

**AETNA**  
**2005 PATIENT MANAGEMENT PROGRAM**  
**DESCRIPTION**

# Patient Management Program Approval

The Patient Management Program was:

Drafted: July 17, 1996 (as Aetna U.S. Healthcare)

Revision Approved:

William C. Popik, M.D.  
Chief Medical Officer

2/25/05  
Date

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Regional Medical Director

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Date

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Chairperson  
Regional Behavioral Health Oversight  
And Advisory Committee

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Date

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Chairperson  
Regional Quality Oversight Committee

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Date

*While this Patient Management Program is believed to be accurate as of Aetna's print date, it is subject to change without notice. This material contains only a partial, general description of our plans and programs. In case of a conflict between a member's plan documents and this information, the plan documents will govern. For a complete description of the benefits available to a particular member, including procedures, exclusions and limitations, refer to the member's specific plan documents, which may include the Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy and any applicable riders. All the terms and conditions of a member's plan and special programs are subject to and governed by applicable contracts, laws, regulations and policies. The availability of a plan or program may vary by geographic service area, and not all plans or programs are available to all members. Certain services, including but not limited to non-emergency inpatient hospital care, require precertification. All benefits are subject to coordination of benefits. All member care and related decisions are the sole responsibility of participating providers and their patients. Aetna does not recommend the self-management of health problems, nor do we promote any particular form of medical treatment. Members should be instructed to consult with their physicians for the advice and care appropriate for their individual needs.*

# Contents

- I. Introduction
- II. Patient Management Philosophy
- III. Mechanism For Updating Program
- IV. Committees
- V. Clinical Review Policies
  - A. Review Protocols
  - B. Determinations and Review Time Frames
  - C. Program Evaluation
- VI. Organizational Structure, Staffing and Staff Performance
  - A. Roles and Responsibilities
  - B. Training and Auditing
  - C. Accessibility
- VII. Components of the Patient Management Program
  - A. Inpatient Services
    - 1. Precertification
      - a. Inpatient Services Notification
      - b. Inpatient Medical Review
    - 2. Concurrent Review
    - 3. Discharge Planning
    - 4. Retrospective Review
    - 5. Pre-Admission and Post Discharge Outreach
  - B. Outpatient Services
    - 1. Precertification-Notification and Medical Review
      - a. Home Health Care/Durable Medical Equipment (DME)
    - 2. Emergency Services
  - C. Case Management
  - D. Other Patient Management Program Components
    - 1. Adverse Determination and Appeal Process
      - a. Initial Adverse Determination Process

- b. Peer-to-Peer Review Process
    - c. Appeal Process
    - d. External Review
  - 2. Non-Participating Provider Referral Authorization Process
  - 3. Transition of Care
- E. Quality Management Indicators
  - 1. Quality of Care Indicators
  - 2. Service Indicators
  - 3. Utilization Management
  - 4. Evaluation of Member and Practitioner Satisfaction with Patient Management Process
- VIII. Specialty Programs
  - A. Healthy Outlook Programs<sup>®</sup> (Disease Management)
  - B. National Medical Excellence Program<sup>®</sup>
  - C. Women's Health Programs
    - 1. Moms-to-Babies Maternity Management Program<sup>®</sup>
    - 2. Infertility Case Management Program
    - 3. Genetic Testing for Hereditary Breast and Ovarian Cancer
    - 4. Breast Cancer Case Management Program
  - D. Government Programs
- IX. Delegated Patient Management
  - A. Purpose/Goals
  - B. Reports/Audits
  - C. Appeals
- X. Components of the Delegated Behavioral Health Patient Management Program
  - A. Program Overview
    - 1. Philosophy
    - 2. Objectives
    - 3. Accountability and Monitoring
  - B. Guidelines for Behavioral Health Contractors
    - 1. Contractor Policy and Procedure Guidelines
    - 2. Reports

3. Clinical Guidelines

- C. Activities

1. Triage and Referral

2. Precertification

3. Inpatient Review/Concurrent Review

4. Discharge Planning

5. Retrospective Record Review

6. Coordination of Member's Care and Transition of Care when Benefits End

7. Case Management

8. Non-Participating Provider Review

9. Appeals

- XI. Confidentiality

## **I. INTRODUCTION**

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Aetna coordinates care and encourages members to be informed participants in decision making. In addition, Aetna evaluates and determines the appropriate level of coverage for medical services provided to our members. To accomplish this, Aetna has developed a comprehensive Patient Management Program.

## **II. PATIENT MANAGEMENT PHILOSOPHY**

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Patient Management is based upon the premise that dedicated staff, performing integrated activities, can contribute to improving the coordination of care delivered to members by independent health care providers within a managed care system in such a manner that an opportunity for an improvement in the quality of care occurs. An integrated managed care system should offer provider contracting based on quality of care and cost effectiveness, a Patient Management Program that addresses the entire continuum of clinical needs, and data analytical capabilities which support a continual improvement in the quality of care and services. Further, this integration should successfully affect all aspects of the coordination of health care benefits, inclusive of, medical/surgical, obstetrical, pediatric and behavioral health needs.

The Aetna Patient Management Program is accomplished through the combined efforts of nurses, social workers, Medical Directors and other staff in multiple Aetna departments and locations.

Aetna's Patient Management philosophy includes the following:

- Putting quality care first;
- Building collaborative relationships with physicians and hospitals;
- Using medical information and technology to its full effect; and,
- Bringing quality service to members and value to plan sponsors.

The Patient Management Program emphasizes early case identification based on predictive tools as well as other medical management approaches. The Patient Management Program operates at regional and national levels. However, oversight is generally consolidated in the regional office structure to promote consistency through health plans and products. This regional structure enhances efficient resource utilization and is designed to maximize administrative efficiency. Since each region has unique needs based on the maturity of its markets and the demographics of the members, their Patient Management Program is tailored to fit these needs as appropriate. The Patient Management Program integrates and complements the Regional Quality Management Program.

The focus of the Patient Management Program is on providing members with access to quality care and service while coordinating benefits based on clinical need. The Patient Management Program defines quality care as treatment that:

- Improves the member's physical and emotional status;
- Promotes health and healthy lifestyles and behaviors;
- Encourages early treatment;
- Involves members in informed decision making;
- Is provided by independent practitioners sensitive to illness-related issues;

- Is based on accepted medical principles;
- Uses technology and other resources effectively;
- Is accessible to members in a timely fashion; and,
- Is sufficiently documented in medical records.

The goals of the Patient Management Program are to:

- Improve the overall health and productivity of members;
- Promote the efficient utilization of medical resources throughout the care continuum;
- Provide consistent administration of benefits, processes and decision making; and,
- Identify and refer potential quality of care concerns to Quality Management for review.

### **III. MECHANISM FOR UPDATING PROGRAM**

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The Patient Management Program is reviewed annually. At the time of annual review, Patient Management staff, Quality Management staff, Precertification staff, Medical Directors, including the Regional Medical Directors and the Chief Medical Officer suggests revisions. The Chief Medical Officer approves the National Patient Management Program Description. The revised, approved national document is then submitted to the Regional Quality Advisory Committee (QAC) for review and recommendations, including applicable state-specific requirements, to the Regional Behavioral Health Oversight and Advisory Committee (RBHOAC) or its equivalent and the Regional Quality Oversight Committee (QOC) for review and adoption.

### **IV. COMMITTEES**

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Ultimate accountability for the management of Aetna’s program to promote improvement of the quality of clinical care and service provided to members rests with the plan Board of Directors (BoD) for HMO-based products, and for PPO-based products, the Aetna Life Insurance Company Board of Directors has delegated ultimate accountability to the Chief Medical Officer (CMO).

The following national and regional committees support the PM Program activities for both HMO and Traditional products.

The BoDs and CMO have delegated responsibility for development, implementation and evaluation of the Patient Management and Quality Management Programs to the Regional **Quality Oversight Committee (QOC)**, a multidisciplinary group composed of the following members:

- Regional Head of Health Care Delivery or Designee (Chairperson)
- Marketing/Sales Manager
- Customer Services Manager
- Quality Management Director
- Quality Management Managers
- Patient Management Representative
- Provider Relations/Network Manager
- Medical Director
- Compliance Representative
- Pharmacy Representative
- Behavioral Health Representative
- Claims/Operations Manager
- Provider Contracting Manager

- Provider Service Center Representative

The QOC establishes priorities for the regional Quality Management and Patient Management Programs, evaluates clinical and operational quality, and integrates quality improvement activities among all departments. The QOC monitors Quality Management and Patient Management activities for consistency with both national and region-wide program goals. The QOC reviews and approves clinical and service indicators/monitors, and quality improvement studies and initiatives. The QOC reviews and adopts Quality Management (including credentialing) and Patient Management policies and procedures. Applicable state-specific policy and procedure amendments are reviewed and approved by the QOC. In addition, the QOC reviews and adopts confidentiality policies developed and approved by the Aetna Privacy Office and monitors practices regarding the collection, use and disclosure of medical information. The QOC receives regular reports from national workgroups and committees for discussion and feedback as necessary. The QOC is responsible for review and evaluation of identified potential quality of care concerns related to facilities/vendors. The QOC provides comprehensive reports on at least a semiannual basis on Quality Management and Patient Management Program activities to the BoD and CMO. The QOC approves the Patient Management Program Description, the Quality Management Program Description, the Annual Quality Management Workplan and Annual Program Evaluation, and approves and oversees delegated activities. The QOC meets at least 8-10 times a year and is chaired by the Regional Head of Health Care Delivery or designee.

To monitor and facilitate quality of care and services to regional members, the QOC has established additional regional committees that report to the QOC. These committees are outlined below.

**Quality Advisory Committee (QAC):** Is delegated by the QOC to manage and provide direction on clinical quality improvement initiatives, and to review and make recommendations on: quality improvement studies and surveys, clinical indicators, member and practitioner/provider initiatives, practitioner/provider communications, selected Aetna policies and procedures, Quality Management Program Description, Annual Quality Management Workplan, Annual Quality Management Program Evaluation and Patient Management Program Description. The QAC reviews clinical criteria and protocols for adoption by the QOC; provides feedback to the National Guideline Committee regarding clinical practice guidelines and preventive health guidelines; provides feedback to the National Pharmacy and Therapeutics Committee regarding the formulary; and refers practitioner-specific performance issues to the Credentialing and Performance Committee (CPC).

The QAC meets at least quarterly and membership includes the following:

- Medical Director, Chairperson
- Six to eight participating practitioners with representation chosen from the following practice areas: family practice, internal medicine, pediatrics, OB/GYN, general surgery, orthopedics and behavioral health. Other specialty providers may be included as necessary for peer review and clinical input.

**Regional Behavioral Health Oversight and Advisory Committee (RBHOAC):** Is delegated authority by the QOC to provide guidance and direction on administrative, clinical and quality issues pertaining to behavioral health (mental health and chemical dependency), as well as approval and oversight of delegated behavioral health activities, such as Quality Management, credentialing, and/or Patient Management. The RBHOAC provides an environment for collaborative initiatives between the region and the behavioral health contractor(s), and facilitates the integration of behavioral health with primary care services. A RBHOAC may be established for each Behavioral Health Contractor. The RBHOAC reports to the QOC, provides analyses of reports and makes recommendations for level of oversight activities and clinical quality and service initiatives.

The RBHOAC meets quarterly, at a minimum and membership includes, but is not limited to:

**Aetna Representatives**

- Regional Quality Management Director (or designee), Chairperson
- Regional Medical Director
- Regional Patient Management Representative
- Quality Management Manager(s) or designees
- Member Services Representative
- Network Representative
- Compliance Representative

**Behavioral Health Contractor Liaisons**

- Medical Director
- Quality Management Representative
- Patient Management Representative
- Network Representative

**Ad Hoc Committees/Work Groups:** Ad hoc committees or work groups may be created to meet specific Patient Management Program needs.

The Chief Medical Officer is responsible for providing national strategic direction and oversight of the Patient Management and Quality Management Programs for all Aetna health plan members, for all products. The following national committees support the Patient Management Program activities.

**The National Medical Services Patient Management Workgroup (PMWG):** Is delegated authority by the Chief Medical Officer to provide strategic direction and oversight of the Patient Management Program for all Aetna health plan members. The PMWG activities include but are not limited to: the ongoing articulation and prioritization of the mission and direction of Patient Management activities; the aggregation and dissemination of Patient Management “best practices”; the proposal of benefit design changes as they affect Patient Management activities and the performance of the company’s business segments; the review and comment on Clinical Policy Bulletins; and the examination of operational and cross-functional barriers to the

performance of Patient Management activities. In addition, the PMWG provides direction to the development of Patient Management policy and procedure and serves as a policy approval body for all national Patient Management policies and procedures.

The PMWG meets at a minimum six (6) times per year and membership includes, but is not limited to the following:

- National Patient Management Medical Director, Chairperson
- Medical Director from each region (5)
- National Accounts Medical Director
- National Medical Director Medical Policy Administration
- National Medical Director Member Advantage Program
- Medical Director Disability
- Regional Patient Management Directors (2)
- National Behavioral Health Medical Director
- Aetna Integrated Informatics Representative
- Product and Plan Design Representative
- National Law Department Representative
- Periodic invited representatives: e.g. Women's Health, Oral Surgery, Pharmacy.

Other national committees that support the Patient Management and Quality Management Program are as follows:

**The National Guideline Committee (NGC):** Serves as the review approval body for clinical practice guidelines and preventive services guidelines taking into consideration feedback received from the regional QACs.

