



Department of Consumer & Business Services

Insurance Division — 2

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Utilization Review
Annual Summary

Utilization review annual summary for 2005.

Due on **June 30** for previous calendar year.

All health benefit insurers that provide utilization review or have utilization review provided on their behalf shall file an annual summary describing all utilization-review policies and utilization-review monitoring activities, including delegated functions. ORS 743.807, OAR 836-053-1130

1. Company name: Aetna Life Insurance Company Filing date: 05/08/06
2. Company address: 151 Farmington Avenue (RE4K Halloran)
City, state, ZIP: Hartford, CT 06156
3. Company Web site: www.aetna.com
4. Name, e-mail address, and phone number of the person completing this form:
Kim Jarosch, jaroschk@aetna.com, (925) 948-4215
5. Name, title, and department of manager responsible for oversight of utilization review:
Dr. Milton D. Schwarz, Regional Medical Director, Health Care Delivery

For the following information, enter the URL, or the name of the publication in which it appears:

6. Time frame for making utilization review decisions:

| | | | |
|---------|--|-------------------|------------------------------------|
| Target: | PM Coverage decisions are made within | Actual (average): | 0-24 hrs – 78.66% |
| | Applicable Department of Labor, NCQA, | | 25-48hrs – 4.34% |
| | URAC, CMS and state-mandated | | 49-72 hrs – 3.42% |
| | timeframes | | greater than 72hrs – 13.59% |

URL, or the publication title, date, and page: 2005 Patient Management Program Description, Section V.B., page 14

7. Specify minimum qualifications for those who make first-level utilization-review decisions:

Professional staff is composed of registered nurses, licensed practical nurses, social workers and physicians. In general, these professionals have a minimum of 3-5 years clinical experience.

URL, or the publication title, date, and page: 2005 Patient Management Program Description, Section VI., page 15

8. Specify minimum qualifications for those who make second-level utilization-review decisions:

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

URL, or the publication title, date, and page: 2005 Patient Management Program Description, Section V.B., page 14 and Section VII.D.1.a., page 33.

9. Do providers participate in making utilization-review decisions?

No Yes At which level(s)?

A treating provider who has not spoken with the Medical Director prior to a clinical coverage denial, may request to speak with a Medical Director or another physician reviewer.

URL, or the publication title, date, and page: 2005 Patient Management Program Description, Section VII.D.1.b., page 33

10. Indicate the sources of clinical information the company researches for utilization-review decisions:

Evidence-based clinical guidelines from nationally recognized authorities to guide utilization management decisions involving precertification, inpatient review, discharge planning, and retrospective review are used: Milliman Care Guidelines, Interqual Intensity, Severity and Discharge, HCIA-Sachs LOS by diagnosis and operation. These guidelines may be applied to Aetna Medicare members unless inconsistent with DMS coverage determinations and regulations.

URL, or the publication title, date, and page: 2005 Patient Management Program Description, Section V.A., pages 10-14



11. List company's steps in developing utilization-review criteria:

See response to question #15 below.

URL, or the publication title, date, and page: _____

12. What action or event causes utilization-review criteria to be revised?

Requests for creation or revision of coverage policy bulletins (CPBs) may be made by Aetna's internal staff, members or providers. CPBs are created and revised by the staff of Aetna's Clinical Policy Unit, based on a comprehensive review of credible, peer-reviewed published medical literature.

URL, or the publication title, date, and page: 2005 Patient Management Program Description, Section V.A., pages 11-14

13. How does the company inform enrollees about changes in utilization-review criteria?

Certificate of Coverage updates; Aetna website [www.aetna.com]; and annual "Health Insights" member magazine.

URL, or the publication title, date, and page: Health Insights, Spring 2005 -- pages 4 and 9

14. How does the company inform providers about changes in utilization-review criteria?

Aetna Office Links Updates, a physician newsletter published every two months; Aetna website (contains specific provider-only information); and via communications between the Provider Network Representatives and Providers.

URL, or the publication title, date, and page: West Region Aetna Office Link Updates, Issue 1 Volume 2, January/February 2005 -- pages 9, 12, 14

15. Is there a procedure for monitoring in-house utilization-review criteria?

No Yes Specify:

At a minimum, monitoring and analysis is performed on an annual basis. The monitors may include data to manage complaints, HEDIS data, use of service measures, tracking/trending member complaints, member-provider satisfaction surveys.

URL, or the publication title, date, and page: 2005 Patient Management Program Description, Section V.C., pages 14-15 and Section VII.E., pages 35-37

16. Does the company delegate any utilization-review activities to outside resources?

No Yes Specify: **Behavioral Health vendor is Magellan**

URL, or the publication title, date, and page: **2005 Patient Management Program Description, Section IX., pages 42-43 and Section X., pages 44-54**

17. Are there procedures for monitoring utilization-review activities delegated to outside resources?

No Yes Specify: **Although Aetna delegates certain patient management functions, we remain accountable for these services to our members. A structured oversight process has been implemented to evaluate the behavioral health contractor's adherence to policies, procedures, standards and criteria. This is accomplished through a 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.**

URL, or the publication title, date, and page: **(In addition to the section mentioned in Question 16) West Region Amendment to 2005 [National] Patient Management Program Description**
