Comp Services maintain accurate information on your practice. (e.g., changes in address, federal tax identification number, etc.). To do this you may call **1-800-937-6824**. Or go to **DirectProvider.com** and use the update feature.
- Work with Coventry Workers' Comp Services and its payers to resolve issues.
- Comply with the requirements on **CoventryWCS.com** for filing a complaint or grievance.
- Understand clients' utilization management and precertification programs.
- Refer injured workers to other Coventry Workers' Comp Services providers. To do so, visit **DirectProvider.com** and use the "Referral Search and Directory Information" link.
- Respond promptly to requests for information related to recredentialing or database updates.
- Submit bills on behalf of injured workers.
- Encourage injured workers' return to work as medically appropriate.
- Report detailed information about the capabilities and limitations of the injured worker.
- Comply with all requests for verbal and written reports
- Keep informed of current workers' compensation regulations.
- Contact your state workers' compensation agency for updated treatment/disability management guidelines and available state training information.

Credentialing

All provider credentialing activities are completed by Aetna. Aetna uses the Council for Affordable Quality Healthcare (CAQH) as its single source of all required provider credentialing information. Under the CAQH program, providers use a standard application and a common database to submit one application to one source to meet the needs of all of the health plans and hospitals participating in the CAQH effort. Visit **CAQH.org** to learn more about CAQH.

Authorizing Aetna access to your application is easy. The CAQH application includes the Healthcare Organization Authorization page. On this page, the user will have to choose **one** of the following options in order for Aetna to be granted access to the application:

- Select the option "To ALL of the healthcare organizations listed above AND to any healthcare organization that in the future represents …".
- Select the option, "To only the healthcare organizations I indicate below …". The user will then have to specifically release Aetna from the list of Authorized Plans

Go to **Aetna.com/health-care-professionals/join-the-aetna-network/how-to-apply.html** or more information on our credentialing process.

Billing

Coventry Workers' Comp Services has partnered with Jopari Solutions to create a comprehensive end-to-end eBilling solution. This solution:

- Allows payers to receive bills directly from providers (via an agent) in an American National Standards Institute (ANSI) compliant format
- Allows providers to receive basic status of bills being processed
- Allows providers to receive electronic remittance advice from payers within required state timelines
- Allows providers to submit appeals and reconsiderations in paper or electronically
- Is expandable to allow Coventry Workers' Comp Services to act as eBill gateway for all client eBill transactions

- Is expandable to accommodate eBill requirements for new states as they adopt eBilling requirements
- Wraps around existing client workflow model to minimize client development and workflow change

Coventry is compliant with all states which require electronic billing. If you are a provider, and wish to become a Coventry Workers' Comp Services eBilling partner, contact Jopari Solutions at **1-866-269-0554**.

State-specific requirements

Go to **CoventryWCS.com** find information about state-specific requirements.

Coventry Auto Solutions

Coventry Auto Solutions offers cost-containment solutions to assist with the rising medical costs associated with medical payments resulting from auto-related injuries. We design best-in-class products and services to help restore the health and productivity of parties injured as a result of an auto injury. We accomplish this by developing and maintaining consultative, trusting partnerships with our clients, providers and other stakeholders, built on a foundation of innovative and customized solutions that support the claims management process.

Coventry Auto Solutions helps injured parties find participating providers in the Coventry Integrated Work® auto network. Payers and injured parties can visit our website, **CoventryAutoSolutions.com**, or call us toll-free at **1-800-793-6074 (TTY: 711)**.

A note about steerage: Although payers may not actively encourage their injured parties to seek treatment through a Coventry Auto Solutions participating provider, injured parties may locate you in a variety of ways. These include:

- Through their group health plan
- After being treated by you through Coventry's network for a prior workers' comp injury
- By locating you through an online provider directory or toll-free number
- By recommendation of a trusted associate or family member

Contact information and links

Coventry Auto Solutions:
1-800-937-6824
CoventryAutoSolutions.com

Payer contact information:
DirectProvider.com

Client identification

Note: Auto payers do not provide ID cards to insureds. Providers may access the Client/Payer list on **DirectProvider.com** in order to determine whether they are participating in the Auto Network for a particular member.

Claims administration information

Verification of compensability: Verify the injured party's compensability status by calling the carrier, payer or claims administrator.