The NGC meets on an as-needed basis to conduct ongoing review and approval of clinical practice guidelines and preventative services guidelines at least every two years. Membership includes, but is not limited to the following:

- Regional Medical Director, Chairperson
- Other Regional Medical Directors
- Aetna Integrated Informatics, Head
- Medical Policy Administration, Head
- National Quality Management, Head
- Business Planning and Reporting, Head
- Member Advantage, Head
- National Behavioral Health Medical Director

**The National Pharmacy & Therapeutics Committee (P & T):**

- Develops and reviews the Aetna formularies (Preferred Drug List) for all Commercial and Medicare pharmacy benefit plans and makes coverage determinations for the Preferred Drug Lists for all pharmacy benefit plans. Determination of co-pay placement is not the purview of the P&T Committee, but is completed by Aetna Pharmacy Management;
- Makes recommendations regarding whether a drug represents an important therapeutic advance, is therapeutically similar to other available products, or has significant disadvantages in safety or efficacy when compared to other similar products in the same therapeutic class;
- Reviews and approves drug Medical Exception criteria, Precertification criteria, Step-Therapy criteria and Pharmacy Clinical Policy Bulletins; and,
- Reviews and supplies comments and recommendations on pharmacy clinical programs.

The P & T's determinations are based on the strength of scientific evidence from literature and database searches from a number of sources and includes, but is not limited to: United States Pharmacopeia-Drug Information (USP-DI), American Hospital Formulary Service Drug Information (AHFS-DI), DrugDex, Medline and other databases, including relevant findings of Federal government agencies, the pharmaceutical manufacturers, medical professional associations, national commissions, and peer-reviewed journals.

The P & T Committee targets monthly meetings but meets no less than six times a year, with ad hoc meetings as necessary. The committee may invite to its meetings persons outside or within Aetna who can contribute specialized or unique knowledge, skills, and judgment.

The membership includes the following members, both internal employees and external members who are practicing physicians and pharmacists:

The P&T Committee has external practicing physicians and pharmacists who are compensated for their work:

- Gerontologist, Geriatric Pharmacist Specialist, Internal Medicine, Family Practice, Endocrinologist, and Cardiologist.

Internal Aetna members on the P&T Committee:

- Director of Formulary Development and Clinical Policy, Co-Chair
- National Clinical Policy Medical Director, Co-Chair
- Medical Director, Behavior Health
- Medical Director, Patient Management
- Pharmacy Director, Clinical Pharmacy Programs

The P&T Committee also consults on an ad hoc basis a list of consulting practitioners in active clinical primary practice with representatives in specialties such as: Allergy, Dentistry, OB/GYN, Pulmonology, Neurology, Psychiatry, Dermatology, Oncology, Gastroenterology, Pediatrics, and other specialists as needed.

**National Patient Safety Work Group (PSWG):** Oversees, coordinates and institutes company-wide initiatives to improve the safety of Aetna members and our communities. The PSWG functions to:

- Develop and prioritize new patient safety initiatives;
- Provide updates on patient safety initiatives identified within the company, within the health care industry, and external to health care;
- Educate the company, members, and plan sponsors regarding information on patient safety issues and Aetna's role in promoting patient safety;
- Develop a common response to requests for proposals (RFP) and requests for information (RFI);
- Provide recommendations on incentives and rewards for structure and outcomes to improve patient safety; and,
- Report to the Chief Medical Officer on activities and accomplishments within the company.

The workgroup meets at least bimonthly and membership includes the following:

- Regional Senior Medical Director, Chairperson
- National Quality Management Medical Director
- National Quality Management Staff Representatives
- Regional Quality Management Representatives
- National Behavioral Health Representative
- National Marketing Representative
- National Network Management Representative
- National Network Operations Representative
- National Network/Provider Relations Representative
- Clinical Pharmacy Management Representative
- National Accounts Representative
- National Patient Management Representative
- Aetna Integrated Informatics Representative
- Human Resources/Employee Communications Representative

Additional national, regional, and local staff is asked to participate on specific ad hoc task forces, as indicated. These task forces may also include external consultants, hospitals, and practitioners.

**Patient Safety Communication Committee (PSCC):** Facilitates consistent communication to all Aetna's constituents (members, employees, participating providers and plan sponsors) regarding information on patient safety issues and Aetna's role in promoting patient safety.

The workgroup meets on an ad hoc basis and membership includes the following:

- Aetna IntelliHealth<sup>®</sup> Representative
- Marketing Communications Representative
- National Quality Management Representative

- Human Resources/Employee Communications Representative
- National Member Health Education Representative
- National Network/Provider Relations Representative
- National Medical Services Provider Communications Representative
- Public Relations Representative
- Product Development & Management Representative
- Aetna Navigator™ Representative
- National Pharmacy Representative

**External Review Oversight Committee:** Provides feedback on outcomes, identifying areas of improvement and assists in facilitating process changes related to initial coverage decisions, appeals and external review by:

- Reviewing potential revisions to Aetna Clinical Policy Bulletins;
- Formulating and operationalizing process improvements;
- Evaluating coverage decision making processes;
- Identifying training needs;
- Providing feedback on external review outcomes to local/regional and national management; and,
- Developing policy and procedures to assure compliance with all external regulatory and accreditation agencies, and to suggest action steps to achieve national consistencies and regulatory and accreditation compliance.

The committee meets quarterly and membership includes the following:

- National Medical Director (Head of Medical Policy Administration), Chairperson
- National Patient Management Medical Director
- Medical Director from each Region
- Government Programs Representatives
- Representative (MD) from National Behavioral Health
- Representative (MD) from Oral/Maxillofacial Surgery
- Representative (MD) from Clinical Claim Review
- Medical Resolution Team (MRT) Managers
- Law Department Representative
- External Review Unit Representatives

**Corporate Appeals Committee (CAC):** Handles all second and/or final level appeals of denials regarding the National Medical Excellence (NME) programs and other second level appeals identified as appropriate by the Regional Medical Directors.

The CAC meets weekly with emergency meetings held as necessary for expedited cases. The membership includes the following:

- Chief Medical Officer, Chairperson
- National Medical Director, Medical Policy Administration, Vice-Chairperson
- National Medical Excellence Medical Director
- National Accounts Medical Director
- National Quality Management Medical Director
- National Patient Management Medical Director
- National Medical Director, Clinical Cost Containment
- Regional Medical Directors - 2 (Rotating Position)
- Clinical Policy Medical Director
- National Medical Services Law Support (non-voting)

**National Risk and Delegation Oversight Committee (NRDOC):** Oversees national risk and delegation agreements, policies, procedures and processes. Oversight includes monitoring and reporting of risk entity and delegate performance and performance metrics and accountability.

The NRDOC meets monthly and membership includes the following:

- Head of Field Network Services, Network Contracting and Strategy, Co-Chairperson
- Chief Financial Officer, Key and Select Accounts, Co-Chairperson
- National Patient Management Medical Director
- Head of Credentialing
- Head of National Quality Management Operations and Performance Improvement
- Chief Compliance Officer
- Head of Internal Audit
- Head of Quality Assurance and Management, National Customer Operations
- Business Advisor(s):
  - ⇒ Head of National Risk Contracting Strategy
  - ⇒ Head of National Delegation Oversight
  - ⇒ Deputy Chief Counsel (Health Delivery)
  - ⇒ Health Delivery Finance

**Task Force on Racial and Ethnic Disparities in Health Care:** Assesses and tracks racial and ethnic disparities in health care and assesses initiatives to improve the quality of care for minority members. The group is charged with addressing the key programmatic, communication, medical, political, technical, and process issues underlying the ability to effectively mobilize and execute.

The task force meets on an ad hoc basis and membership includes the following:

- Aetna Chairman & CEO, Chairperson
- Aetna Vice President and Chief of Staff, Office of the Chairman, Vice-Chairperson
- Head of Aetna Integrated Informatics
- Head of Marketing, Middle Market Accounts
- Aetna Foundation, President
- Communications Staff Representative
- Head of Business Communications
- Head of Diversity
- Head of Investor Relations
- Member Advantage Medical Director
- National Quality Management Medical Director
- National Quality Management Representative
- General Counsel

**Advisory Committee on Racial and Ethnic Disparities in Health Care:** External group of eight eminent physicians and scholars that helps Aetna identify areas of focus and courses of action that demonstrate the potential to have the most impact in addressing disparities.

The committee meets on an ad hoc basis.

## **V. CLINICAL REVIEW POLICIES**

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### **A. Review Protocols**

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Aetna Patient Management and Precertification staff use evidence-based clinical guidelines from nationally recognized authorities in conjunction with the terms of the member's benefit plan to guide utilization management decisions involving precertification, concurrent review, discharge planning, and retrospective review. Aetna staff consult guidelines from the following sources: Milliman Care Guidelines<sup>®</sup> (Seattle, WA: Milliman USA); InterQual<sup>®</sup> Intensity, Severity and Discharge (InterQual ISD) criteria (San Francisco, CA: McKesson Health Solutions); and Solucient<sup>®</sup> (Evanston, IL: Solucient, L.L.C.); Aetna Clinical Policy Bulletins; other Aetna recognized criteria; and applicable state and federal guidelines. Aetna's Oral and Maxillofacial Surgery (OMS) Unit uses the American Association of Oral and Maxillofacial Surgeons (AAOMS) Parameters and Pathways 2000: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (ParPath 2000) version 3.0 to guide utilization management decisions for oral and maxillofacial surgery services. The relevant guidelines used in making coverage

decisions are made available, upon request, to Aetna members and their treating physicians. Aetna Clinical Policy Bulletins can be accessed on Aetna's internet website, [www.Aetna.com](http://www.Aetna.com).

Aetna's delegated behavioral health contractors consult Aetna's Level of Care Assessment Tool (LOCAT) in making decisions about the medically necessary level of care for behavioral health services. Aetna's Level of Care Assessment Tool (LOCAT) is a set of internally developed and validated evidence-based clinical guidelines for behavioral health services. The American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised: (ASAM PPC-2R) (Chevy Chase, MD: American Society of Addiction Medicine) are considered in decisions regarding the medically necessary level of care for chemical dependency services. Note: For Texas insured members, the Texas Alcohol and Drug Addiction Criteria (28 TAC §§3.8001-3.8022) is utilized in place of ASAM. Aetna's Mixed Services Guidelines are used to clarify responsibilities and facilitate care coordination of members with co-morbid medical and mental health conditions.

Aetna's utilization management criteria are reviewed annually by Aetna's regional Quality Advisory Committees for recommendations, and reviewed by the regional Quality Oversight Committees and Regional Behavioral Health Oversight and Advisory Committees for adoption.

Aetna medical benefit plans generally exclude from coverage medical technologies that are considered experimental and investigational and/or not medically necessary. Aetna's Clinical Policy Bulletins (CPBs) express Aetna's views regarding the experimental and investigational status and medical necessity of medical technologies (e.g., medical and surgical procedures, devices, pharmaceuticals, biological products, and behavioral health activities), and the organizational and supportive systems within which such care is provided.

Aetna's CPBs are based on credible scientific evidence in the peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, recommendations of physician specialty societies, the views of physicians practicing in related clinical areas, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies. The following factors are considered in evaluating medical technologies:

- Whether the medical technology has final approval from the appropriate governmental regulatory bodies;
- Whether the scientific evidence permits conclusions about the effect of the medical technology on health outcomes;
- Whether the medical technology improves net health outcomes;
- Whether the medical technology is at least as beneficial as any established alternatives;
- Whether the medical technology is more costly (taking into account all health expenses incurred in connection with the medical technology) than an alternative technology at least as likely to produce equivalent therapeutic or diagnostic results; and,

- Whether improvements are attainable outside of investigational settings.

Questions about the experimental and investigational status and medical necessity of a medical technology usually arise from Aetna's clinical staff (medical or pharmacy directors or other clinical staff) in the context of preauthorization, precertification, or retrospective claim review. In some instances, an assessment may be conducted at the request of other Aetna business areas (e.g., Aetna's Special Investigations Unit, Legal Department, Aetna Senior Management), from Aetna's Regional Quality Advisory Committees (QACs), from medical technology vendors (e.g., pharmaceutical or medical device manufacturers), or from participating Aetna healthcare providers. In addition, the Clinical Policy Unit may initiate an assessment at its own initiative, based on new information about a medical technology that is material to its experimental and investigational status or medical necessity. The Clinical Policy Unit Medical Director and the Chairman of the Clinical Policy Council determine whether a formal CPB on the medical technology needs to be developed or revised. The following factors are considered in prioritizing requests for revising or creating new CPBs:

- Whether a new formal policy or policy revision is necessary to support specific Aetna functions (e.g., precertification, claim reimbursement, special investigations, etc.);
- The potential impact of the medical technology on Aetna and its members;
- The quantity and importance of questions that have arisen regarding the medical technology;
- New evidence, guidelines, consensus statements or other information that is material to the experimental and investigational status or medical necessity of the medical technology; and,
- Changes in the regulatory status of the medical technology relevant to its experimental and investigational status or medical necessity.

For each medical technology selected for evaluation, the Clinical Policy Unit conducts a comprehensive search of the peer-reviewed published medical literature indexed in the National Library of Medicine PubMed Database, assesses the regulatory status of the technology, reviews relevant evidence-based clinical practice guidelines and related documents indexed in the Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse Database, and reviews relevant technology assessments indexed in the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Database. In addition, the opinions of relevant experts may be obtained where necessary.

