



Department of Consumer & Business Services

Insurance Division — 2

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Utilization Review  
Annual Summary

Utilization review annual summary for 2008.

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

- Company name: Aetna Life Insurance Company Filing date: 06/30/2009
- Company address: 151 Farmington Avenue  
City, state, ZIP: Hartford, CT 06156
- Company Web site: www.aetna.com
- Name, e-mail address, and phone number of the person completing this form:  
Reina Galanes; GalanesR@aetna.com; 510-522-6432
- Name, title, and department of manager responsible for oversight of utilization review:  
Dr. Milton D. Schwarz, Regional Medical Director, Regional Health Care Management Head, West

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

- Time frame for making utilization review decisions:

Target:	<p>Coverage decisions are made within applicable Department of Labor (DoL/ERISA), National Committee for Quality Assurance (NCQA), Centers for Medicare &amp; Medicaid Services (CMS), and state mandated time frames whether activities are delegated or not. Aetna Behavioral Health coverage decisions are additionally subject to URAC accreditation requirements.</p> <p>Urgent Concurrent - 24 to 72 hours Urgent Precertification - 72 hours Routine (non-urgent) Precertification - 15 calendar days Retrospective - 30 calendar days</p>	Actual (average):	<p>0-24 hours - 84.08% 25-48 hours - 4.61% 49-72 hours - 2.61% &gt;72 hours - 8.70%</p>
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URL or the publication title, date, and page: 2008 Aetna Health Connections Utilization Management Program Description, page 16, April, 2008  
NCM 504-01 Timeliness Standards for Coverage Decisions and Notification Policy, Attachments A & B, November, 2008

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

**Nurses, social workers, pharmacists, counselors and therapists who perform clinical reviews as part of the benefit determination process or who participate in the medical management process (e.g., Case Management or Disease Management) must hold a current and valid professional license and, as required by the position, certification in their professional field.**

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URL or the publication title, date, and page: **MO 1000-01 Aetna Clinical Personnel License Requirements Policy, page 2, April, 2008**

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

**All physicians, chiropractors, psychiatrists, clinical psychologists and dentists (DDS and DMD), participating in the benefit determination process must undergo Aetna's credentialing and recertification process, which includes verification of professional license and board certification**

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URL or the publication title, date, and page: **MO 1000-01 Aetna Clinical Personnel License Requirements Policy, page 2, April, 2008**

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

No  Yes At which level(s)? **Peer-to-peer review is defined as the process through which a treating practitioner makes a request verbally or in writing to discuss a denial of coverage determination with an Aetna peer reviewer. Peer-to-peer review is a focused discussion initiated by the treating practitioner that may precede or follow the issuance of a coverage denial determination and is not an additional level of review or an appeal.**

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**506-01 Peer to Peer Policy, page 2, October 2008**

URL or the publication title, date, and page: **2008 Aetna Health Connections Utilization Management Program Description, page 29, April, 2008**

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

**Aetna licensed clinical 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 (Seattle, WA: Milliman USA); Aetna Clinical Policy Bulletins; the Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCD), and Local Coverage Determinations (LCD); 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 01) version 3.0 to guide Utilization Management decisions for oral and maxillofacial surgery services.**

**Aetna's CPBs are based on evidence in the peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies. This includes review by Aetna's Clinical Policy Council and external practicing clinicians, and approval by Aetna's CMO or his/her designee. The goals of the CPBs are to make significant new advances available to members as soon as appropriate, and to prevent unproved, ineffective and obsolete technologies from receiving coverage.**

**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. 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 LOCAT is a set of internally developed evidence-based clinical guidelines**

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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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Aetna PCPBs are used to guide coverage determinations of the experimental/investigational status and medical necessity of outpatient prescription medications for Aetna 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.

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, accepted drug compendia, 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:

- Accepted pharmacy drug compendia (United States Pharmacopeia-Drug information (USP-DI);
- American Health-Systems Formulary Service-Drug Information (AHFS-DI);
- MicroMedex DrugDex;
- 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, Annals of Pharmacotherapy).

The P&T Committee is responsible for approving PCPBs, precertification and step-therapy criteria. The PCPBs and criteria are re-reviewed periodically, as new clinical information becomes available, and at least once annually.

