Office manual for health care professionals

Aetna Better Health of Ohio Dual Preferred (HMO SNP)

aetna™

aetnabetterhealth.com/ohio-hmosnp

Contents

You've told us what's important to you. As a result, we developed this manual to help you navigate the often challenging world of health care. This manual is specific to the Aetna Better Health of Ohio Dual Preferred (HMO SNP) plan. Because our members are also required to have either partial or full Medicaid with another payor, this plan is considered a Dual Special Needs Plan (DSNP) which falls under the Medicare Advantage Organization (MAO) umbrella. Our members receive Medicare Advantage (MA) services & benefits. These terms and acronyms are used frequently throughout this manual.

Whether you're new to Aetna or have participated with us for years, we believe you'll find the office manual helpful in your day-to-day work. It contains meaningful information that makes it easier for you to work with us more effectively and efficiently. Topics range from how to get claims paid faster to learning how to reduce administrative burdens. We designed the office manual to give you more time to focus on what's most important to you — improving the health and well-being of your patients.

If you're new to Aetna's network

We have tools and resources to introduce you to working with Aetna. To find these tools, visit our website. For additional information, you can also reference our Provider Manual.

Information you need to know

We also recommend you learn more about the following topics:

- **Secure provider website**: You'll notice the term secure provider site used throughout the office manual. You can perform most electronic transactions through this website. That includes submitting claims, checking patient benefits and eligibility and requesting precertification. You have to register to use the website.
- **Patient advocacy**: As advocates on behalf of your patients who are Aetna plan members, you should review and become familiar with the member rights and responsibilities outlined in the office manual.
- **Informed consent:** You're responsible for providing your patients with all the information relevant to their conditions. This includes all health care alternatives, including potential risks and benefits, even if their plan doesn't cover the option.
- **Patient emergencies:** If your Aetna patients need emergency care, they have coverage 24 hours a day, 7 days a week, anywhere in the world.
- **Providing information:** By providing us with complete and accurate medical information and diagnoses, you help us make appropriate coverage determinations.
- **Independent contractors:** As indicated in our physician agreements, participating health care professionals are not employees or agents of Aetna or any of our affiliates.
- **Guidance on coverage:** If you're unsure whether a particular service or treatment is considered medically necessary or experimental/investigational under a patient's plan, consult our contact our Precertification department at 866-742-7210.
- **Appeals:** You can appeal adverse benefits determinations and physician or other health care professional adverse reimbursement decisions. Members may have the right to an external review if the circumstances of the appeal meet the criteria for external review. Medicare appeals will follow the guidelines set by the Centers for Medicare & Medicaid Services (CMS).
- **Products:** We use the following product groupings throughout the office manual to simplify references to the variety of benefits plans. (Not all products are available in all areas.)

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

Department	Contact Information
Aetna Better Health of Ohio Dual Preferred (HMO SNP)	1-800-260-3166
Precertification	1-866-742-7210 (Select Precertification from the menu) Fax: 959-282-8790
Pharmacy Management Precertification	Phone: 1-800-260-3166 Fax: 1-844-807-8452
Mail Service Order Form	1-800-641-6444 Online: https://www.aetnabetterhealth.com/ohio-hmosnp/members/rxdrugs
Informed Health® Line	1-800-575-5999
Medicare Service Center	1-800-MEDICARE (1-800-633-4227)
Aetna electronic payer submitted ID number	50023
Non-PAR Provider Appeal Submission	All non-participating provider Claims Appeals must include a completed appeal form & supporting documentation, as well as a completed Waiver of Liability (WOL) form. Our appeal form and the WOL form are located on our website at: https://www.aetnabetterhealth.com/ohio-hmosnp/providers/forms PDF version: Non-Par Provider Appeal Form Waiver of Liability (WOL) Statement Mail to: Aetna Better Health of Ohio Dual Preferred (HMO SNP) ATTN: Grievance & Appeals 7400 West Campus Road New Albany, Ohio 43054
PAR Provider Dispute Submission	All disputes must include a completed dispute form & supporting documentation. Our dispute form is located on our website at: https://www.aetnabetterhealth.com/ohio-hmosnp/providers/forms PDF version: Par Provider Dispute Form Mail to: Aetna Better Health of Ohio Dual Preferred (HMO SNP) P.O. BOX 64205 PHOENIX, AZ 85082

Website	Link
Aetna Better Health of Ohio Dual Preferred (HMO SNP)	aetnabetterhealth.com/ohio-hmosnp/
Aetna's Secure Provider Website	aetnabetterhealth.com/ohio-hmosnp/providers/portal
Harvard Health	health.harvard.edu/
Aetna Women's Health program	aetna.com/individuals-families/womens-health.html
Aetna Compassionate Care program	aetna.com/individuals-families/member-rights-resources/compassionate-care-program.html
Council for Affordable Quality Healthcare (CAQH)	caqh.org/
Aetna Medicare	aetna.com/individuals-families/medicare-plans.html
Aetna Better Health of Ohio Dual Preferred online Provider Directory	aetnabetterhealth.com/ohio-hmosnp/find-provider

Electronic solutions

Overview

Electronic solutions for provider offices and facilities
From the time an Aetna member schedules an appointment through claims payment, we're committed to making it easy for your office or practice to work with us electronically.

Take advantage of our suite of electronic transactions and increase your office's efficiency. Below we highlight key features and benefits of our available electronic transactions.

Aetna Better Health of Ohio Dual Preferred (HMO SNP) encourages providers to electronically submit claims, through Emdeon. Please use Submitter ID 38692 when submitting claims to the health plan for both CMS 1500 and UB 04 forms.