Both new and revised CPB drafts undergo a comprehensive review process. This includes review by Aetna's Clinical Policy Council, the head of Aetna's Medical Policy Administration (MPA) Department, Aetna's Legal Department, and external practicing clinicians. The Clinical Policy Council is comprised of Aetna pharmacists and Medical Directors from the Medical Policy Administration Department, National Accounts Department, Behavioral Health Department, Clinical Pharmacy Department and Regional Patient Management Units. Draft CPBs are sent to the Chief Medical Officer or his designee for review and final approval.

Clinical Policy Bulletins are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants more frequent review.

All new and revised CPBs are reviewed by Aetna's Quality Advisory Committees, composed of practicing clinicians that participate in Aetna medical plans. This review may occur either prior to or after publication of the CPB on Aetna's websites. Recommendations from Aetna's Quality Advisory Committees are sent to the Clinical Policy Unit for review. The Clinical Policy Unit prepares a response to each of the QAC recommendations and may draft further revisions to the CPB as appropriate for consideration by Aetna's Clinical Policy Council.

Approved new, revised and updated CPBs become effective when published on Aetna's CPB websites. A complete index of published CPBs can be found on Aetna's Intranet site at: <http://aetnet.aetna.com/mpnt/cpb.html> and on Aetna's Internet site at: <http://www.aetna.com/cpb/index.html>.

Aetna's Pharmacy Clinical Policy Bulletins (PCPBs) are used to guide coverage determinations of the experimental/investigational status and medical necessity of outpatient prescription medications for Aetna's pharmacy benefit plans. Aetna PCPBs also provide criteria to be considered in decisions involving coverage of drugs subject to step therapy or precertification requirements, and coverage exceptions for drugs included on Aetna's Formulary Exclusion List.

Coverage of outpatient prescription medications may also be subject to formulary restrictions. Information regarding the process by which outpatient prescription medications are selected for inclusion on Aetna's formulary and the factors that are considered in formulary selection are available to members and providers through the Aetna® Medication Formulary Guide which is available on Aetna's website at <http://www.aetna.com/formulary>. Information about Aetna's Formulary is distributed to Aetna members upon enrollment and updated information is made available annually thereafter. Aetna's participating providers receive copies of Aetna's Medication Formulary Guide when they join Aetna and may request updated copies annually thereafter. The most current formulary information is available on the website.

An Aetna Pharmacy Management clinical pharmacist develops PCPBs for medical exception, precertification, and step therapy coverage criteria. All PCPBs are developed in consultation with physicians specializing in a particular field of practice. Coverage criteria are developed based on nationally recognized evidence-based guidelines and evidence in nationally recognized peer-reviewed published medical literature. A literature search is performed to document clinical medical evidence from a number of sources, including but not limited to: Medline and other databases, relevant findings of federal government agencies (e.g., National Institutes of Health, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention), medical professional associations (e.g., American Medical Association, American Academy of Pediatrics, American College of Cardiology), national commissions (e.g., Institute of Medicine, Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults), and peer-reviewed journals (e.g., Journal of the American Medical Association, New England Journal of Medicine, Annals of Internal Medicine, Drugs, and Annals of Pharmacotherapy).

PCPBs are reviewed by Aetna Pharmacy Management, Aetna Medical Directors, and practicing physicians and pharmacists. The National Pharmacy and Therapeutics Committee (P&T) is responsible for approving precertification and step therapy criteria. The P&T Committee reviews qualitative comments and the proposed criteria. After review by the P&T Committee, the criteria are presented to Aetna Pharmacy Management for adoption. The criteria are re-reviewed periodically, as new clinical information becomes available.

## B. Determinations and Review Time Frames

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Patient Management and Precertification coverage decisions are made within applicable Department of Labor (DoL), National Committee for Quality Assurance (NCQA), American Accreditation Healthcare Commission (URAC), Centers for Medicare & Medicaid Services (CMS), and state mandated time frames whether activities are delegated or not.

Medical Directors make all final decisions resulting in a denial of coverage for services on the basis of medical necessity. The Medical Directors conducting reviews have the education, training and experience commensurate with Patient Management or Utilization Management reviews. Medical Directors are available twenty-four hours per day, seven days per week for consultation on coverage decisions. Administrative denials based on the absence of any clinical information, as well as those related to plan benefit limitations or exclusions, may be issued without Medical Director review.

Behavioral health medical necessity denial decisions are rendered by a licensed psychiatrist. Pharmacy denial decisions are rendered by a licensed pharmacist or physician reviewer.

Neither Aetna nor delegated contractors compensate employees conducting Patient Management/Utilization Management reviews based on denials of coverage. There are no financial incentives to Patient Management/Utilization Management decision-makers for encouraging denials of coverage or service. In addition, staff is trained to focus on the potential risks of under-utilization as well as over-utilization of services.

## C. Program Evaluation

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Aetna evaluates the effectiveness of the Patient Management Program through:

- Analysis of outcome data;
- Tracking and trending utilization activities in all components of medical care;
- Monitoring patterns of care for potential over and under-utilization;
- Surveying member and provider satisfaction;
- Tracking and trending member complaints and appeals;
- Evaluating consistency of inter-reviewer reliability in applying criteria in making coverage decisions; and,
- Providing oversight of delegated Patient Management Programs.

The Patient Management Program is monitored and evaluated by licensed and non-licensed Patient Management and Precertification personnel on a regular basis.

Assessment tools are used to evaluate compliance with Patient Management policies and procedures, NCQA and URAC standards, as well as state or federal laws and regulations. A process is in place to evaluate inter-reviewer reliability.

The Patient Management Program is evaluated annually and on an ongoing basis by the Quality Advisory Committee, Quality Oversight Committee and Regional Behavioral Health Oversight and Advisory Committee or the equivalent.

## **VI. ORGANIZATIONAL STRUCTURE, STAFFING AND STAFF PERFORMANCE**

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Aetna's Patient Management and Precertification professional staff is composed of registered nurses, licensed practical or licensed vocational nurses, social workers, and physicians. In general, these professionals have a minimum of three to five years of clinical experience. Clerical staff supports all functions.

The Aetna Regional Medical Director has ultimate responsibility for oversight and implementation of the Patient Management Program for the region. Reporting to the Regional Medical Director, Medical Directors are responsible for the daily activities of Patient Management (PM) operations.

Board certified specialists of all types and training are available to assist in making coverage determinations.

The Aetna Behavioral Health Program is overseen nationally by a Behavioral Health Medical Director who has ultimate responsibility for the implementation of the behavioral health aspects of the Patient Management Program.

### **A. Roles and Responsibilities**

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#### **Regional Medical Director**

- Provides clinical and business leadership in support of strategic business objectives;
- Promotes quality and medical appropriateness of care;
- Acts as critical medical leader for external providers and plan sponsors, including regulatory & accrediting agencies, and community in general;
- Leader in improving and maintaining positive relations with providers, facilities, customers and consultants;
- Key business partner in network development strategy to maintain member access to high quality medical care;
- Key contributor in the development, maintenance and support of a marketable, high quality, cost effective provider network;
- Participates in the development, implementation, maintenance and support of designated provider contracts; and,
- Manages the medical management workforce and is responsible for all performance management and employee development activities.

### **Medical Director**

- Leads the clinical staff in the coordination of quality, cost effective care on behalf of members utilizing their available benefits;
- Acts as critical leader for external providers, plan sponsors, regulatory & accrediting agencies, and community in general; and,
- Provides strategic medical management leadership.

### **Patient Management Director**

- Provides strategic and operational direction for the delivery of performance based medical management;
- Develops and manages the regional health services organization focused on managing medical cost and improving clinical outcomes, member satisfaction with providers, and provider satisfaction;
- Selects and builds strong teams through training, diverse assignments, coaching, monitoring, auditing, performance management and other development techniques;
- Serves as a liaison with regulatory and accrediting agencies and other Health business units;
- Directs or provides enhancements to business processes, policies and infrastructure to improve operational efficiency;
- Manages budget;
- Formulates and implements strategy for achieving Key Performance Measures;
- Coordinates and manages Health Services Management functions provided by non-market services (e.g., delegated utilization activities);
- Develops, implements and evaluates policy and procedures which meet business needs; and,
- Serves as technical, professional and business resource.

### **Care Management Manager/Supervisor**

- Oversees and monitors the implementation of Aetna medical management services (including, but not limited to: inpatient care coordination, discharge planning, case management, disease management, and precertification) to meet business goals and maintain compliance with Aetna policies and procedures;
- Implements clinical policies and procedures in accordance with NCQA, URAC, state and federal standards and mandates;
- Assesses developmental needs and collaborates with others to identify and implement action plans that support the development of high performing teams;
- Serves as a content model expert and mentor to the team regarding practice standards, quality of activities, problem resolution and critical thinking;
- Manages resources responsible for identification of members for specialty programs, development and implementation of care plans, enhancement of medical appropriateness and quality of care, and the monitoring, evaluation and documentation of care;

- Communicates productivity expectations, balances workload (e.g., daily team meetings to discuss new referrals), monitors efficiency and initiates control measures to minimize variances in workload over time;
- Oversees implementation and monitoring of best practice approaches and innovations to better address the member's needs across the continuum of care; and,
- Establishes an environment and work style that promotes the concept of teamwork, cross product integration, and continuum of care thinking that results in strong performance.

### **Continuum of Care Manager**

- Establishes and monitors regional implementation of continuum of care philosophies and programs through matrixed relationships with Care Management Teams;
- Identifies case management training needs through observation, audit results and evaluation of case management reports, and collaborates with national and regional training staff to ensure development and implementation of training programs as needed to support case management process;
- Utilizes predictive modeling and case finding tools to identify cases for case management screening and assessment;
- Serves as a liaison between National Medical Services (NMS), Specialty Services and other continuum of care staff and the region for successful implementation of continuum of care programs;
- Collaborates with Medical Directors, Care Team Manager(s) and Supervisor(s) to monitor the quality of case management activities and develop corrective action as needed;
- Participates in national efforts to develop effective methods to identify members prior to an acute care episode who are appropriate for Continuum of Care programs;
- Participates in the development of workflows and tools and functions as a resource to the Care Management Manager and Supervisor in implementing new workflows and tools;
- Works with the regional staff on the Case Management Program and cost savings internal quality reviews, monitors outcomes, and facilitates change as indicated; and,
- Serves as a liaison to Disease Management, National Medical Excellence, Moms to Babies Programs and other centralized national programs.

## **Case Manager**

- Conducts comprehensive clinical assessments of members' care needs and determines approaches to meeting needs either through Aetna, the member's benefits plan or external programs and services;
- Applies data driven methods of member identification for case management following appropriate procedures for identifying, screening and assessing member needs;
- Utilizes proactive and predictive identification techniques to appropriately refer members to alternative specialty programs (e.g., Disease Management);
- Develops case management plans based upon comprehensive assessments that encompass member psychosocial needs;
- Evaluates and identifies health care service delivery using clinical knowledge to sequence services so that the member receives care in the most appropriate setting;
- Evaluates, periodically, the member's progress in meeting case management plan goals, and revises and coordinates plan with attending physician accordingly when appropriate;
- Applies case management concepts to complex issues and problem solving techniques in order to promote optimum member outcomes (e.g., provides information about alternative coverage or continuing care opportunities, as appropriate, and informs members of ways to obtain that coverage or care in the event the benefits end and the members still needs care, or when a member has a need that is not covered by the benefit plan);
- Applies and or interprets appropriate clinical criteria and guidelines, standardized case management plans, policies, procedures and regulatory standards for appropriate administration of plan benefits;
- Consults with supervisors and/or Medical Directors to overcome barriers to meeting case management plan goals, and revises and coordinates plan with attending physician accordingly when appropriate;
- Administers the hospital care, case management and quality management processes in compliance with various laws and regulations, URAC and NCQA standards and, Case Management Society of America (CMSA) standards where applicable, while adhering to company policy and procedures; and,
- Promotes communication, both internally and externally to enhance effectiveness of medical management services (e.g., physicians, claim administrators, plan sponsors, and third party payers as well as members, family members and health care team members respectively).

## **Inpatient Care Coordinator**

- Reviews and evaluates member's clinical history and current medical condition to identify needed medical services;
- Authorizes and coordinates the required services in accordance with the benefit plan;

- Determines appropriate level of coverage for inpatient stay by using clinical judgment and applying Milliman Care Guidelines, or Interqual criteria to meet the member's needs;
- Applies and/or interprets appropriate clinical criteria and guidelines, policies, procedures and regulatory standards for appropriate administration of plan benefits;
- Refers cases to the Medical Director and confers with the Medical Director, as appropriate, (to include presentation of cases at Medical Director rounds) to address barriers to meeting inpatient care and discharge planning goals and objectives;
- Utilizes proactive and predictive identification techniques to appropriately refer members to alternative specialty programs (e.g., Disease Management, Case Management);
- Conducts clinical assessments of members' care needs and determines approaches to meeting needs either through Aetna, the member's benefits plan or external programs and services;
- Evaluates, periodically, the member's progress in meeting the inpatient care plan and discharge goals and revises and coordinates the plan with the hospital discharge planner, the attending physician, and the member/family when appropriate;
- Coordinates discharge plans to home or alternative levels of inpatient care;
- Identifies potential alternative services based upon member benefit plan, other resources, local infrastructure, and individual needs;
- Evaluates and identifies health care service delivery using clinical knowledge in determining the most appropriate setting by identifying opportunities for members to utilize participating providers and services;
- Applies care management concepts to complex issues and problem solving techniques in order to promote optimum outcomes (e.g., evaluates the member's needs, and recommends appropriate cost effective alternatives);
- Administers the hospital care processes in compliance with various laws and regulations, URAC and NCQA standards, while adhering to company policy and procedures;
- Provides the appropriate level of assistance to facilitate coordination of care;
- Identifies and escalates potential quality of care concerns through established channels; and,
- Promotes communication, both internally and externally to enhance effectiveness of medical management services (e.g., physicians, claim administrators, plan sponsors, and third party payers as well as members, family members and health care team members respectively).

