



Department of Consumer & Business Services

Insurance Division — 2

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Utilization Review  
Annual Summary

Utilization review annual summary for 2006.

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: 06/24/07
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:  
Reina Galanes, GalanesR@aetna.com, 510-522-6432
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:	<b>Utilization Management coverage decisions are made within applicable Department of Labor (DOL), National Committee for Quality Assurance (NCQA), American Accreditation Healthcare Commission (URAC), Centers for Medicare &amp; Medicaid Service (CMS), and state mandated time frames whether the activities are delegated or not.</b>	Actual (average):	<b>0-24 hrs - 80.04%</b>
			<b>25-48 hrs - 5.51%</b>
			<b>49-72 hrs - 3.11%</b>
			<b>&gt;72 hrs - 13.59%</b>

URL, or the publication title, date, and page: Aetna 2006 Patient Management Program Description p. 15, Section V.B. Determination and Review Time Frames

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

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 expertise.

URL, or the publication title, date, and page: Aetna 2006 Patient Management Program Description p. 16, Section VI. Organizational Structure, Staffing, and Staff Performance

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

**Aetna physician Medical Directors and dentists (Oral and Maxillofacial Surgeons) make all final decisions resulting in a denial of coverage for services on the basis of medical necessity. Behavioral health medical necessity coverage denial decisions are rendered by a licensed psychiatrist or, a denial decision may be rendered by a licensed psychologist (unless prohibited by state law) when the requested services are within the scope of practice and the psychologist's clinical experience provides sufficient experience to reivew the coverage request. A licensed psychologist does not review coverage requests for inpatient care or prescription medications. Pharmacy coverage denial decisions are rendered by a licensed pharmacist (unless prohibited by state law) or physician reviewer.**

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URL, or the publication title, date, and page: **Aetna 2006 Patient Management Program Description**  
**p. 15, Section V.B. Determination and Review Time Frames**

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

No  Yes At which level(s)?

**The Patient Management peer-to-peer review process is not an additional level of review or an appeal but rather a focused review/discussion between a treating practitioner and either a Medical Director, dentist (Oral and Maxillofacial Surgeon), psychiatrist, psychologist, or pharmacist who have not spoken about the particular coverage denial determination prior to the issuance of that determination.**

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URL, or the publication title, date, and page: **Aetna 2006 Patient Management Program Description**  
**p. 37, Section VII.D.1.b Peer-to-Peer Review Process**

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

**Aetna clinical staff use evidence-based clinical guidelines from nationally recognized authorities to guide utilization management decisions involving precertification, concurrent review, discharge planning, and retrospective review.**

**Aetna precertification and inpatient review staff consult Milliman Care Guidelines, Aetna Clinical Policy Bulletins (CPBs), and Medicare coverage policies. Aetna's Oral and Maxillofacial Surgery Unit uses the American Association of Oral and Maxillofacial Surgeons Parameters and Pathways 2000: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (ParPath 01) version 3.0 to guide utilization management decisions for oral and maxillofacial surgery services. Aetna's pharmacy staff consult Aetna's Pharmacy Clinical Policy Bulletins (PCPBs) for prescription medications.**

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**Aetna's CPBs and PCPBs 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.**

**Aetna's behavioral health staff utilizes Aetna's Level of Care Assessment Tool (LOCAT), 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) and, Aetna's Mixed Services Guidelines in making coverage decisions about the medically necessary level of care for behavioral health services.**

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URL, or the publication title, date, and page: **Aetna 2006 Patient Management Program Description**  
**p. 11-14, Section V.A. Review Protocols**

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

Both new and revised CPB drafts undergo a comprehensive review process. 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. The process includes review by Aetna's Clinical Policy Council, the head of Aetna's Medical Policy Administration (MPA) Department, Aetna's Legal Department, external practicing clinicians, and approval by Aetna's Chief Medical Officer or designee. All new and revised CPBs are reviewed by Aetna's Quality Advisory Committees, composed of practicing clinicians that participate in Aetna medical plans.