Contact your Provider Services representative for more information on electronic billing. Or you can mail hard copy claims or resubmissions to:

Aetna Better Health of Ohio Dual Preferred
PO Box 64205
Phoenix, AZ 85082

Resubmitted claims should be clearly marked "Resubmission" on the envelope.

For out-of-network providers seeking payment of claims for emergency, post-stabilization and other services authorized by us, please refer to the policies and procedures in the provider manual.

Working directly with Aetna

Verifying Enrollee Eligibility

All providers, regardless of contract status, must verify an enrollee's eligibility status prior to the delivery of non-emergent, covered services. An enrollee's assigned provider must also be verified prior to rendering primary care services. Providers are NOT reimbursed for services rendered to enrollees who lost eligibility or who were not assigned to the PCPs panel (unless, s/he is a physician covering for the provider).

Enrollee eligibility can be verified through one of the following ways:

- Telephone Verification: Call our Member Services Department to verify eligibility at 800-260-3166. To protect the enrollee's confidentiality, providers are asked for at least three pieces of identifying information such as the enrollees identification number, date of birth and or address before any eligibility information can be released.
- Secure Portal Verification: Enrollee eligibility search & panel rosters are found on our Secure Website Portal. Contact our Provider Services Department for additional information about securing a confidential user name and password to access the site. Note eligibility files are only updated once a month and are only available to PCPs and those providers acting as PCPs.

Secure Provider Portal Resources

The Secure Provider Portal is a web-based platform that allows us to communicate enrollee healthcare information directly with providers. Providers can perform many functions within this web-based platform. The following information can be attained from the Secure Web Portal:

- Enrollee Eligibility Search – Verify current eligibility of one or more enrollee
- Panel Roster – View the list of enrollees currently-assigned to the provider as the PCP
- Provider List – Search for a specific provider by name, specialty, or location
- Claims Status Search – Search for provider claims by enrollee, provider, claim number, or service dates. Only claims associated with the user's account provider ID will be displayed.
- Remittance Advice Search – Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user's account provider ID will be displayed.
- Provider Precertification Look up Tool – Search for provider authorizations by enrollee, provider, authorization data, or submission/service dates. Only authorizations associated with the user's account provider ID will be displayed. The tool will also allow providers to:
  - ◊ Search Precertification requirements by individual or multiple Current Procedural Terminology/ Healthcare Common Procedure Coding System (CPT/HCPCS) codes simultaneously.

- ◊ Review Precertification requirement by specific procedures or service groups.
- ◊ Receive immediate details as to whether the codes are valid, expired, a covered benefit, have prior authorization requirements, and any noted Precertification exception information.
- ◊ Export CPT/HCPS code results and information to Excel.
- ◊ Make certain staff works from the most up-to-date information on current Precertification requirements.
  - Submit Authorizations – Submit an authorization request online. Three types of authorization types are available:
    * Medical Inpatient
    * Outpatient
    * Durable Medical Equipment – Rental
  - Healthcare Effectiveness Data and Information Set (HEDIS®) – Check the status of the enrollee's compliance with any of the HEDIS measures. A "Yes" means the enrollee has measures that they are not compliant with; a "No" means that the enrollee has met the requirements.

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website or call our Provider Services Department at 800-260-3166.

Electronic funds transfer (EFT)

EFT allows you to discontinue paper checks and get your payments up to a week faster.

- Save paper and manage your business effectively with a convenient audit trail.
- Sign up to receive emails when payments have been transmitted to your bank.
- To access the form to sign up for EFT, please visit our website at aetnabetterhealth.com/ohio-hmosnp/providers/resources

Online claim Explanation of Benefits (EOB)

Through Aetna's secure provider website, you can eliminate even more paper by accessing your EOBs online.

- Access EOBs online 7 days a week, within 24 hours of claims processing.
- View, download and save as a PDF or print EOBs, as needed.
- Receive notification when EOBs become available.
- EOB activity page allows multiple search criteria to access all available EOBs.

Electronic remittance advice (ERA)

Our ERA transaction provides EOB information electronically.

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

To access the form to sign up for ERA, please visit our website at aetnabetterhealth.com/ohio-hmosnp/providers/forms.

Working through clearinghouse vendors: Transactions by vendor

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

View a listing of our electronic vendors and the transactions they support.

If you have questions, please call Provider Services at 800-260-3166 between the hours of 7:00 AM to 4:00 PM, Monday through Friday CST. For more information visit aetnabetterhealth.com/ohio-hmosnp .