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URL or the publication title, date, and page:

2008 Aetna Health Connections Utilization Management Program Description, pages 13-15, April, 2008  
Process for Review and Approval of Aetna Clinical Policy Bulletins (CPBs), page 1, January, 2007

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

**Aetna licensed clinical 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 (Seattle, WA: Milliman USA); Aetna Clinical Policy Bulletins; the Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCD), and Local Coverage Determinations (LCD); 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 01) version 3.0 to guide Utilization Management decisions for oral and maxillofacial surgery services.**

**Aetna's CPBs are based on evidence in the peer-reviewed published medical literature,**

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technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies. Both new and revised Clinical Policy Bulletins drafts undergo a comprehensive review process. This includes review by Aetna's Clinical Policy Council and external practicing clinicians, and approval by Aetna's CMO or his/her designee. The goals of the CPBs are to make significant new advances available to members as soon as appropriate, and to prevent unproved, ineffective and obsolete technologies from receiving coverage. 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 when necessary.

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. 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 LOCAT is a set of internally developed 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.

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

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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, accepted drug compendia, 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:

- Accepted pharmacy drug compendia (United States Pharmacopeia-Drug information (USP-DI);
  - American Health-Systems Formulary Service-Drug Information (AHFS-DI);
  - MicroMedex DrugDex;
  - 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,
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- Peer-reviewed journals (e.g., Journal of the American Medical Association, New England Journal of Medicine, Annals of Internal Medicine, Drugs, Annals of Pharmacotherapy).

The P&T Committee is responsible for approving PCPBs, precertification and step-therapy criteria. The PCPBs and criteria are re-reviewed periodically, as new clinical information becomes available, and at least once annually.

2008 Aetna Health Connections Utilization Management Program Description, pages 13-16

URL or the publication title, date, and page:

Process for Review and Approval of Aetna Clinical Policy Bulletins (CPBs), pg. 1, January, 2007

Aetna's CPB - <http://www.aetna.com/cpb/index.html>

Aetna's Pharmacy Clinical Policy Bulletins - <http://www.aetna.com/products/rx/pcpb.html>

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. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of the medical technologies addressed. If the Clinical Policy Unit determines that new evidence or other information has emerged to warrant a change in Aetna's clinical policy, a revised CPB is prepared. If no new evidence has emerged that would warrant a change in Aetna's position, the CPB may be updated with additional supporting background information and references. Each revised and updated CPB is submitted to Aetna's Clinical Policy Council for review and approval.**

**Upon request, Aetna's Clinical Policy Unit evaluates and renders an opinion on the experimental and investigational status and medical necessity of a medical technology that is considered for coverage under Aetna medical benefit plans. Requests usually come 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 business areas of Aetna (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 and medical necessity.**

URL or the publication title, date, and page:

Process for Review and Approval of Aetna Clinical Policy Bulletins (CPBs), page 2, January 2007

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

**Certificate of coverage updates and Aetna's external website**

URL or the publication title, date, and page:

[www.aetna.com](http://www.aetna.com) (Health Coverage Information)

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

**Provider Newsletters, Health Care Professional Aetna secure external website, and [www.Aetna.com](http://www.Aetna.com) (Health Coverage Information). A What's New section is posted with the CPBs and a Modified This Month section is posted with the PCPBs.**

URL or the publication title, date, and page:

<https://www.aetna.com> (Health Coverage Information)

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 QACs, and for behavioral health clinical criteria, by the Aetna BH QAC. Criteria are reviewed by the regional QOCs and the Aetna BH QOC for adoption.**

URL or the publication title, date, and page:

2008 Aetna Health Connections Utilization Management

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: **Aetna may delegate Utilization Management responsibilities to entities that are certified by the National Committee for Quality Assurance (NCQA) or to entities that demonstrate capability to Aetna's satisfaction. All entities considered for Utilization Management delegation 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 NCQA, 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 Utilization Management activities. When Utilization Management is delegated, Aetna remains responsible to verify that the Delegated Entity functions are performed in accordance with Aetna's standards, as well as applicable laws and regulations.**

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URL or the publication title, date, and page: **2008 Aetna Health Connections Utilization Management Program Description, pages 42, April 2008**

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