## Care Management Associate

- Performs initial review and triage of Care Management Team tasks;
- Identifies the principal reason for admission, the facility, and the member product to correctly apply focused intervention tools (FIT);
- Screens members using targeted business rules and processes to identify needed medical services, makes appropriate referrals to medical services staff and coordinates the required services in accordance with the benefit plan;
- Monitors non-targeted cases for entry of appropriate discharge date and disposition;
- Identifies and refers outlier cases (e.g., length of stay) to clinical staff;
- Identifies triggers for referral into Aetna's Case Management, Disease Management, Mixed Services, and other specialty programs;
- Conducts initial screening of cases referred to Case Management;
- Utilizes eTUMS and other Aetna systems to build, research and enter member information, as needed;
- Coordinates and arranges for health care service delivery under the direction of a nurse or Medical Director in the most appropriate setting by identifying opportunities for the member to utilize participating providers and services;
- Performs pre-admission and post-discharge calls in accordance with policy and procedure;
- Promotes communication, both internally and externally, to enhance effectiveness of medical management services (e.g., health care providers, and health care team members respectively);
- Performs non-medical research pertinent to the establishment, maintenance and closure of open cases;
- Provides support services to team members by answering telephone calls, taking messages, researching information and assisting in solving problems;
- Maintains accurate and complete documentation of required information that meets risk management, regulatory, and accreditation requirements;
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality;
- Assists in the research and resolution of claims payment issues through referred inquiries; and,
- Supports the administration of hospital care, case management and quality management processes in compliance with applicable laws and regulations, URAC and NCQA standards, and Case Management Society of America (CMSA) standards (as applicable), while adhering to company policy and procedures.

### **Nurse Consultant/Retrospective Review**

- Reviews medical documents to make benefit determinations;
- Applies and or interprets appropriate clinical criteria and guidelines, standardized case management plans, policies, procedures and regulatory standards for appropriate administration of benefits and/or to facilitate optimum outcome;
- Interprets relevant medical policy and applies benefit determinations to an identified case;
- Forwards potential quality of care or utilization compliance concerns to the appropriate area for further review or investigation;
- Refers cases, as appropriate, to the Medical Director;
- Utilizes proactive and predictive identification techniques to appropriately refer members to alternative specialty programs (e.g., Disease Management, Case Management); and,
- Documents required information accurately and completely to meet regulatory, accreditation, and risk management requirements.

### **Patient Management Administrative Assistant**

- Performs a wide variety of administrative support (e.g., typing, filing and phone support) for the Patient Management Department.

### **Integrated Provider Service Center Staff provides Patient Management support through the following roles:**

#### **Precertification Nurse**

- Receives calls, faxes and internally forwarded coverage requests from providers or members, applies appropriate clinical criteria and makes appropriate referrals to Medical Directors. Authorizes coverage and coordinates the requested service/procedure in accordance with the benefit plan;
- Consults with supervisors and/or Medical Director when coverage criteria are not met;
- Utilizes proactive and predictive identification techniques to appropriately refer members to alternative specialty programs (e.g., Disease Management, Case Management);
- Evaluates and identifies health care service delivery using clinical knowledge in determining the most appropriate setting by identifying opportunities for members to utilize participating providers and services;
- Promotes communication, both internally and externally, to enhance effectiveness of medical management services (e.g., physicians, claim administrators, plan sponsors, third party payors as well as members, family members, and health care team members respectively);
- Applies and/or interprets appropriate clinical criteria and guidelines, policies, procedures and regulatory standards for appropriate administration of plan benefits;
- Interprets relevant medical policy/benefits for an identified case;

- Provides the appropriate level of activity to facilitate coordination of care;
- Identifies members that may have other co-morbidities and may benefit from activities at the individual or population based level;
- Advocates for members to the full extent of existing health benefits coverage and programs;
- Interprets medical policy and guidelines to make appropriate coverage decisions;
- Identifies and escalates potential quality of care concerns through established channels;
- Administers the precertification processes in compliance with various laws and regulations, URAC and NCQA standards, and Case Management Society of America (CMSA) standards (as applicable), while adhering to company policy and procedures; and,
- Provides accurate and complete documentation of required information that meets risk management, regulatory, and accreditation requirements.

#### **Inbound Queue Associate**

- Performs intake of calls from members or providers regarding services via telephone, fax or EDI;
- Performs registration of activities in accordance with the benefit plan for services not designated for medical review;
- Performs non-medical research including eligibility verification, COB, and benefits verification;
- Maintains accurate and complete documentation of required information that meets risk management, regulatory, and accreditation requirements;
- Screens requests for appropriate referral to medical services staff including precertification reviews to the nurse consultant and transactions involving members active in Case Management to the Case Manager;
- Promotes communication, both internally and externally, to enhance effectiveness of medical management services (e.g., physicians, claim administrators, plan sponsors, third party payors as well as members, family members, and health care team members respectively); and,
- Supports the administration of the precertification process in compliance with various laws and regulations, URAC and NCQA standards, while adhering to company policy and procedures.

## **B. Training and Auditing**

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A consistent and comprehensive 3-week new-hire orientation is provided for all Patient Management staff. During the first six months on the job, new staff members are required to participate in a period of on-the-job preceptorship and role-specific training. Formal training is delivered via a “blended” methodology including face-to-face classroom sessions, “virtual” sessions and self-paced/eLearning modules. Patient Management training delivery staff is co-located in the regional sites. This staff reports centrally into National Patient Management. The Patient Management design and development staff (comprised of Patient Management subject matter experts), report to

the National Customer Operations (NCO) organization. Both the Patient Management design and development staff and the Patient Management delivery staff have the responsibility of measuring the effectiveness of the curricula. Staff is encouraged to participate in external educational programs and conferences to maintain their competency in the subject matter. A formal Medical Director Training Program is provided to new Medical Directors. In addition, on an as needed basis, Medical Directors receive one-on-one training sessions with other experienced Medical Directors. Clinical staff is encouraged to participate in regular Continuing Medical Education programs.

To maintain consistent application of the criteria and delivery of the Patient Management Program, Aetna monitors all professionals for inter-reviewer reliability on an annual basis. Consistency in the application of criteria and the individual's contribution to the Patient Management Program according to policy is verified by a number of methods, as described in Patient Management policy and procedure including selection of a random sample of Utilization Management and Case Management files for internal quality reviews. The inter-reviewer reliability internal quality review tool is one method utilized to evaluate staff performance. When opportunities for improvement are identified, a re-training program is developed when the opportunity includes a group, and individual action plans are developed with the staff as appropriate. Staff who does not meet Aetna's performance benchmarks are given feedback, additional training or information as needed, and then re-evaluated to assess the success achieved by the performance improvement plan.

## C. Accessibility

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Staff is available 24 hours/day, seven days/week via a toll free number. Urgent coverage requests received after normal business hours are addressed and routine inquires and requests are prioritized and answered, as appropriate, on the next business day. The toll free number to access the member's designated Patient Management Unit is printed on the member ID card.

Requests with respect to urgent or emergent issues related to discharge planning, transportation, or services by non-participating providers are forwarded to the on-call Medical Director for immediate handling as needed. A Medical Director is on call via beeper during all non-business hours.

## **VII. COMPONENTS OF THE PATIENT MANAGEMENT PROGRAM**

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Aetna offers various combinations of the Patient Management Program to plan sponsors and individuals. Not all programs are available to all members. Depending on the specifics of each unique health benefit plan the following components may be included:

- A. Inpatient Services
  - 1. Precertification
    - a. Inpatient Services Notification
    - b. Inpatient Medical Review
  - 2. Concurrent Review
  - 3. Discharge Planning
  - 4. Retrospective Review
  - 5. Pre-Admission and Post Discharge Outreach
- B. Outpatient Services
  - 1. Precertification - Notification and Medical Review
    - a. Home HealthCare/Durable Medical Equipment (DME)
  - 2. Emergency Services
- C. Case Management
- D. Other Patient Management Program Components
  - 1. Adverse Determination and Appeal Process
    - a. Initial Adverse Determination Process
    - b. Peer-to-Peer Review Process
    - c. Appeal Process
    - d. External Review
  - 2. Non-Participating Provider Referral Authorization Process
  - 3. Transition of Care
- E. Quality Management Indicators
  - 1. Quality of Care Indicators
  - 2. Service Indicators
  - 3. Utilization Management
  - 4. Evaluation of Member and Practitioner Satisfaction with Patient Management Process

## A. Inpatient Services

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### 1. *Precertification*

Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services.

A precertification list, which identifies services, supplies and procedures that require precertification, has been established and is reevaluated and adjusted periodically with a Patient Management core team of Medical Directors and Patient Management department directors.

The precertification process permits advance eligibility verification, determination of coverage, and communication with the physician and/or member (precertification). It also allows Aetna to coordinate the member's transition from the inpatient setting to the next level of care (discharge planning), or to refer members for specialized programs such as Disease Management or the Case Management Program. Precertification may either be done telephonically or electronically, through an Electronic Data Interchange (EDI) or Internet solution. There are two components of precertification, notification and medical review.

#### *a. Inpatient Services Notification*

Notification is the process of gathering basic information about an inpatient service before services are rendered. This information allows proactive management of the case or can trigger referral to programs such as Case Management for high-risk maternity care. Notification is a data entry precertification process and does not require a judgment or interpretation of medical necessity. Notification may either be done telephonically or electronically through an Electronic Data Interchange (EDI) or Internet solution. The electronic solutions are available 24 hours/day six and one-half days a week.

The purpose of notification is to:

- Determine member eligibility for services and benefits;
- Facilitate accurate and timely claim adjudication;
- Identify opportunities for referral to Case Management, National Medical Excellence or other specialty programs after determining that benefits are available;
- Assess provider utilization patterns;
- Investigate potential alternative benefit opportunities (e.g. Coordination of Benefits, Worker's Compensation, Medicare fee for service as primary carrier, subrogation);
- Identify utilization issues that may adversely impact care to members (e.g., over or under utilization);
- Initiate pre-admission discharge planning when feasible; and,
- Assign length of stay for tracking purposes.

### *b. Inpatient Medical Review*

Inpatient medical review requires that the treating physician or hospital utilization staff provide information regarding the patient's medical condition and proposed treatment or service. Once this information is obtained, Utilization Review/Patient Management staff uses nationally recognized guidelines and resources such as Milliman Care Guidelines<sup>®</sup> and InterQual<sup>®</sup> ISD criteria to guide the precertification, concurrent review, discharge planning and retrospective review processes. To the extent certain Utilization Review/Patient Management functions are delegated to integrated delivery systems, independent practice associations or other provider groups ("Delegates"), such Delegates utilize criteria that are scientifically based and approved by Aetna.

Decisions are made based on criteria discussed above as well as the individual needs of the member, taking into account the make up of the local network.

## *2. Concurrent Review*

Concurrent review encompasses those aspects of Patient Management that take place during the provision of services at an inpatient level of care. Concurrent review is conducted on-site or telephonically. The concurrent review process includes:

- Obtaining necessary information from providers and facilities concerning the care provided to members;
- Assessing members' clinical condition and the ongoing medical services and treatments to determine benefit coverage;
- Identifying continuing care needs early in the inpatient stay to facilitate discharge to the appropriate setting;
- Identifying members for referral to covered specialty programs such as Case Management, Behavioral Health and Disease Management; and,
- Planning and coordination for discharge.

The goals of concurrent review include:

- Determining coverage for appropriateness of admission and level of care;
- Determining the appropriate level of coverage and appropriate level of care for continued inpatient care;
- Verifying member benefits and coordination of covered services and supplies;
- Determining payment to providers commensurate with the services being rendered and according to applicable contracts and agreements;
- Identifying potential quality of care concerns involving network providers;
- Providing discharge planning assistance early and throughout the process;
- Working closely with hospitalists (as applicable) to eliminate redundancy in functions;
- Identifying cases for referral to the Case Management Program, Disease Management Programs, National Medical Excellence Program, Moms to

Babies Maternity Management Program<sup>®</sup>, other Women's Health Programs, and behavioral health contractors;

- Identifying potential alternative benefits (e.g., Coordination of Benefits, Worker's Compensation, Medicare fee for service as primary carrier, subrogation) not noted during precertification;
- Identifying cases requiring Medical Director review; and,
- Identifying individual needs of the member, taking into account the local healthcare delivery system.

When the Inpatient Care Coordinator or Case Manager identifies a potential issue, they may review the issue with the attending physician or other physicians participating in the care of the member.