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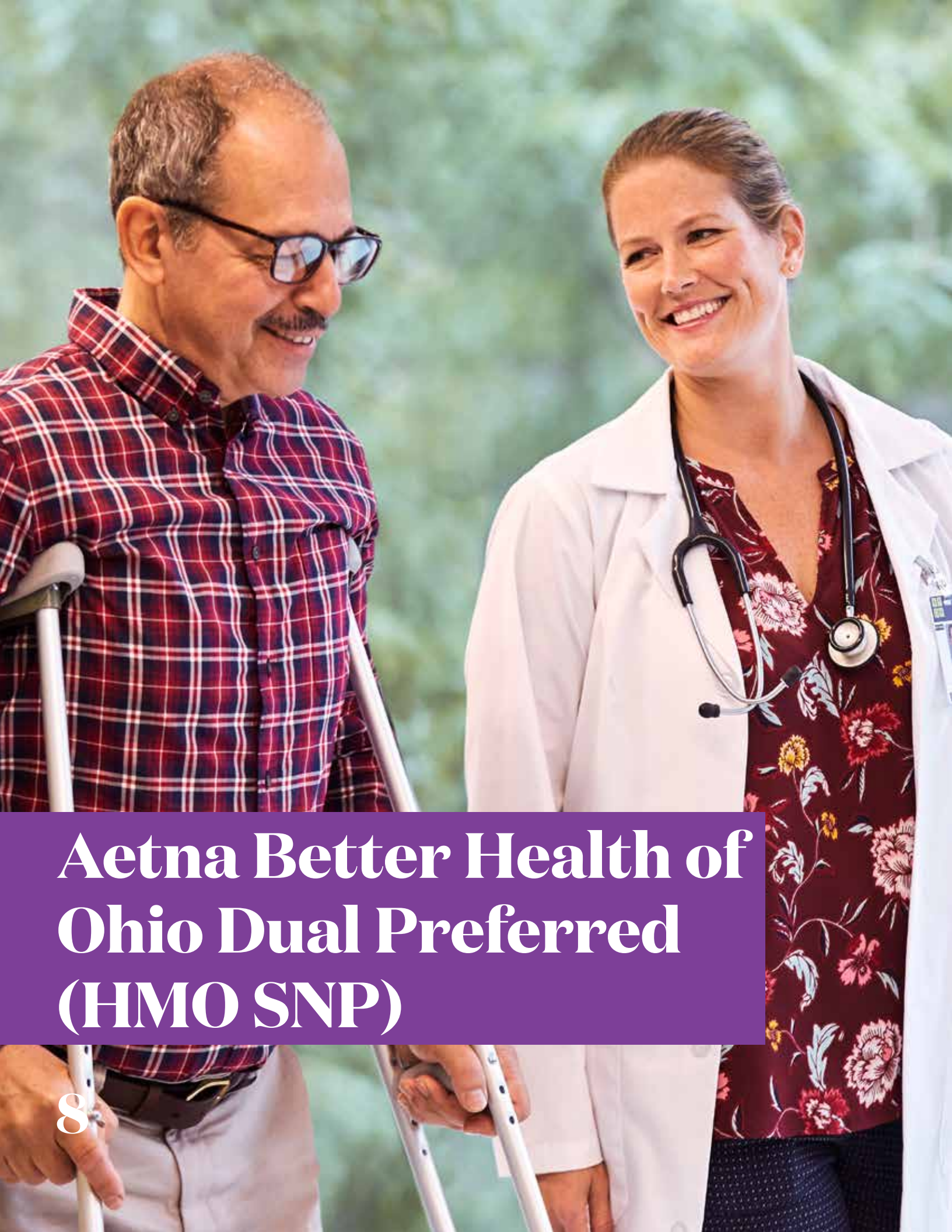


Aetna Better Health of Ohio Dual Preferred (HMO SNP)

Aetna Better Health of Ohio Dual Preferred (HMO SNP) plans

Aetna contracts with the Centers for Medicare & Medicaid Services (CMS) to offer the Aetna Better Health of Ohio Dual Preferred (HMO SNP) plan. As such, we're considered a Medicare Advantage organization (MA). All MA plans are required to offer Medicare Parts A and B medical benefits and to follow CMS' national and local coverage decisions. MA plans may also offer Medicare Part D benefits (MA-PD).

The Aetna Better Health of Ohio Dual Preferred (HMO-SNP) plan services members residing in these select Texas counties:

Region	Counties
Northwest	Fulton, Lucas, Ottawa, Wood
Northeast	Stark, Summit, Mahoning, Trumbull, Columbiana, Portage, Wayne

For specific plan information, visit our website at aetnabetterhealth.com/ohio-hmosnp.

Aetna Medicare HMO plan members are required to receive all covered services, with the exception of emergent or urgently needed services and out-of-area renal dialysis, through Aetna Medicare network providers. "Network Provider" means all providers who are in the service or surrounding area and have a contract with the Aetna Medicare Advantage (HMO), or its subcontractors, for the delivery healthcare services to its members. Aetna Medicare (HMO) plans require members to select a participating PCP and, except for those benefits described in the member's plan documents as direct-access benefits and emergency or urgent care, members must have a referral from their PCP to obtain covered specialty services or care in a facility.

Home assessment program

As part of our ongoing quality improvement efforts, we periodically offer in-home health assessments to our Aetna Better Health of Ohio Dual Preferred (HMO SNP) members. It's possible your patients may be asked to participate in this free, comprehensive assessment. The assessment is strictly voluntary. It will be performed in the patient's home by a licensed provider. If one of your patients is selected to participate in this program, the completed assessment will be mailed to you.

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

Quality improvement program

Annual Chronic Care Improvement Programs (CCIPs) and Quality Improvement Projects (QIPs) are implemented and maintained for members in accordance with CMS requirements. These quality improvement programs are designed and conducted to have a beneficial effect on health outcomes and beneficiary satisfaction.

An annual CCIP is in effect for members with chronic conditions to help improve health outcomes and quality of care. Several programs are available to support your patients and to help them make healthy lifestyle choices.

An annual QIP is in effect for members and will focus on a significant aspect of clinical and nonclinical care and health disparities to help improve health outcomes, improve satisfaction and quality of care. Programs are available to encourage your patients to get the care and preventive services they need.

Medicare prescription drug plans

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

- Deductible, not to exceed $415 for 2019.
- Coverage gap: Once a member reaches $3,820 in covered Medicare Part D drug expenses, he or she will pay no more than 37 percent for covered generics and 25 percent for covered brand drugs, including a manufacturer discount of up to 50 percent off covered brand drug costs until reaching the True Out-of-Pocket (TrOOP) threshold of $5,100. Most individual and group Aetna PDP and MA-PD plans provide supplemental gap coverage.