- **Utilization management and precertification:** Contact the carrier, payer or claims administrator to verify utilization management or precertification requirements.
- **Billing, payment and claims:** Provider and clinic claims for patients are typically billed **electronically** or on the CMS-1500 and UB-04 (or successor) forms and submitted by the provider's office to a payer. Incomplete forms or claims sent to the incorrect address may cause delays in payment.
- **Contracted amounts and PPO allowable:** The injured party should not be balance billed for the difference between the contracted amount and the total billed charges.
- **Guarantees of payment, pre-payment agreements and separate-fee arrangements:** Providers should not enter into separate contracted-amount agreements with Coventry clients.
- **Covered services not medically necessary:** Injured parties will not be billed for services that are determined to be "not medically necessary."
- **Billing follow up:** Initial billing follow-up calls should be made to the carrier, payer or claims administrator.

- **Explanation of review (EOR):**
  - This varies from payer to payer
  - For questions related to an EOR, call the Customer Service telephone number located on the specific EOR

Provider responsibilities

As a participant in the Coventry Integrated Network℠, you need to do the following:

- Obtain prior authorization when required by the auto payer for proposed services.
- Communicate treatment plans to injured parties clearly.
- Respond promptly to requests for injured party status and medical records.
- Familiarize yourself with the auto payers and accept PPO contract allowable as payment in full (to avoid balance billing).
- Help Coventry Auto Solutions maintain accurate information on your practice. (For example, changes in address, federal tax identification number). To do this, you may call **1-800-937-6824**. Or go to **DirectProvider.com** and use the update feature.
- Work with Coventry Auto Solutions and its payers to resolve issues.
- Comply with the requirements for filing a complaint or grievance.
- Understand clients' utilization management and precertification programs.
- Respond promptly to requests for information related to recredentialing or database updates.
- Submit bills on behalf of injured parties.
- Comply with all requests for verbal and written reports.

First Health® and Cofinity® networks

About First Health and Cofinity

Our networks include the First Health Network and Cofinity Network. First Health is one of the nation's largest and most respected preferred provider organizations. It consists of more than 5,000 hospitals, over 90,000 ancillary facilities and over 1 million health care professional service locations. Cofinity is a leading regional network in Michigan and Colorado. You'll know when your patient is a member. One of our network logos will be on the identification card.

Our relationships with providers are an important part of our success. We are committed to making sure providers receive the latest information, technology and tools available when serving your patients.

First Health serves a wide range of payers, including third-party administrators, carriers, employers, Taft-Hartley trusts and government entities. More than 5.5 million people access the First Health network each year.

We serve the needs of student plans, unions and health plans, as well as self-insured employer groups and international payers.

Our provider portal

Our provider portal, **DirectProvider.com**, allows providers secure access to claims and pricing sheets for First Health's networks. Providers can:

- Search for claims by patient or physician
- View and print pricing sheets
- Research and correct misdirected claims

To register, providers will need a tax identification number (TIN), health plan name and provider ID number. If you need help registering, please contact Net Support at **1-866-284-8041**.

Eligibility
Go to **DirectProvider.com** to find eligibility information.

Call the payer phone number listed on the patient's ID card.

If you don't have access to the website or the ID card, call **1-800-937-6824** (option 3).

Referrals
Find a participating specialist on **FirstHealth.com** with the "Locate a Provider" button.

Call the payer phone number listed on the patient's ID card.

If you don't have access to the ID card, call **1-800-937-6824** (option 3).

Claims submission
Send claims electronically to the payer ID number listed on the patient's member ID card.

Send paper claims to the address listed on the patient's ID card.

If you don't have access to the ID card, call **1-800-937-6824** (option 3).

Claims status
Call the payer phone number listed on the patient's ID card.

If you don't have access to the ID card, call **1-800-937-6824** (option 3).

Claims follow-up
Go to **FirstHealth.com** to follow up on claims.

Call the payer phone number listed on the patient's ID card.

If you don't have access to the website or the ID card, call **1-800-937-6824** (option 3).

Fee schedules
Access **DirectProvider.com**, and select the "Request a Fee Schedule" tab for:

- Current or future fee schedules
- Full or sample schedules
- Single procedure code or range
- Changed values (future only)

Provider services
Call **1-800-937-6824** (option 3) for:

- All inquiries about the First Health Network
- Demographic updates
- Credentialing or contract requests
- Provider participation verification

Complaints and grievances
Request a copy of the First Health Complaints and Grievances process.

- Write to: First Health Complaints and Grievances, 3611 Queen Palm Dr., Ste 201, Tampa, FL 33619.
- Call Provider Services at **1-800-937-6824** (option 3).

See the First Health Network Provider Reference Guide available on **DirectProvider.com** for more information.

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