A member's treating physician may decide to revise the treatment plan to reflect more appropriate utilization. When an agreement on coverage cannot be reached, the member's case is reviewed by a Medical Director. The attending or primary care physician (PCP) may be contacted by the Medical Director to discuss the issue further before making a final coverage determination. If information needed to make a determination is not available from either the physician or hospital, coverage of the day(s) in question may be denied. When the information available is insufficient to render a determination, a decision may also be made to request the pertinent portions of the medical record in order to perform a retrospective review.

It is intended that, through the Patient Management Program, all inpatient coverage decisions be made concurrently unless appropriate information is not available from physicians and/or hospital utilization management staff.

### *3. Discharge Planning*

Discharge planning for the confined member is defined as a collaborative, prospective planning process that includes the hospital or other alternate care provider, Aetna, other healthcare providers, the treating physician, a member and his/her family to facilitate transitioning the member to a setting appropriate to his/her clinical needs in as timely and efficient a fashion as possible.

Discharge planning may be initiated at any stage of the Patient Management process. Assessment of potential discharge planning needs begins at the time of notification, and coordination of discharge plans commences upon identification of post discharge needs during precertification or concurrent review. The discharge plan considers the age/social status, prior history, prior admissions, home safety issues and psychosocial issues. The discharge plan may include initiation of a variety of services or benefits to be utilized by the member upon discharge from an inpatient stay. Referral to internal resources may include Case Management, Disease Management Programs and vendors, Women's Health and National Medical Excellence. External referrals and services may include: transfer to inpatient skilled nursing, sub-acute care or rehabilitation facilities, home health care, durable medical equipment and supplies, social work services, community resources, and support groups.

Discharge planning goals include:

- Determination of benefits according to applicable contracts and agreements;

- Prevention of readmission through the promotion of optimal recovery;
- Delivery of care in the appropriate setting;
- Continuity of care; and,
- Cost-effective utilization of appropriate resources;
- Identification of cases for referral to Case Management Program, Disease Management Programs, National Medical Excellence Program, Moms to Babies Maternity Management Program<sup>®</sup>, other Women's Health Programs, and behavioral health contractors.

#### 4. *Retrospective Review*

Retrospective review is the process of reviewing coverage requests for initial certification after the service has been provided or when the member is no longer an inpatient. Retrospective review includes making coverage determinations for the appropriate level of service consistent with the member's needs at the time of service after confirming the member's eligibility and benefit plan.

The purpose of retrospective review is:

- To review initial requests for certification that are made after discharge or after the provision of service, and in anticipation of claim adjudication, for procedures and services included on the Aetna National Participating Provider Precertification List or on a plan sponsor specific member precertification list;
- To analyze submitted documentation to determine coverage and rationale behind failure to follow precertification or notification requirements;
- To identify and refer appropriate members to available Aetna programs, such as Disease Management or Case Management;
- To identify and refer potential quality and/or utilization issues; and,
- To initiate appropriate follow-up action, based on quality or utilization issues.

Aetna's effort to monitor the services provided to members by independent health care providers includes the retrospective review of claims submitted for payment, and a review of a given case for potential quality and utilization concerns. These concerns are identified through three main sources:

- Patient Management/Precertification Department review (nurse reviewers identify a potential quality assessment/utilization review concern during precertification, concurrent review, or Case Management activities);
- The routine selection of claims based upon predetermined criteria; and,
- Special requests (e.g., grievances, complaints, chart review, confirmation of administrative data sets, etc.).

#### 5 *Pre-Admission and Post Discharge Outreach (for select inpatient diagnoses or procedures)*

The focus of the Aetna Patient Management Call Program is to provide members with access to quality care and service while coordinating benefits for medically appropriate services. The Call Program, available for select inpatient diagnoses or procedures, is a unique component of the Patient Management Program, developed to:

- Proactively assess a member's preparedness for admission and plan for potential discharge needs while focusing on lengths of stay and transitions across levels of care (pre-admission call) and;
- Evaluate for and address potential discharge needs while focusing on re-admission rates (post-discharge call).

Members are identified for participation by specific diagnosis or procedure code related to a scheduled inpatient elective admission or a recent discharge, unless otherwise specified by a plan sponsor.

- The Call Program includes a pre-admission call option and a post-discharge call option.
- Pre-admission calls focus on members with select inpatient diagnoses that generally involve a procedure or service for which the optimal recovery course may be significantly impacted by early assessment and identification of discharge needs.
- Pre-admission calls promote patient safety in areas of adequate post-discharge support and availability of appropriate equipment.
- Post-discharge calls focus on members with inpatient diagnoses or procedures that generally require post-discharge coordination of medical or surgical services.
- Post-discharge calls promote patient safety in areas of medication management, use and availability of appropriate equipment, post-hospitalization follow-up with treating practitioners, and promotion of preventive care measures.
- Both pre-admission and post-discharge calls focus on a short-term plan that can be implemented successfully within three (3) active calls or less. Cases that may extend beyond this parameter are screened for referral to specialty programs such as Case Management.
- The Call Program is applicable for all members with the selected diagnoses or procedures including those active in Case Management.

## B. Outpatient Services

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### 1. *Precertification-Notification and Medical Review* (not available for all Aetna Traditional products)

The outpatient service precertification process, and the development and evaluation of the Precertification List for outpatient services follow the same processes observed for inpatient services for those members who have coverage for this benefit under their health benefit plan. As with inpatient services, some outpatient services require only notification. Notification and precertification may either be done telephonically or electronically through an Electronic Data Interchange (EDI) or Internet solution.

Referrals to participating specialists, most diagnostic services and outpatient surgical procedures using participating network providers generally do not require prospective review by Aetna. However, the terms of a member's particular coverage may require prospective review for such services.

Specialists participating with Aetna may typically perform "automatic studies," as a part of their initial evaluation, without receiving specific authorization to do so. In addition, several "Direct Access" programs exist. Members may seek routine care through these specialists without PCP referral, within the limits of their benefit plan.

Requests for referrals to non-participating specialists are reviewed through the precertification process by the Precertification staff under a Medical Director's direct supervision. All requests for coverage for behavioral health services by non-participating providers are reviewed by the delegated behavioral health contractor.

#### a. *Home Health Care/Durable Medical Equipment (DME)*

Managing, coordinating and tracking certain outpatient services or supplies not connected with an inpatient stay are also functions performed by the Patient Management and Precertification staff. Home health care, electric beds, motorized wheelchairs and scooters, limb and torso prosthetics and customized braces are examples of services and equipment that may require coverage approval by the Precertification or Case Management staff in order for benefits to be available. Behavioral health contractors perform authorizations for psychiatric outpatient services, including home health care.

Requests for these services may be received from the attending or Primary Care Physician, specialist physicians or other providers for members in the home or outpatient setting. Since most services are of an on-going nature, initial certification is followed by a period of care coordination and utilization monitoring. Goals of this process are:

- Assessment of the level and quality of the services provided;
- Determination of the coverage for the proposed treatment;
- Identification of care and treatment alternatives, when appropriate; and,
- Identification of members for referral to specialty programs such as Case Management or Disease Management for members who have coverage under their health plan benefits.

## 2. *Emergency Services*

Aetna's definition of "Emergency Services" includes the "prudent lay person" standard definition in compliance with the Balanced Budget Act of 1997. Accordingly, an emergency medical condition is "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part."

## C. Case Management

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Case Management is defined as a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes<sup>1</sup>.

Case Managers review and coordinate services for members with multiple and complex needs, (e.g. cardiac care, complex pediatric care, oncology, transplantation, etc.) and for members who are at risk for high cost or high utilization. Case Management staff strives to enhance the member's quality of life, support continuity of care, facilitate provision of services in the appropriate setting and manage cost and resource allocation to promote quality, cost-effective outcomes. Case Managers collaborate with the member, family, caregiver, physician and healthcare provider community to coordinate care, with a focus on member education and maximizing quality outcomes.

Case Managers provide the member with information about alternative coverage or continuing care opportunities, as appropriate, and inform the member of ways to obtain that coverage or care in the event the member's benefits end and the member requires additional care. Alternative options for coverage or care may include local, state, or federally funded agencies or non-profit organizations.

The objectives of Case Management are to provide early identification and intervention for members who would benefit from:

- Improved skill in self management;
- Referral to Disease Management Programs and/or to the designated Behavioral Health Contractor;
- Improved transition and coordination among multiple providers and/or levels of care;
- Coordination of end of life care needs;
- Assistance to maximize the effective use of a limited health plan benefit;
- Reduction of acute exacerbation of a chronic illness; and,
- Reduction of avoidable costs.

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<sup>1</sup> Case Management Society of America  
Aetna Health and/or Aetna Life Insurance Company  
2005 PM Program Description  
Proprietary and Confidential  
FOR INTERNAL USE ONLY

Members may be identified for Case Management through various internal sources including Claims, Member Services, Hospital Services, Behavioral Health, National Medical Excellence, Disease Management, high dollar claimant reports, PULSE, Aetna's Predictive Modeling tool, Condition Analysis tools, and other Business Associates that may have access to members or data, such as utilization management delegates, or Pharmacy. External referrals are also accepted from sources such as the Primary Care Physician, family members and Health Risk Assessments (HRAs).

Members referred to Case Management are screened and assessed prior to acceptance into the program. Only those members likely to benefit from Case Management are accepted into Case Management. Case Management is generally a voluntary service without a Plan requirement for participation.

Once accepted into Case Management, Case Managers, in coordination with the attending physician, member, or member designee, develop a Case Management plan. The Case Manager's plan may reflect short and long-term goals. Short-term goals may be associated with assisting the member and the member's health care providers with effective health event management, while long-term goals may be focused on assisting the member and the member's health care providers with identifying plans that anticipate potential future health care needs. The Case Manager's activities are targeted to facilitate the achievement of the member's health goals. Progress toward the achievement of the expected outcome is monitored and tracked. For each member in active Case Management, progress in meeting Case Management plan goals and objectives is reviewed on a regular basis. The Medical Director and Supervisor assess potential barriers to quality and efficient care and are available to the Case Management staff as a resource. Cases are closed when the objectives have been met, if the member requests closure, when the active involvement of a Case Manager can no longer positively impact the expected outcome of the member's health status or when a plan of care is in place and the member or their designee understands the plan and barriers to compliance with the case management plan have been minimized.

Delegated behavioral health contractors perform high-risk Case Management activities and report these activities to the Regional Behavioral Health Oversight and Advisory Committee (RBHOAC).

## D. Other Patient Management Program Components

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### 1. *Adverse Determination and Appeal Process*

#### a. *Initial Adverse Determination Process*

Denials are non-certifications or decisions of non-coverage for services or supplies, based on either administrative or clinical reasons. Clinical denials are denials of coverage for proposed or provided medical services or supplies that, based on consideration of available information, by licensed medical professionals, do not meet accepted criteria for coverage. Administrative denials are denials of coverage for proposed or provided services that are based on reasons other than clinically based rationale. Administrative denials involve decisions not requiring clinical judgment that are based on contractual or benefit exclusion, limitation, or exhaustion, or the absence of any clinical information.

**Only licensed physician Medical Directors make clinical coverage denial decisions for reasons related to medical necessity.** Coverage denial letters describe the rationale for the denial, delineate any unmet criteria, standards and guidelines, include the availability of the specific coverage criteria or policy provisions used in the benefit determination and inform the provider and member of the applicable appeal process. Clinical coverage denial letters also inform the provider(s) of the Medical Director's availability to discuss the denial decision.

*b. Peer-to-Peer Review Process*

The Patient Management peer-to-peer review process is a focused review/discussion between a treating practitioner and a Medical Director who have not spoken about the particular denial determination prior to the issuance of that determination. The treating physician speaks with either the Medical Director who made the initial determination to deny coverage or to an available Medical Director, if the Medical Director who made the initial determination is not available. The peer-to-peer process is not an additional level of review or an appeal, but rather a focused review/discussion between a treating practitioner and a Medical Director who have not spoken prior to the issuance of a denial of coverage determination.

*c. Appeal Process*

Aetna has written policies and procedures in place that permit members or their authorized representatives to appeal coverage decisions. Written correspondence informing providers and members of the coverage determination describes the appeal process and how to file an appeal. The member, the member's authorized representative, or the provider on behalf of the member, may request an expedited appeal when a delay in decision-making might seriously jeopardize the life or health of the member. In addition, if a physician with knowledge of the member's medical condition determines that the appeal involves urgent care, the claim or appeal is expedited. Aetna and the delegated behavioral health contractor follow applicable state and federal requirements when informing members of their appeal rights and in processing appeals. Once a member has exhausted the applicable appeal process, eligible members are offered the option of requesting an independent external review of a coverage denial based on medical necessity, or the experimental/investigational nature of the proposed or rendered service or supply, or as required by applicable law or regulation.

*d. External Review*

Aetna offers an external review program for all members enrolled in fully insured HMO-based health benefit plans, fully insured Traditional health benefit plans and most self-funded HMO-based health benefit plans. Aetna Medicare members can appeal to an external review organization following the processes established by the Centers for Medicare and Medicaid Services. Traditional self-insured plan sponsors must elect the external review program for their members to be eligible to participate in this process. Certain states mandate separate review processes that may differ from the Aetna process. The information below addresses the Aetna sponsored external review process, which is available in the absence of a state mandated process. [Note: The process outlined below does not apply to Medicare member appeals which are governed by the appeals

process (including review by an independent entity) pursuant to federal regulations.]