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

- Catastrophic coverage level: For 2019, once a member reaches $5,100 in TrOOP costs for covered Part D drugs, the member's maximum cost sharing for covered Part D drugs will be the greater of 5 percent or $3.40 for generic drugs (or those prescription drugs treated like generic), or $8.50 for all other prescription drugs.
- Quantity limits, step therapy and precertification requirements apply to certain prescription drugs.
- Formulary: The Aetna Medicare prescription drug formulary (also known as the "Aetna Medicare Preferred Drug List") differs from the formularies applicable to Aetna's commercial pharmacy plans. The Medicare prescription drug formulary can be found at: aetnabetterhealth.com/ohio-hmosnp/formulary

Transition-of-coverage (TOC) policy

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

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

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

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

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

Whether an individual is a new or renewing member, if the member's initial prescription is for less than the full transition amount (30 days), the member can get multiple fills up to the 30-day supply.

If a member lives in a long-term care facility and is entitled to a transition supply, Aetna will cover multiple fills up to a 31-day supply (unless the prescription is for fewer days) during the member's transition period. Members may also be entitled to receive a transition fill outside of their transition period in certain circumstances.

Aetna sends a TOC notice to members via first-class mail within three business days from the date the transition fill claim is processed. The letter:

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

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

You can view Tr ansition rules for our Medicare Prescription Drug process at aetnamedicare.com/en/prescription-drugs/check-medicare-drug-list.html

Additional prescription drug plan information

- **Days' supply**: Generally, a 1-month prescription may be filled for up to a 30-day supply. A member may obtain up to a 3-month (90-day) supply of maintenance medications from either a participating retail pharmacy or through a

participating mail-order vendor.

- **Mail-order drug option**: A member may obtain up to a 90-day supply of maintenance medications from our preferred CVS Caremark® Mail Service Pharmacy.

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

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

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

Also, by law, the following categories of drugs are not covered by Medicare Part D:

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

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

Note: *Most injectable medications and oral drugs not covered under Medicare Part B will be considered Medicare Part D drugs, but coverage will be determined by the formulary. Precertification is required for Medicare Part B situational drugs. If you have questions regarding whether a medication is covered under Medicare Part B versus Medicare Part D, contact the Pharmacy Precertification unit at 1-800-260-3166 for assistance.*

Additional important Aetna Medicare information

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

Collecting all Aetna Better Health of Ohio Dual Preferred (HMO-SNP) plan member cost sharing

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

of payment. The rules regarding collection of Medicare beneficiary cost-share amounts applicable in traditional Medicare apply to Aetna Better Health of Ohio Dual Preferred (HMO SNP) as well. Therefore, providers must collect all applicable cost-share amounts from Aetna MA plan members. To waive the cost share is a direct violation of federal laws and regulations. This action puts Aetna and your compliance at risk.

Access to facilities and records

Medicare laws, rules and regulations require that contracted providers retain and make available all records pertaining to any aspect of services furnished to MA plan members or their contract with the MAO for inspection, evaluation and audit for the longer of: (1) a period of 10 years from the end of the contract period of any Aetna Medicare contract, or (2) the date the Department of Health and Human Services or the Comptroller General or their designees complete an audit, or (3) the period required under applicable laws, rules and regulations.

Access to services

We have established programs and procedures to:

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

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

Medicare Medical Loss Ratio (MLR) requirements

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

These new requirements apply to any provider contracted with an MAO to participate in their Medicare network that retains medical/drug cost data that the MAO uses to calculate Medicare MLRs for which the MAO does not have independent access. Under these new regulations, MAOs "are required to maintain evidence of the amounts reported to CMS and to validate all data necessary to calculate MLRs" for 10 years from the date such calculations were reported to CMS.

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

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

Advance directives

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

MA organization determination (OD) process

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

decision/determination concerning the following items:

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

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

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

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

As a provider who has elected to participate in the Medicare program, you should understand which services are covered by original Medicare and which are not. Aetna Better Health of Ohio Dual Preferred (HMO SNP) plans are required to cover everything that Original Medicare covers, and in some instances may provide coverage that is more generous or otherwise goes beyond what is covered under Original Medicare.

As an Aetna Medicare contracted provider, you are expected to understand what is covered under the Aetna Better Health of Ohio Dual Preferred (HMO SNP) plan. CMS mandates that providers who are contracted with an MAO, such as Aetna Better Health of Ohio Dual Preferred (HMO SNP), are not permitted to hold a member financially responsible for payment of a service not covered under the member's MA plan unless that member has received a pre-service OD notice of denial from Aetna before such services are rendered. If the member does not have a pre-service OD notice of denial from Aetna on file, you must hold the member harmless for the non-covered services. You must not charge the member any amount beyond the normal cost-sharing amounts (i.e., copayments, coinsurance and/or deductibles).

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

Providers and members can initiate pre-service ODs. You must go through this process to determine if the requested/ordered service is covered prior to a member receiving it, or prior to scheduling a service such as a lab test, diagnostic test or procedure. The procedure to request a pre-service OD is similar to the procedure to request a Precertification. Please call the number on the back of the member's ID card and ask for a pre-service OD to determine if the service will be covered for the member. Once Aetna makes a determination, the member will be notified of the decision. You will only be able to charge the member for the service if the member has already received the decision from Aetna before you render the services in question to the member.