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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 nationally recognized sources.

PCPBs are reviewed by Aetna Pharmacy Management, Aetna Medical Directors, regional Quality Advisory Committees, the Aetna Behavioral Health Quality Advisory Committee, and practicing physicians and pharmacists. The National Pharmacy and Therapeutics Committee (P&T) is responsible for reviewing and approving medical exception, precertification and step-therapy criteria. After review by the P&T Committee, the criteria are presented to Aetna Pharmacy Management for adoption.

The Level of Care Assessment Tool (LOCAT) is a set of internally developed and validated evidence-based clinical guidelines for behavioral health services that 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.

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URL, or the publication title, date, and page: [Aetna 2006 Patient Management Program Description p. 11-14, Section V.A. Review Protocols](#)

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

Clinical Policy Bulletins are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants more frequent review. Aetna's utilization management criteria are reviewed annually for recommendations by Aetna's regional Quality Advisory Committee and for behavioral health clinical criteria, by the Aetna Behavioral Health Quality Advisory Committee.

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.

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URL, or the publication title, date, and page: [Aetna 2006 Patient Management Program Description p. 11-14, Section V.A. Review Protocols](#)

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

The relevant guidelines used in making coverage decisions are made available, upon request, to Aetna members and their treating practitioners.

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 Internet site at: <http://www.aetna.com/cpb/index.html>.

Information regarding the process by which outpatient prescription medications are selected for inclusion on Aetna's Preferred Drug List and the factors that are considered in the selection process are available to members and providers through the Aetna Preferred Drug Guide which is available on Aetna's website at <http://www.aetna.com/formulary>. Information about Aetna's Preferred Drug List is distributed to Aetna members upon enrollment and updated information is made available annually thereafter. The most current Preferred Drug List information is available on the website.

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URL, or the publication title, date, and page: **Aetna 2006 Patient Management Program Description**  
**p. 14, Section V.A. Review Protocols**  
**[www.aetna.com/cpb/index.html](http://www.aetna.com/cpb/index.html)**

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

In addition to that which is listed in #13 above, all new and revised CPBs are reviewed by Aetna's Quality Advisory Committees, composed of practicing clinicians that participate in Aetna medical plans. Aetna publishes a physician newsletter "OfficeLinks" on a bi-monthly to quarterly basis, which provides updates to specific medical and pharmacy criteria. The newsletter is available by mail, email, or by accessing secure provider website which is available to participating and non-participating providers.

Aetna's participating providers receive copies of the Aetna Preferred Drug Guide when they join Aetna and may request updated copies annually thereafter.

**Aetna Behavioral Health Insights newsletter.**

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URL, or the publication title, date, and page: **Aetna 2006 Patient Management Program Description**  
**p. 11-14, Section V.A. Review Protocols**  
**[www.aetna.com](http://www.aetna.com)**  
**OfficeLinks - each 2006 addition addresses specific criteria**  
**changes for medical and/or pharmacy**  
**[Aetna Behavioral Health Insights, December 2006. p. 9](#)**

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

No  Yes Specify: **Aetna's utilization management criteria are reviewed annually for recommendations by Aetna's regional Quality Advisory Committee and for behavioral health clinical criteria, by the Aetna Behavioral Health Quality Advisory Committee. Criteria are reviewed by the regional Quality Oversight Committees and the Aetna Behavioral Health Quality Oversight Committee for adoption.**

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URL, or the publication title, date, and page: **Aetna 2006 Patient Management Program Description**  
**p. 11-14, Section V.A. Review Protocols**

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

No  Yes Specify: \_\_\_\_\_  
URL, or the publication title, date, and page: \_\_\_\_\_

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

No  Yes Specify: **N/A**  
URL, or the publication title, date, and page: \_\_\_\_\_