Eligible members may request an external review if coverage is denied upon completion of the applicable appeal process and it has been determined that the proposed or rendered service or supply is not medically necessary or is experimental or investigational in nature. The cost of the service or supply at issue (including pharmacy cases and dental issues) for which the member is financially responsible must exceed \$500.

If upon the final level of review Aetna upholds the coverage denial and it is determined that the member is eligible for external review, the member is informed in writing of the steps necessary to request an external review.

Aetna's National External Review Unit facilitates the external review process and refers appropriate cases to an Independent Review Organization that is responsible for choosing the physician reviewer with the appropriate expertise to examine the case. Physician reviewers are required to be board certified by the appropriate American Medical Specialty Board in the clinical specialty/area at issue. Members are not charged a professional fee for external review. The decision of the independent external review expert is binding on Aetna and when applicable, the plan sponsor.

## *2. Non-Participating Provider Referral Authorization Process (not available for all Aetna Traditional products)*

The nurses who review non-participating provider referrals, requests for approval of coverage for out-of-network services at the in-network referred level of benefits, work under the direction of the Medical Director. All requests for non-participating behavioral health referrals are reviewed by the delegated behavioral health contractor(s). In general, coverage for the use of a non-participating provider is approved for elective care only if the member requires a unique, highly specialized service that is not otherwise available from a provider within the Aetna participating provider network. The Medical Directors and the nurses in this unit consider continuity of care issues for members with complex medical problems when reviewing such requests.

The Medical Director is responsible for all coverage denial decisions. If the request for the coverage of services provided by the non-participating provider is denied, the decision is communicated in writing to the member, the non-participating provider and the requesting provider. The requesting provider is also informed of participating providers within the network who are qualified to render the services.

The purpose of the non-participating provider referral review is to:

- Review member and physician requests for the use of non-participating providers if the member in question: (1) does not have an out-of-network benefit option; or (2) has an out-of-network benefit option, but has requested that the service be covered as an "in-network" referred benefit;
- Monitor and facilitate the coordination of the quality of care delivered to members under the care of non-participating providers; and,
- Promote access to quality treatment centers and physicians.

### 3. *Transition of Care*

The Transition of Care process provides guidelines for the transition of care of members who are enrolling in an Aetna plan, including an Aexcel or Aexcel Plus plan, are moving from one network plan to another, or are receiving care from a physician or therapist whose contract has been discontinued within the last 90 calendar days for reasons other than quality deficiencies (e.g., business reasons or practitioner choice) [an inactive provider]. These guidelines are used when a member is engaged in an “Active Course of Treatment” and the member’s treating provider is not participating in the network of the member’s plan. Aetna may provide coverage for a member who has met certain requirements to continue an “Active Course of Treatment” with a non-participating provider for a transitional period of time without penalty, at the new/preferred plan benefit level.

## E. Quality Management Indicators

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Clinical and service indicators of quality are established and monitored on a regular basis in order to assess health plan performance in the management of clinical care and service. The Quality Advisory Committee (QAC) reviews and makes recommendations on clinical indicators. Clinical and service indicators are approved by and reported to the Quality Oversight Committee (QOC). For PPO-based products, quality indicators are also reviewed on a national basis by the National PPO Quality Council. All indicators are trended for change over time. Indicators which are outside target ranges established for the indicator provide the basis for quality improvement projects.

### 1. *Quality of Care Indicators*

Potential quality of care concerns identified are referred to Quality Management for investigation, tracking, trending, and reporting to the appropriate review committee. Examples of situations that may be considered for review include, but are not limited to:

- Member expressed concern about quality;
- Practitioner expressed concern about previous medical management;
- Questionable medical or behavioral health management identified during case review for Utilization Management, Disease Management, or other clinical review; and
- Allegation concerning inappropriate conduct on the part of a practitioner.

Behavioral Health delegated contractors report adverse events to Regional Quality Management.

### 2. *Service Indicators*

Aetna monitors Precertification staff telephone responsiveness and both Precertification staff and Patient Management staff decision making and notification time frames. Average Speed of Answer (ASA), Telephone Abandonment Rate, and Turn Around Times (TAT) for decisions and notifications are monitored, trended, and reported to the QOC on a quarterly basis. Indicators which do not meet target ranges established for the indicator provide the basis for quality improvement projects.

### 3. *Utilization Management*

Patient Management has mechanisms in place to monitor its Patient Management Program to detect potential under or over-utilization of services and monitor against their thresholds. The region identifies relevant utilization data, establishes thresholds and monitors against these thresholds to detect potential under or over utilization. At a minimum, monitoring and analysis is performed on an annual basis. The monitors may include data to manage utilization, HEDIS data, Use of Service measures, tracking/trending member complaints, member/provider satisfaction with the Patient Management process, and costs for each product line. For HMO, at least one monitor is related to behavioral health. If qualitative analysis of cause and consequences identifies potential over or under utilization, the region performs the same type of monitoring and analysis at the level of the practitioner and provider site as relevant. If indicated, initiatives are identified and implemented. The initiative(s) are related specifically to the barrier(s) or specific circumstances identified from the causal analysis to achieve improvement when performance is measured again. In addition, at specified intervals, the region measures the effectiveness of the initiatives to determine if measurable improvement occurred.

#### *4. Evaluation of Member and Practitioner Satisfaction with Patient Management Process*

Aetna has mechanisms in place to evaluate member and practitioner satisfaction with the Patient Management and the Precertification process. Member complaint tracking and trending is one measure that may be utilized. In addition, Aetna conducts the annual CAHPS<sup>®</sup> 3.0H Member Satisfaction Survey version for the commercially insured, and uses the results of the Medicare version of the CAHPS<sup>®</sup> Member Satisfaction Survey conducted by CMS's contractor for Medicare Advantage members.

Practitioner satisfaction is surveyed using the Aetna Physician Survey. This survey is conducted in two parts. Primary Care Physicians (PCPs) receive one version of the survey. It is sent to a sample of PCPs contracted for all products. Only one physician in an office receives a survey. There is a different version of the survey for practice managers. A modified survey tool is used to survey Obstetrician practitioner satisfaction and corresponding site practice managers. The results of both the Member and Physician Satisfaction Surveys are reviewed to determine areas of dissatisfaction. Barrier analysis is performed to determine the reasons and consequences of the results as an important step to identifying effective initiatives, if indicated.

## VIII. SPECIALTY PROGRAMS

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### A. Healthy Outlook Programs<sup>®</sup> (Disease Management)

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Disease Management is the member-centered multi-disciplinary management of chronic disease, across the health care continuum, with the goal of improving health and controlling costs. This program is available for all HMO-based members and for Traditional members depending on the benefits selected by the employer. In addition to internally developed and managed Disease Management programs, the Aetna Healthy Outlook Programs utilizes a nationally-recognized award-winning outside vendor to educate members about their condition and how modifying their lifestyle, including diet, exercise, and medication compliance may help improve their health status or overall well being. Disease Management programs are designed to encourage members to work effectively with their physicians and to take an active role in their health care by:

- Encouraging member acceptance and self-management of their condition to reduce or prevent complications thereby decreasing associated medical costs;
- Supporting physicians in the management of chronic disease by providing them with nationally recognized and accepted evidence-based clinical guidelines and educational materials;
- Increasing the use of screening and prevention strategies to avert disease complications through predictive modeling and risk stratification; and,
- Monitoring the key indicators that foster positive outcomes for both the member and the employer including clinical, functional, and financial data as well as member knowledge about their condition and satisfaction with the Aetna program.

Depending on the severity of their condition, members may also receive individualized Case Management, intensive educational counseling on topics pertinent to the member's condition, self-monitoring equipment and disease specific educational materials in the forms of booklets, videos, newsletters, and action plans. Because chronic illness is often accompanied by depression, a key component of the Disease Management Programs is screening and referral for depression. As a result of screening, members identified with this condition are also offered an informational booklet entitled *Caring for Depression-Helping People with Chronic Physical Conditions Deal with Depression*. The Aetna approach to Disease Management is characterized by:

#### **Member Identification Process**

Members are identified in a variety of ways including member self-referral, physician referral, internal staff identification and identification using administrative data by Aetna Integrated Informatics, Inc. (AetInfo). In addition, real-time member identification using pharmacy prescription and Utilization Management (UM) hospital discharge data have been added to further enhance the identification process. Members are stratified, when possible, to assess the appropriate level of program services. Stratification levels are assigned as follows:

- AetInfo assigns stratification levels 1 (lowest) through 5 (highest), based primarily on demographics, co-morbidities, and a member's use of various health

resources in the past. Members placed in severity level 5 are predicted to be at greatest risk for hospitalization or exacerbation.

- Members identified using Utilization Management and pharmacy data are unassigned but considered moderate or high risk due to an exacerbation or hospitalization;
- Disease Management staff assign a risk level as low, moderate, or high using the risk assessment tool in eTUMS.

The impact of early identification through predictive modeling and risk stratification helps to significantly slow or prevent the complications of chronic diseases, thereby improving a member's quality of life and reducing medical costs.

### **Member and Physician Communication**

Upon identification, members and physicians receive introductory information explaining the educational opportunities available and encouraging participation.

The Healthy Outlook Programs are an opt-out type of program. This means identified members are considered enrolled. Enrollment status is characterized as logged, active, pended, or closed. The member may opt-out at any time since participation is voluntary.

All members identified for the Healthy Outlook Programs (logged status) receive program level activities including bi-annual newsletters, and access to a disease management nurse via a toll free number, 24 hours a day, 7 days a week. An active enrollment status means the member is actively engaged with a disease management nurse. That engagement may include one or more of the following: assessment, teaching, monitoring, provision of educational materials and communicating with the member and their treating physician.

The Healthy Outlook Program currently addresses asthma, congestive heart failure (CHF), coronary artery disease (CAD), diabetes, and low back pain (LBP). The Low Back Pain program is being reviewed and redesigned and the new program is expected to be introduced during 2005.

## **B. National Medical Excellence Program<sup>®</sup>**

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Aetna's National Medical Excellence (NME) Program<sup>®</sup> was created to focus on the evaluation and coordination of transplants and certain other rare or complex conditions. The team, including a Senior Medical Director and dedicated clinical and administrative staff, assist eligible members to access appropriate, covered treatment at facilities with demonstrated expertise. The Program includes the following components:

- The National Transplantation Program assists members in need of solid organ and tissue (bone marrow and stem cell) transplants and helps arrange covered care at an Institutes of Excellence (IOE) transplant facility. To ensure continuity of care and member satisfaction, the Transplant Manager coordinates all of the member's needs from transplant approval through the post transplant period.
- The National Special Case Program provides referral management services for Aetna members with very complex conditions that are not commonly encountered in routine patient management activities. NME assists in evaluating the diagnosis/provider, offering consideration for the referral to other alternative providers if available/appropriate, and authorizing travel and lodging

reimbursement in certain circumstances. The following represent the kind of cases that are generally considered to be NME Special Cases:

- Any diagnosis or procedure that is so rare that only a very small number of providers in the United States have acquired in-depth experience in providing care for members with that condition. These members should be evaluated at a large teaching facility prior to referral to NME.
- Certain non-transplant Clinical Policy Bulletins (CPB)s contain references indicating that NME should be consulted for benefit determination or referral management.
- In the absence of an applicable CPB concerning a serious illness, other situations in which an Aetna Medical Director determines (consistent with applicable coverage documents) that certain experimental treatments for that illness constitute covered benefits.
- The Out-of-Country Care Program is Aetna's case management program for members who have an emergency situation while temporarily traveling out of the country. The NME Case Manager evaluates the capability of the out-of-country facility. If the facility is not able to treat the member, the NME Case Manager coordinates transfer to the nearest facility that can effectively treat the member.
- The Pediatric Congenital Heart Surgery Network provides access to the congenital heart surgery IOE network for covered pediatric congenital heart surgery.
- The Aetna Global Benefits (AGB) Domestic Care Program provides utilization and case management activities for AGB members who obtain medical care in the United States.
- The Hemophilia Program matches members with hemophilia with appropriate services. In many cases these members are introduced to Hemophilia treatment centers where members with Hemophilia are managed by a team of professionals that includes a Hematologist, a Physical Therapist, and a Medical Social Worker. The NME Case Manager provides these members with information about the most cost effective quality provider for their Factor.

The National Medical Excellence Program utilizes the IOE Network of facilities, which have demonstrated expertise in their field and have met Aetna's credentialing requirements for transplant and transplant related care. This unit works closely with the Special Claim Customer Service Unit to coordinate customer service and claim payment, including transportation and lodging reimbursement.

## C. Women's Health Programs

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Aetna has designed a variety of benefits and programs to promote women's health and is committed to educating female members about the lifelong benefits of preventive health care. Aetna also makes accessing gynecological care easy for Aetna members; no referrals are needed for routine ob/gyn office visits and routine obstetrical care, well-woman exams, Pap smears, and office visits for gynecologic problems and follow-up care. The Aetna Women's Health Programs offers the following:

### 1. *Moms-to-Babies Maternity Management Program*<sup>®</sup>

The Moms-to-Babies Maternity Management Program is available to most female members in Aetna's HMO-based plans (HMO, QPOS, USAccess, Aetna Open Access HMO and Golden Medicare Plan). Members of other Aetna plans may or may not be eligible for the program, depending on an individual employer's plan design. Providers and/or members call the toll-free Member Services telephone number on the member's ID card to determine whether a member is eligible to participate in this program. This program features:

- Assistance in accessing prenatal care benefits;
- Coordination of care and preauthorization of medically indicated services;
- Educational materials that include information on: normal pregnancy, dental health, postpartum depression, newborn care, and high risk pregnancy;
- A pregnancy risk survey, which helps identify potential risk factors and pregnancy complications;
  - ⇒ Members that are stratified as high risk are assigned an obstetric Case Manager who follows the member throughout her pregnancy and provides education and outreach focused on the identified risk factors. The Case Manager sets up medically indicated home health care services. (e.g., smoke-free Moms-To-Be™ Smoking Cessation Program; and Preterm Labor Education Program).
- Focused, educational information "For Dad or Partner";
- Translation services, including up to 150 different languages, to assist members in communicating with program staff; and,
- Program materials in Spanish.