Medicare PDP coverage determinations and exceptions process

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

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

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

The following actions are considered coverage determinations:

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

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

Exceptions process

The exceptions process can be initiated for the following situations:

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

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

The member, his or her appointed representative or the prescribing physician can submit an exceptions request either orally or in writing by contacting us at:

Phone: 1-800-260-3166
OH_DualPreferred_AppealsandGrievances@aetna.com

Medicare coverage determinations and exception requests have a strict turnaround time for completion. It is critical that you send your requests to the correct areas of Aetna Medicare so we may handle them appropriately for our members. Send all Medicare prescription drug requests to OH_DualPreferred_AppealsandGrievances@aetna.com or call our pharmacy precertification unit at:

Phone: 1-800-260-3166

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

MA and Medicare PDP member grievance and appeal rights

Medicare beneficiaries are entitled to specific CMS-mandated appeal and grievance rights. Aetna has a dedicated Medicare Grievance and Appeal Unit to process all member appeal and grievance requests. Appeals and grievances are processed in accordance with the standard and expedited requirements and timeframes.

We may require the cooperation and/or participation of contracted providers in our internal and external review procedures relating to the processing of Medicare member appeals and grievances. If necessary, contracted providers should instruct the member to contact us for his or her MA plan appeal rights, as well as inform the member of his or her right to receive, upon request, a detailed written notice from us regarding coverage for services. Members should be directed to contact Member Services using the phone number listed on their Aetna ID card.

When a Medicare member appeals a denied service or a denial of a service they believe they are entitled to, we may need clinical records from you. We require all requests for clinical records to be handled by you as promptly as possible. There are instances where we have less than 48 hours to respond to an appeal and your clinical information is imperative to making an accurate and timely decision. For a complete description of our MA and Medicare PDP appeal and grievance procedures and time frames, and how to contact Aetna if you are assisting a member with this process, refer to the following links:

- Part D Complaints, Coverage Decisions, and Appeals
- Non-Part D Complaints, Coverage Decisions, and Appeals

Obligation to respond to requests for records

We are required to ask our network providers to give us clinical documentation to help make coverage decisions for pharmacy or medical services. Under our contract with you, you're obligated to provide this information to us promptly upon request. Our clinical staff will contact your office by phone and fax when we need documentation. The timelines for making coverage decisions are short and highly regulated, so it is critical that you provide us with the requested clinical information on a timely basis. If you don't, it adversely impacts your patients' access to care and results in unnecessary coverage denials. Please make sure your staff knows they must respond quickly to medical record requests. Failure to respond may impact your future participation status.

Confidentiality and accuracy of member records

Contracted providers must safeguard the privacy and confidentiality of, and ensure the accuracy of, any information that identifies a DSNP plan member. Original medical records must be released only in accordance with federal or state laws, court orders or subpoenas. Specifically, our contracted providers must:

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

Refer to the Privacy Practices section for further information.

Coverage of renal dialysis services for Medicare members temporarily out of area

An MA plan member may be temporarily out of the service area for up to six months. MAOs must pay for renal dialysis services obtained by an MA plan member from a contracted or non-contracted Medicare-certified physician or health care professional while the member is temporarily out of his or her MA plan's service area.

Direct access to in-network women's health specialists

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

Direct-access immunizations

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

Emergency services

Refer to the Your Rights section under 'For Members' of the our website for more information on emergency services.

Health risk assessment

We perform an initial health risk assessment of each new MA plan member within 90 days of his or her enrollment in an Aetna MA plan. This health risk assessment is completed by telephone for all new MA plan members. The information obtained through the survey is sent to the member's primary care physician.

Receipt of federal funds, compliance with federal laws and prohibition on discrimination

Payments received by contracted providers from MAOs for services rendered to MA plan members include federal funds; therefore, an MAO's contracted providers are subject to all laws applicable to recipients of federal funds, including, without limitation: (1) Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84; (2) the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91; (3) the Rehabilitation Act of 1973; (4) the Americans with Disabilities Act; (5) Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law; (6) the False Claims Act (31 U.S.C. §§ 3729 et. seq.; (7) the anti-kickback statute (section 1128B(b) of the Social Security Act); and (8) Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR parts 160, 162 and 164.

In addition, our contracted providers must comply with

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

Provider terminations

When a provider's participation in the Aetna Medicare network is terminated, CMS requires that Aetna make a good faith effort to provide written notice of the termination at least 30 calendar days prior to the termination effective date to all MA plan members who are patients seen on a regular basis by the provider. However, note that when a PCP is terminated from the Aetna Medicare network, all members who are patients of that PCP must be notified of the PCP's termination at least 30 days prior to the termination effective date. According to your contract you must give advanced notice to Aetna prior to terminating your agreement, for example, 90 – 120 days prior to terminating or based on your contractual language.

Financial liability for payment for services

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

Note: *CMS issued a memo to MAOs dated September 17, 2008, ("CMS Guidance") providing guidance regarding balance billing by providers of certain individuals enrolled in both a Medicare Advantage plan and a State Medicaid plan ("Dual Eligible beneficiaries"). More specifically, this CMS Guidance states that providers are prohibited from balance billing Dual Eligible beneficiaries who are classified as Qualified Medicare Beneficiaries (QMB) for Medicare Parts A and B cost sharing amounts. The CMS Guidance explains that providers must accept Medicare and Medicaid payment(s), if any, as payment in full. A QMB has no legal liability to make payment to a provider or MA plan for Medicare Part A or B cost sharing, and a provider may not treat a QMB as "private pay patient" in order to bill a QMB patient directly. In addition, the CMS Guidance states that federal regulations require a provider treating an individual enrolled in a State Medicaid plan, including QMBs, to accept Medicare assignment. Providers participating in Aetna's Medicare networks are required to provide covered services to Aetna Medicare Dual Eligible beneficiaries enrolled in Aetna's MA) plans ("Dual Eligible members") and comply with all of the requirements set forth in this CMS Guidance. Participating providers must accept Aetna's payment as payment in full or bill Medicaid for the Dual Eligible member's copayment.*

Medicare Compliance Program requirements

If you are contracted with us to provide administrative and/or health care services for our MA plans, you are considered a "First Tier entity." Although we contract with First Tiers to provide administrative and/or health care services for our Medicare plans, in the end, we're responsible for fulfilling the terms and conditions of our contract with CMS and meetings applicable Medicare program requirements. As a First Tier, you are responsible for complying with relevant Medicare program requirements. And, if you subcontract health care or administrative services, those subcontractors are considered Downstream Entities and as a First Tier, you must ensure that your Downstream Entities comply with applicable laws and regulations. CMS requires that Aetna's First Tier, Downstream and Related Entities (FDRs) fulfill Medicare Compliance Program requirements.

What requirements apply to FDRs?

CMS requires that Aetna's FDRs fulfill specific Medicare Compliance Program requirements. We describe those requirements in our First Tier, Downstream and Related Entities (FDR) Medicare Compliance Program Guide (FDR Guide). Review the FDR Guide and ensure you have internal processes in place to support your compliance with the requirements. . Additionally, you should communicate the Medicare Compliance Program requirements to your Downstream Entities. You can find the FDR Guide onhttp://www.aetna.com/health-care-professionals/medicare.html.

Code of Conduct/Compliance policies

FDRs must distribute a code of conduct and/or compliance policies to employees within 90 days of hire or contracting, when updates are made, and annually thereafter. You can provide either Aetna's Code of Conduct and Compliance Policies or your own comparable code of conduct or compliance policies, to your employees and downstream entities that support Aetna's Medicare plans.

Fraud, Waste and Abuse training

Effective January 1, 2016, First Tiers must provide the

CMS Fraud, Waste and Abuse training to applicable employees and Downstream Entities assigned to provide administrative and/or health care services for our Medicare plans within 90 days of hiring or contracting, and annually thereafter. This training is available on the Medicare Learning Network and is titled Combating Medicare Parts C and D Fraud, Waste, and Abuse Training. You can also download it here. You may be exempted from completing training but only if you are "deemed." You are considered deemed if you participate in traditional fee-for-service Medicare or if you are accredited as a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) supplier.

General Compliance training

Effective January 1, 2016, First Tiers must provide CMS' General Compliance training to applicable employees and Downstream Entities assigned to provide administrative and/or health care services for our Medicare plans within 90 days of hiring or contracting, and annually thereafter. CMS' training is available on the Medicare Learning Network and is titled Medicare Parts C and D General Compliance Training.
You can also download it here.

Exclusion list screening

FDRs and their employees may not be excluded from participation in federally funded health care programs. Prior to hire or contracting, and monthly thereafter, FDRs must screen their employees and downstream entities against the following lists:

- Office of Inspector General (OIG) List of excluded Individuals and Entities
- General Services Administration (GSA) System for Award Management (SAM)
- Centers for Medicare & Medicaid Services Preclusion List (eff. 1/1/19)

What may happen if you don't comply

If our FDRs fail to meet these CMS Medicare compliance program requirements, it may lead to:

- Development of a corrective action plan
- Retraining
- Termination of your contract and relationship with Aetna. Our actions in response to noncompliance will depend on the severity of the compliance issue. If an FDR identifies areas of noncompliance (for example, refusal of an employee to complete the required Fraud, Waste and Abuse training), they must take prompt action to fix the issue and prevent it from happening again.

Make sure you maintain documentation

You are required to maintain evidence of your compliance with the Medicare compliance program requirements for no less than ten years after the year in which such evidence was created. Aetna or CMS may request that you provide documentation of your compliance with these requirements.

Annual attestation

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

To complete your attestation:
Log into Aetna.com

1. Click on Providers
2. Click on "Products & Programs"
3. Click on Medicare
4. Click on "2018 Medicare Compliance FDR Attestation"
5. Complete the Adobe sign form

Report concerns or questions

If you identify noncompliance or Fraud, Waste and Abuse, you can report it to Aetna by using the reporting mechanisms outlined in our Code of Conduct. We prohibit retaliation for good-faith reporting of concerns.

If you have questions about the requirements that apply to FDRs or if you have difficulty finding our FDR Guide, contact the Service Center. You can also email us at MedicareFDR@aetna.com.

Temporary move out of the service area

CMS defines a temporary move as: (1) an absence from the service area (where the member is enrolled in an MA plan) of six months* or less, and (2) maintaining a permanent address/residence in the service area. An MA plan member is covered while temporarily out of the service area for emergent, urgent and out-of-area dialysis services. If a member permanently moves out of the MA plan service area or is absent for more than

six months[1], the MAO must disenroll the member from the MA plan.

Urgently needed services

Urgently needed services are covered services provided to a member that are non-preventive or non-routine, and needed to prevent the serious deterioration of a member's health following an unforeseen illness, injury or condition. Urgently needed services include conditions that cannot be adequately managed without immediate care or treatment, but do not require the level of care provided in the emergency room.

Physicians/health care professionals and marketing of MA plans

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

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

Physicians and other health care professionals may discuss, in response to an individual patient's inquiry, the various benefits of MA plans. Physicians are encouraged to display plan materials for all plans with which they participate.

Physicians and health care professionals can also refer their patients to 1-800-MEDICARE, the State Health Insurance Assistance Program, the specific MAO marketing representatives or CMS' website at medicare.gov for additional information. Physicians and health care professionals cannot accept MA plan enrollment forms.

Aetna follows the federal anti-kickback statute and CMS marketing requirements associated with Medicare marketing activities conducted by providers and related to Aetna Medicare plans. Payments that Aetna makes to providers for covered items and/or services will be fair market value, consistent with an arm's length transaction, for bona fide and necessary services, and otherwise will comply with relevant laws and requirements, including the federal anti-kickback statue.