### **Program Enrollment**

Participating OB care providers are encouraged to notify Aetna following the first prenatal care visit to activate enrollment for eligible members in the Moms-to-Babies Program. Members can also register for the program through the Aetna Navigator or by directly contacting the Moms-to-Babies Maternity Management Program at 1-800-272-3531.

### **Authorizations for Outpatient and Homecare Services**

For members enrolled in Aetna's Moms-to-Babies Maternity Management Program, any necessary authorizations for care not provided in the OB care provider's office or through direct access must be coordinated by the Moms-to-Babies Program at 1-800-272-3531. Members not enrolled in the maternity management program must have any necessary authorizations coordinated through the Aetna Precertification Unit. The toll-free number for this unit is on the member's ID card.

## ***2. Infertility Case Management Program***

The Aetna Infertility Case Management Program is a rich education and information resource for members who are experiencing infertility. The program provides clinical education regarding covered infertility benefits and may guide members to a select network of infertility providers for services which may or may not be covered. To verify a member's infertility benefits, providers and/or members call the toll-free Member Services telephone number on the member's ID card.

Once covered infertility benefits have been identified, the Infertility Case Management Program provides any appropriate authorizations required under the plan for eligible members. Some benefits may vary due to group size, state mandates or employer choice.

### 3. *Genetic Testing for Hereditary Breast and Ovarian Cancer*

Available to Aetna members in all plans who meet specific criteria which indicate a higher risk for developing breast or ovarian cancer. Aetna's Genetic Testing promotes early identification by providing confidential genetic testing to members at risk for developing inheritable breast and ovarian cancer. Individuals at high risk include those with a family history of breast and/or ovarian cancer and those with a relative who is known to have a mutation in the BRCA1 or BRCA2 genes (specific criteria developed by the American College of Medical Genetics are detailed in Clinical Policy Bulletin #227 available at [www.aetna.com](http://www.aetna.com)).

Providers or members can call toll free (1-877-794-8720) for more information about the program or to obtain the authorization request form.

### 4. *Breast Cancer Case Management Program*

This program is available to Aetna members in HMO plans (HMO, QPOS, USAccess, Aetna Open Access HMO and Golden Medicare Plan), and assists female members who have been diagnosed with breast cancer in making informed choices for their care.

Features of this program include:

- Second opinions at breast cancer Centers of Excellence;
- Member education about breast cancer and Aetna benefits; and,
- Daily access to a registered nurse, who can help coordinate care with the member and her doctor, hospital and specialists. The nurse is also trained to provide telephone support for members and their families.

## **D. Government Programs**

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Aetna recognizes the special needs of Medicare beneficiaries and, in some regions; Aetna has developed specialized Patient Management units to:

- Review Health Risk Assessments for new Medicare members;
- Help facilitate access to quality, covered health care services for Medicare members;
- Continually assess the potential needs of the Medicare population by utilizing administrative data sources; and,
- Provide specialized Geriatric Case Management services to Medicare members age 65 and over.

## **IX. Delegated Patient Management**

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Delegation is a process by which Aetna agrees to grant an outside entity (the “Delegated Entity”) the ability to perform specified functions or activities on its behalf. Each Delegated Entity must demonstrate conformance to Aetna’s program requirements for all delegated activities. Performance of these activities by the Delegated Entity is documented in an agreement between the parties.

Aetna may delegate Utilization/Patient Management responsibilities to entities that are certified by the National Committee for Quality Assurance (NCQA) or American Healthcare Commission (URAC) or which demonstrate capability to Aetna’s satisfaction. All entities considered for Utilization Management delegation, but not holding current NCQA or URAC certification for Utilization Management, are evaluated pre-contractually for their Utilization Management capability. Aetna remains responsible for oversight of all delegated activities, whether they are fully or partially delegated. Aetna has developed a structured oversight process, in accordance with the relevant standards of the NCQA, URAC, other accrediting organizations, and the Centers for Medicare & Medicaid Services (CMS), which include initial, periodic, and interim reviews and reports to evaluate programs of entities which have requested delegation and to which Aetna has delegated Patient Management activities. When Patient Management is delegated, Aetna remains responsible to verify that Patient Management functions are performed in accordance with these standards, as well as applicable laws and regulations.

## A. Purpose/Goals

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The goals of delegated Patient Management activities include all of the goals previously outlined for non-delegated Patient Management in addition to:

- Delivery of the most appropriate covered level of care;
- Increased member satisfaction;
- Ease of administration and determination of responsibility;
- Support and training to providers;
- Establishment of guidelines for providers;
- Management of provider performance using data collection, analysis and reporting;
- Flexibility to target specific markets/conditions;
- Improved efficiencies; and,
- Net expense reduction.

## B. Reports/Audits

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Reports include an annual written evaluation of the Patient Management Program provided by the Delegated Entity to the health plan’s Patient Management Department. This evaluation must include, but is not limited to:

- An aggregation and analysis of the performance measures submitted on a quarterly basis;
- A description of any updates or modifications to the delegated entity’s Patient Management Program, policies and procedures;

- A description of any updates or modifications to the criteria used in Patient Management services;
- A determination of the delegated entity's compliance with the health plan policy; and,
- The adherence to NCQA and URAC standards.

The health plan has a structured oversight process that may include initial, periodic, and interim reviews to evaluate the Delegated Entity's programs. The health plan performs an annual on-site or desk-top review to determine the delegated entity's compliance with the health plan standards and policies. This audit includes, but is not limited to:

- Evaluating the Patient Management Program description plan;
- Evaluating the Patient Management Program's policies and procedures; and,
- Evaluating the existence of the following:
  - ⇒ Confidentiality policy;
  - ⇒ Patient Management Committee that oversees Patient Management processes;
  - ⇒ Patient Management Program;
  - ⇒ Patient Management Policy and Procedure Manual;
  - ⇒ Behavioral Health Contractor's Standards Manual;
  - ⇒ Written Patient Management protocols or criteria;
  - ⇒ Authorization policy and procedure;
  - ⇒ Denial procedure;
  - ⇒ Periodic, at least semi-annually, substantive evaluation of regular specified reports; and,
  - ⇒ Mechanism for notifying the Health Plan of updates and reports.

There are five levels of compliance determined by the audit: full compliance, significant compliance, partial compliance, minimal compliance, and non-compliance. The Delegated Entity's program is evaluated by the Regional Quality Oversight Committee (QOC) or the Regional Behavioral Health Oversight and Advisory Committee for Behavioral Health (RBHOAC) for HMO, or the Behavioral Health PPO Based Products Oversight Workgroup or other equivalent committee to determine if the program meets the minimum Patient Management standards to maintain a delegated status. The QOC or appropriate oversight committee may alter the delegation determination at any time if they determine that the delegate's activities do not meet the plan's requirements.

## C. Appeals

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The review of complaints, grievances and appeals is generally not delegated, but may be delegated for behavioral health. Regardless, both Aetna and the delegate follow the Aetna Member Complaint and Appeal Resolution Process.

# **X. COMPONENTS OF THE DELEGATED BEHAVIORAL HEALTH PATIENT MANAGEMENT PROGRAM**

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Patient Management of behavioral health is delegated to a behavioral health contractor(s) who provide varying utilization review activities in this specialty area.

## A. Program Overview

### 1. *Philosophy*

Aetna is committed to quality-based managed behavioral health (BH) care. In keeping with that commitment, Aetna has developed the following philosophy regarding behavioral health services:

- The integration of services for the mind and body is a priority for integrated care. Behavioral health contractor(s) should collaborate with other providers of care. Behavioral health services are based on a biopsychosocial (mind, body and social environment) model.
- Members should have access to medically necessary covered behavioral health services so that treatment may begin relatively early, when possible, in the disease process. A complete and accurate clinical evaluation performed by a qualified practitioner is a pre-foundation for appropriate treatment.
- Coverage for certain medically-acceptable treatment modalities, based on medical necessity, should be available to members. Having access to a range of services promotes quality, cost-effective care.
- Network development, Quality Management and Patient Management should be consistent with the needs of the National, Regional, and Local Health Plan.
- Behavioral health contractor(s) agree to adhere to all standards outlined in the two (2) manuals provided by Aetna to the behavioral health delegated contractor(s) that describe the key elements of Aetna's HMO and Traditional-based Behavioral Health Programs and the accountability for each activity. Behavioral health contractor(s) are required to meet all standards set forth in these manuals. Aetna monitors compliance with these standards and criteria.

## 2. Objectives

The primary objectives of the Behavioral Health Patient Management Program are:

- To provide access to the appropriate level of care, which is geographically accessible and delivered by an appropriate practitioner for persons with a mental health/chemical dependency condition;
- To provide guidelines for determining the medically necessary level of care;
- To facilitate continuity and coordination of care for members;
- To utilize participating providers whenever appropriate;
- To coordinate and integrate mental health and chemical dependency treatment services with other medical/surgical care;
- To educate other providers about behavioral health issues; and,
- To evaluate provider performance.

Subject to Aetna oversight, and in compliance with Aetna, NCQA and URAC standards, and federal and state law requirements, the behavioral health contractor(s) is required to provide the following Patient Management activities as required by plan/product design, including, but not limited to:

- Precertification;
- Concurrent review at the levels of care defined by the plan;
- Case Management (including high-risk behavioral health and medical comorbidity cases);
- Discharge planning;
- Level one appeals for Traditional-based members;
- Evaluation of requests for coverage for the use of non-participating providers, especially for transition of care;
- Collaboration with primary care physicians, staff from Aetna's medical Patient Management Programs, Aetna's Disease Management Programs and other health programs including Moms-to-Babies to provide continuity and integration of care; and,
- Benefit administration and tracking (as applicable).

## 3. Accountability and Monitoring

In delegated arrangements, Aetna delegates certain Patient Management functions, but remains accountable for these services to its members. Consequently, a structured oversight process has been implemented to evaluate the behavioral health contractor(s) adherence to policies, procedures, standards and criteria that comprise Aetna's Behavioral Health Patient Management Program. Aetna oversees performance of the behavioral health contractor(s) through review of regular reports, periodic meeting summaries, committee minutes, clinical and service monitoring reports, annual on-site review, workgroups, and other audits or activities deemed appropriate by Aetna. The Aetna Behavioral Health Program is overseen nationally

by a Behavioral Health Medical Director who has ultimate responsibility for the implementation of the behavioral health aspects of the Patient Management Program.

The behavioral health contractor(s) program is evaluated by the Regional Behavioral Health Oversight and Advisory Committee (RBHOAC) for HMO products and the Behavioral Health PPO Based Products Oversight Workgroup for PPO based products to determine if the program meets Patient Management standards to maintain a delegated status. The behavioral health oversight committee may request that Aetna investigate altering the delegation determination at any time if they determine that the delegate's activities do not meet the plan's requirements.

Aetna's Behavioral Health Medical Director provides overall clinical leadership for implementation of the Patient Management Program.

The behavioral health contractor(s) must have a psychiatrist on-call at all times, 24 hours a day, 365 days a year, to provide behavioral health consultation and to supervise and make Patient Management decisions, on a case-specific basis for those products providing 24 hour access.

Aetna requires that the behavioral health contractor(s) comply with Aetna's standards and policies that are consistent with industry standards, NCQA, URAC, and all applicable state and federal law requirements. Aetna requirements include, but are not limited to:

- Promoting integration of behavioral health with medical/surgical care through collaboration of activities;
- Maintaining consistent standards for members on both the behavioral health and the medical/surgical side of Patient and Quality Management; and,
- Responding to employer and regulatory requirements.

## B. Guidelines for Behavioral Health Contractor(s)

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### *1. Contractor Policy and Procedure Guidelines*

At a minimum, there must be compliance with the following standards:

- Use of Aetna-approved behavioral health guidelines for making coverage decisions, including Level of Care Assessment Tool (LOCAT), American Society of Addiction Medicine (ASAM) guidelines, and/or any specific state-mandated criteria such as the Texas Alcohol and Drug Addiction criteria (TCADA) (28 TAC §§3.8001-3.8022);
- Documentation of Patient Management decisions and protocols utilized in the Patient Management record;
- Dissemination, at least annually, of clinical guideline information and significant changes to network practitioners;
- Implementation of a mechanism for checking the consistency of the application of LOCAT, ASAM and TCADA criteria among Medical Directors and other reviewers (inter-rater/reviewer reliability); and,
- For HMO-based products, a description of the contractor plan, capacity and methodology for producing an Annual Patient Management Program

Evaluation Report that includes the contractor's evaluation of performance against the annual Patient Management Work Plan for the year under review.