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

Annual notice of change

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

Services received under private contract

As specified by Medicare laws, rules and regulations, physicians may "opt out" of participating in the Medicare program and enter into private contracts with Medicare beneficiaries. If a physician chooses to opt out of Medicare due to private contracting, no payment can be made to that physician directly or on a capitated basis for Medicare-covered services. The physician cannot choose to opt out of Medicare for some Medicare beneficiaries but not others, or for some services but not others. The MAO is not allowed to make payment for services rendered to MA members to any physician or health care professional who has opted out of Medicare due to private contracting, unless the beneficiary was provided with urgent or emergent care.

Claims/billing requirements

Physicians and health care professionals must use valid

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

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10 CM) codes and code to the highest level of specificity. Complete and accurate use of CMS' Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required.

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

- The ICD-10 CM codes must be to the highest level of specificity.
- Report all secondary diagnoses that impact clinical evaluation, management and/or treatment.
- Report all relevant codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

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

Submission of Medicare claims and encounter data for risk adjustment

The Balanced Budget Act of 1997 (BBA) specifically required implementation of a risk-adjustment method no later than January 1, 2000. In 2000 – 2001, encounter data collection was expanded to include outpatient hospital and physician data. Risk adjustment is used to fairly and accurately adjust payments made to MAOs by CMS based on the health status and demographic characteristics of an enrollee. CMS requires MAOs to submit diagnosis data regarding physician, inpatient and outpatient hospital encounters on a quarterly basis, at minimum.

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

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

Coexisting conditions

Certain combinations of coexisting diagnoses for an enrollee can increase their medical costs. The CMS-HCC model for coexisting conditions that should be coded for hospital and physician services are as follows:

- Code all documented conditions that coexist at time of encounter/visit and that require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Physicians and hospital outpatient departments should not code diagnoses documented as "probable," "suspected," "questionable," "rule out" or "working." Rather, physicians and hospital outpatient departments should code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results or other reason for the visit.

Risk adjustment medical record validation

Annually, CMS conducts a medical record review to validate the accuracy of the risk-adjustment data submitted by the MAO. Medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient and physician diagnoses submitted by the provider to the MAO. In addition, Aetna Better Health of Ohio Dual Preferred (HMO SNP) regulations require that providers submit samples of medical records for validation of risk-adjustment data and the diagnoses reported by Aetna to CMS, as required by CMS.
Therefore, providers must give access to and maintain medical records in accordance with Medicare laws, rules and regulations. (Refer to the "Access to facilities and records" section on page 13.) CMS may adjust payments to the MAO based on the outcome of the medical record review.

Providers of hospice-related services

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

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

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

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

CMS physician incentive plan: General requirements

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

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

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

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

◊ The patient panel size

◊ The amount and type of stop loss protection

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

CMS physician incentive plan: Substantial financial risk

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

CMS physician incentive plan: Stop loss protection requirements

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

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

Participating providers with physician incentive plan arrangements must maintain, at their sole expense, any stop loss coverage required to be maintained under applicable laws and regulations in connection with any such physician incentive plan arrangements. They must also provide evidence of such coverage to Aetna upon request.

Medicare Advantage organization (MAO) obligations

The MAO is prohibited from restricting a physician or health care professional from advising his or her patients about their health status, treatment options, the risks and benefits of those treatment options, or the opportunity to refuse treatment and/or express preferences about future treatment decisions.

Member Programs/ Resources

Aetna Compassionate Care

The goal of the Aetna Compassionate Care program is to offer help to members and their families facing the advanced stages of an illness. The program offers support and resources to help them cope more effectively with the physical and emotional challenges that lie ahead.

For more information, go to Aetna Compassionate Care.

Aetna medical management

Our medical management programs are designed to help our members achieve their optimal health. Within the portfolio of programs is our disease management program, our enhanced case management program, our integrated clinical programs for behavioral health, and pharmacy, as well as an expanding suite of wellness programs.

For more information, call 1-800-260-3166

Aetna disease management

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

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

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

Informed Health Line

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

When members call, nurses can provide them with a video link to help promote more education/support about the health topic they discussed. The nurse selects the appropriate video from over 400 choices, with more videos added throughout the year. Each video is about two to three minutes long. This video library replaces the audio library we formerly used. Research shows that well-designed videos are more effective in delivering instructions.

The video library was created by the Healthwise production, animation and user experience team. Each video goes through a comprehensive medical review process to ensure it provides the latest and most accurate health information available.

How it works

1. Members start by speaking to an Informed Health Line nurse.

2. Next, the nurse emails the member a link to the video library.

3. Members can visit the link and watch the video as often as they want, free of charge.

There is no limit to the number of video links a member may receive from the Informed Health Line nurse.

The video library helps to:

- Provide further education/support on various health topics
- Share information in a simple way, with an empathic tone
- Engage viewers with easy-to-understand health topics and an expressive visual style
- Conveniently connect members to information

Institutes of Excellence™

Institutes of Excellence is Aetna's network of participating facilities for the following services:

- Solid organ, blood and marrow transplants
- Transplant-related services, including evaluation and follow-up care

Institutes of Quality®

Institutes of Quality is a designation that facilities can achieve for certain clinical services (e.g., bariatric surgery, selected orthopedic and cardiac procedures).

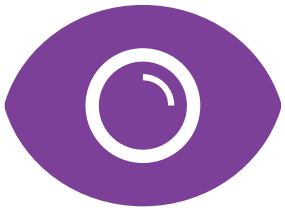
We base this designation on our evaluation of their processes and outcomes (e.g., mortality rates, readmission rates) for these procedures.