With regard to denial of coverage decisions, policies and procedures must include, at minimum, the following:

- All clinical denials are rendered by a board-certified, licensed psychiatrist employed and/or directly contracted by the behavioral health contractor, either as a Medical Director or as a physician advisor. Where state mandated, the denial must be rendered by a psychiatrist licensed to practice in that state;
- Denial reasons are clearly described and made available to members, providers and practitioners in accordance with applicable law, NCQA and URAC requirements;
- Denial letters are approved by Aetna, include all appropriate state-mandated or ERISA language (as appropriate), and information regarding the appeals process;
- Denial decisions, both verbal and written, meet NCQA and URAC requirements, and all applicable laws;
- For Aetna Golden Medicare Plan or Aetna Golden Choice Plan members, all denial letters meet the Centers for Medicare and Medicaid (CMS) guidelines and protocols;
- Appeals of behavioral health contractor(s)'s Patient Management denials are directed to Aetna for review except for Traditional-based members where level one appeals are delegated;
- Depending on plan fiduciary responsibility, an Aetna psychiatrist renders the appeal determination or Aetna notifies the self-insured plan sponsor who is claim fiduciary of the responsibility to process member appeals;
- Clinical appeal determinations processed by Aetna or the behavioral health contractor are rendered by a licensed, board certified psychiatrist. Where state law mandates, reconsiderations and appeals of utilization review non-certifications are evaluated by a medical doctor licensed to practice in that state; and,
- Clinical appeal determinations processed by Aetna or the behavioral health contractor meet NCQA and URAC requirements and applicable laws.

## 2. *Reports*

Reports include an annual written evaluation of the Patient Management Program, Work Plan, and revised Patient Management Program description provided by the behavioral health contractor(s) for presentation to the Regional Behavioral Health Oversight and Advisory Committee (RBHOAC), or its equivalent, which has approval authority for oversight activities from the Quality Oversight Committee. The results of the behavioral health contractor(s)'s annual evaluation should parallel the work plan for the year. It should assess the overall effectiveness of the Patient Management Program and include:

- Analysis of utilization data, including inter-reviewer reliability statistics and turn around times for Patient Management decisions;
- Trending of service and quality indicators (e.g., provider satisfaction, adverse events, over/under-utilization, etc.);
- Quantitative and qualitative analyses, including barrier analysis;
- Action plans and/or changes of protocols as a result of ongoing analysis approved by Aetna;
- Summary of data from all required reporting for the calendar year; and,
- Evidence that the behavioral health contractor(s)'s Patient Management Program, policies and procedures have been reviewed, updated, revised (if appropriate), have involved network practitioners in development, and have been dated and signed by the behavioral health contractor(s)'s Medical Director and Patient Management Committee.

Behavioral health contractor(s) reports are standardized as described in the Behavioral Health Contractor Standards Manual for HMO and the Behavioral Health Contractor Standards Manual for PPO-Based Products, and include:

- Case Management activities;
- Denial data;
- Status of reported adverse events;
- Statistics of Patient Management decisions for behavioral health and chemical dependency:
  - ⇒ Inpatient admission;
  - ⇒ Partial hospitalization;
  - ⇒ Intensive outpatient treatment; and,
  - ⇒ Outpatient treatment.
- Quarterly reports;
- Annual documents;
- Patient Management internal quality reviews for:
  - ⇒ Inter-rater reliability; and,
  - ⇒ Timeliness of Patient Management decisions.

Other reports may include: Practitioner Satisfaction Survey Reports, action plans for improvement and Patient Management Committee Minutes.

### 3. *Clinical Guidelines*

Decisions regarding level, type and duration of care are made using the LOCAT, ASAM or TCADA, and/or Mixed Services Guidelines presented in the Aetna Behavioral Health Contractor Standards Manual for HMO and the Behavioral Health Contractor Standards Manual for PPO-Based Products as guidelines. These tools are not intended to replace the professional judgment exercised by properly trained, licensed, and experienced behavioral health clinicians and professionals with regard

to the provision of care in accordance with accepted standards of care. Other guidelines are used in states that mandate their use.

#### **Level of Care Assessment Tool**

The Aetna “**LOCAT**” instrument, with its attached scoring guidelines, helps determine appropriate levels and types of care for members in need of evaluation and treatment for mental health conditions and for members in need of placement in specialized psychiatric or mental health facilities or units. The Level of Care Assessment Tool (LOCAT) is a tool which Aetna has been utilizing and updating since 1990. Over the years, the LOCAT has been modified to address the treatment needs of children, adolescents, adults and the geriatric population. Behavioral health contractor(s) are required to utilize the LOCAT with regard to the collection of information and the provision of care, in accordance with accepted standards, to members.

#### **The American Society of Addiction Medicine Guidelines**

The American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R) is a nationally-recognized criteria set that helps determine appropriate levels and types of care for members in need of evaluation and treatment for substance-related disorders and for members in need of placement in specialized chemical dependency detoxification or rehabilitation facilities or units. Note: For Texas insured members, the Texas Alcohol and Drug Addiction Criteria (28 TAC §§3.8001-3.8022) is utilized in place of ASAM.

#### **The Aetna Mixed Services Guidelines**

The Aetna Mixed Services Matrix helps outline appropriate levels and types of care, and the types of collaboration necessary between Aetna Patient Management staff and the designated behavioral health contractor staff, for members with combinations of medical/surgical and behavioral health (mental health/chemical dependency) conditions and diagnoses.

## **C. Activities**

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### *1. Triage and Referral*

The initial call is conducted by a non-clinical telephonic intake/customer service worker for verification of membership and benefits. Non-licensed staff does not provide clinical referral and triage. Callers seeking clinical services that are not related to routine appointments are directed to the Care Management Department for an initial telephonic assessment to obtain information that forms the basis for:

- Determining the level of urgency for treatment services (life threatening emergency, non life threatening emergency, urgent or routine care);
- The level of care needing behavioral health; and,
- The provider characteristics suited to meet the individual needs or preferences of each member.

The assessment data is used to arrange for care with regard to a member's needs, preferences, and a network provider's expertise.

Written triage and referral protocols are in place to facilitate appropriate access according to the following levels of care:

- Life threatening emergency is a condition that requires immediate intervention to prevent death or serious harm to the member or others;
- Non-life threatening emergency is a condition that requires rapid intervention to prevent acute deterioration of the member's clinical state or condition;
- Urgent is a situation that is less clinically compelling than an emergency situation. A referral for urgent level of care services is made when the clinical situation would likely deteriorate if the member was not seen in a timely fashion; and,
- Routine is a clinical situation that is considered to be sufficiently stable. A referral for routine care is one in which it is considered to not have a negative impact on the member's condition by offering a face-to-face assessment within ten (10) calendar days following the request for service.

## 2. *Precertification*

Note: These remarks apply to only those products that require precertification for that specific level of care.

Precertification is defined as the process of determining the eligibility and appropriateness of the proposed level of care and place of service. Collection of complete and accurate clinical data is an important element in the successful completion of the precertification process. The purpose of precertification is:

- To assess medical necessity and appropriateness of care for coverage purposes;
- To determine member eligibility for services and benefits;
- To establish that care is being rendered at an appropriate site by an appropriate provider;
- To identify members who will benefit from Case Management;
- To investigate potential coordination of benefits with other health benefits coverage;
- To identify members appropriate for mixed services guidelines; Disease Management services; and,
- To initiate pre-admission discharge planning.

## 3. *Inpatient Review/Concurrent Review*

Concurrent review is the process of determining utilization and clinical needs at the time the particular service is being rendered for a member, including:

- Evaluating a member's current status for continued stay and level of care;
- Identifying potential utilization review and quality concerns; and,

- Identifying members who will benefit from Case Management services and Disease Management Program planning for transition to the next level of care.

#### 4. *Discharge Planning*

The behavioral health contractor(s) is responsible for initiating discharge planning at the time of admission and for facilitating transition to lower levels of care on the day of discharge or the next business day. Upon discharge, members are triaged to the next level of care for follow-up. A written discharge plan should exist for all Aetna members discharged from a hospital or residential facility where they received mental health or chemical dependency treatment.

#### 5. *Retrospective Record Review*

Retrospective review is the process of evaluating a record after the service or treatment has been provided in order to make a determination of coverage and member eligibility. This includes:

- Verification of member eligibility and benefits in accordance with the applicable plan documents;
- Identification and referral to the Case Management Program when appropriate;
- Identification of any potential quality of care issues and referral, as appropriate, for review; and,
- Medical necessity determinations and authorizations.

In compliance with state and federal mandates and confidentiality laws, the behavioral health contractor(s) requests relevant medical records from the practitioners and/or hospitals. Records are directed to the appropriate parties for utilization and quality reviews.

#### 6. *Coordination of a Member's Care and Transition of Care when Benefits End*

The behavioral health contractor(s) is responsible for providing Case Management services where required in the delegation agreement and in accordance with plan design. The behavioral health contractor's Care/Case Managers work closely with network providers and Aetna Patient Management staff in order to be prepared for a situation where benefit limits have been maximized and, hence, coverage is no longer available. In accordance with accepted professional guidelines and standards for clinical practice, members in active treatment are not abandoned. Rather, appropriate policies are in place to support the safe transition of each member from one provider to another under a different benefit plan, private pay or publicly-funded arrangement. The behavioral health contractor(s) provide, in part:

- **Exchange of benefits:** Aetna recognizes that continued treatment with the same practitioner may be beneficial. Accordingly, when defined in plan documents and state regulations allow, an exchange of inpatient benefits for

outpatient benefits may occur. When this benefit is available, it will be exercised in accordance with the applicable state law;

- **Positive practices by contractor:** In accordance with acceptable standards of medical care, the option of lower cost services such as support groups and group therapy is offered.

In the event the member's benefits end and the member still needs care, the case manager will attempt to provide the member with information about alternative coverage or continuing care opportunities, as appropriate, and inform the member of ways to obtain that coverage or care. Alternative options for coverage or care may include local, state or federally-funded agencies or non-profit organizations.

## 7. *Case Management*

Case Management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual member's needs. Case Management is provided by behavioral health contractor(s) for any member in treatment where required in plan design.

Three kinds of special high-risk Case Management programs are an integral part of the behavioral health contractor(s)'s provision of behavioral health services to Aetna's membership:

- High risk behavioral health Case Management;
- High risk medical/behavioral health Case Management (members with behavioral health conditions and medical co-morbidities). This includes members appropriate for Aetna Medical Healthy Outlook Programs (e.g., asthma, diabetes, low back pain, and heart failure); and,
- The Medical/Psychiatric High Risk Case Management Co-Location Program designed to enhance the continuum of case management services for Aetna HMO-based members and Aetna Traditional-based members enrolled in plans that include the Med/Psych DM Program through on-site availability of Magellan Behavioral Health clinical staff, otherwise known as Magellan Co-Located Case Managers (MCCM) at each of the Aetna regional Patient Management office locations.

High-risk Case Management criteria and policies and procedures are outlined in Aetna's Behavioral Health Contractor Standards Manual-HMO and the Behavioral Health Contractor Standards Manual for PPO-Based Products.

## 8. *Non-Participating Provider Review*

For plans requiring a PCP referral, a written referral from the member's Primary Care Physician requesting coverage for routine outpatient behavioral health services by a practitioner who is not contracted with the behavioral health contractor(s)'s network is considered a "non-par" request.

As with any "non-par" request, a determination of coverage must be individually evaluated by the behavioral health contractor(s) based on medical necessity, appropriate level of care, and plan benefit availability.

## 9. Appeals

Level one appeals are delegated to the behavioral health contractor for Traditional-based products; however, Aetna performs level one appeal review for HMO-based products. Level two appeals are handled by Aetna for both Traditional - and HMO-based products. Regardless, both Aetna and the behavioral health delegate follow the Aetna Member Complaint and Appeal Resolution Policy.

Appeals are not delegated for Golden Medicare Plan or Aetna Golden Choice Plan.

Plan sponsors who are self-insured claim fiduciaries are responsible for processing their employee appeals.

## **XI. CONFIDENTIALITY**

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Aetna considers nonpublic personal member information private and confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. Aetna protects the privacy of this information in accordance with federal and state privacy laws, including the HIPAA Privacy Rules, as well as Aetna's own company privacy policies. Participating network providers, vendors, and consultants who help administer the health plan are required by contract to keep member information confidential, as required by applicable law. Aetna and health care providers must also give members access to their medical records within a reasonable time after any request. When necessary or appropriate for the care or treatment of members, the operation of the health plan, or to conduct related activities, Aetna discloses nonpublic member information to health care providers (doctors, dentists, pharmacies, hospitals and other providers and facilities), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits members receive under the plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents.

Aetna also uses the information internally for the foregoing purposes. Some of the ways in which nonpublic member information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, Disease and Case Management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health claims and analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. Aetna considers the foregoing activities key for the operation of our health plans. To the extent permitted by law, Aetna uses and discloses nonpublic member information as provided above without member authorization. However, Aetna recognizes that many members do not want to receive unsolicited marketing materials unrelated to their health benefits. Aetna does not disclose nonpublic member information for these marketing purposes unless the member authorizes. Aetna also has policies addressing circumstances for release of member information when members are unable to give authorization.

Members can obtain a copy of the Notice of Aetna's Privacy Practices which describes in greater detail the policies concerning use and disclosure of personal member information, and how they

can access information about themselves, by calling the toll-free Member Services number on the member's ID card or visiting our Internet site at [www.aetna.com](http://www.aetna.com).