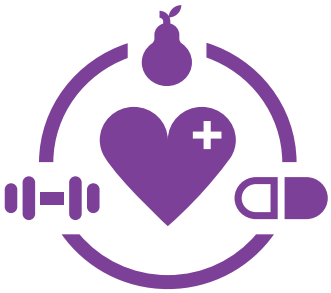
Women's health

The Women's Health Policies and Procedures Manual explains

Member Supplemental Benefits Grid

 **Hearing Services**	**Vendor** Hearing Care Solutions (HCS) **What is provided** • One (1) routine exam per calendar year • One (1) fitting and one (1) evaluation for hearing aids per calendar year • $1000 towards hearing airds ($500 per ear) per calendar year
 **Non-emergenct transporation**	**Vendor** Logisticare **What is provided** • 24 one-way trips to plan approved locations per calendar year • Services may be provided by a taxi (sedan/van), a paralift (wheelchair accessible vehicle), a stretcher van or a non-emergency ambulance transport **Important notes** • Enrollees or their representatives will need to call in and schedule this transporation • This benefit will be used first before any Medicaid transportation benefits Plan approved locations are defined as any locations where authorized services will be received by the enrollee.
 **Dental services (adult)**	**Vendor** DentaQuest **What is provided** Maximum plab benefit coverage amount of $1000 per calendar year for the following: • Preventive care ◊ Exams and cleanings (2x yearly) ◊ One ser of x-rays (1x yearly) ◊ Flouride (1x yearly) • Comprehensive care ◊ Diagnostic services and simple extractions ◊ Endodontics and periodontics (e.g. root canals and implants) ◊ Prosthodontics (e.g. dentures and denture repairs ◊ Other oral/maxillofacial surgery

 **Vision services (adult)**	**Vendor** VSP Vision Care **What is provided** • One (1) routine eye exam per calendar year **$250** per calendar year to use towards: • Contacts • Lenses • Frames (including upgrades)
 **Silver Sneakers**	**Benefit description** Offers free access to approved gyms and specialized fitness classes. **What is provided** • Fitness club membership • Orientation to the gym facility and equipment • Website access and a toll-free phone number for customer support as needed At home fitness kits for members that do no reside near a participating facility or prefer to exercise at home. Kit type and contents may vary. Please call 1-888-423-4623 for more information Important notes Enrollees deciding to join will receive a Silver Sneakers membership ID card to use at participating facilities.
 **Over-the-counter (OTC) credit**	**Vendor** InComm **What is provided** Each month, enrollees may receive **$55** towards approved OTC medications from a catalog of eligible items. Ordering may be done by phone, mail or online. **Important notes** The $55 is a “use it or lose it” benefit each month. Interested enrollees can call the health plan and request an OTC card. A member services representative (MSR) will process the request and the card will be activated and mailed to the enrollee’s verified address.
 **Smoking Cessation**	**Benefit description** Assistance with stopping the use of tobacco and nicotine products. **What is provided** Unlimited face-to-face counselling sessions visits in a 12-month period. **Important notes** the counselling sessions must be provided by a qualified doctor or other Medi-care-recognized practitioner.

Smoking cessation (continued)	Nicotine Replacement Therapy (NRT), such as patches, gums and lozenges, are not covered as part of this benefit. Nicotine patches, gum and lozenges may be included in the OTC catalog and, if so, may be obtained using available OTC funds.
 **Home-delivered meals**	**Vendor** GA Foods **What is provided** 14 meals delivered to an enrollee's home weekly (7 days). **Important information** After an inpatient discharge from a hospital, enrollees are eligible for 14 nutritious pre-cooked frozen meals delivered to their home.
 **Podiatry (adult foot care)**	**Benefit description** Routine foot care for adults. **What is provided** Three (3) visits per calendar year **Important notes** • There is a 20% coinsurance for this benefit. Enrollee needs to verify with their Medicaid plan whether or not this cost is picked up • Visits must be scheduled with an in-network provider to be covered. • Podiatry services require a referral
 **Health education**	**Benefit description** Information regarding health plan and community resources available to improve member health, increase self-care skills and encourage healthy behaviors through advise, education and monitoring. **What is provided** • Plan issued newsletters and online resources • Disease management for specific conditions such as asthma, diabetes and congestive heart failure **Important notes** As part of this benefit, Aetna reaches out to educate those enrollees that frequest the emergency department, but it is available to other enrollees as well.
 **Remote Access Technologies**	**Benefit description** Technology-based solutions to bridge the gap in access to care for rural or other remote access enrollees. **What is provided** Nurse hotline available 24 hours a day, seven (7) days a week.

Remote access technologies (continued)	**Important notes** The nurse hotline is called the **Aetna Integrated Health (IHL)** and may be accessed by calling the plan number and following prompts for IHL.
 **Worldwide emergency/**	**Benefit description** Enrollees may go to an emergency room (ER) or urgent care center in another country (outside of the United State) to receive emergent or urgent care services. **Important notes** The enrollee would be covered at 80% of the cost with a 20% coinsurance. Whether or not another Medicaid plan will pick up this 20% coinsurance is dependent upon the enrollee's coverage plan with that Medicaid carrier.
 **Outpatient blood services**	**Benefit description** When a Medicare beneficiary receives blood, there are costs associated with the processing and handling of these blood services. **What is provided** This supplemental benefit waives the deductible associated with the first three (3) pints of blood received by the enrollee.

Program name	Contact information
Beginning Right Maternity Program	1-800-260-3166
Breast Cancer Management Program	1-800-260-3166
BRCA Genetic Program (genetic testing for breast and ovarian cancers)	1-800-260-3166
Infertility Program	1-800-260-3166

Member rights and responsibilities

Advance Directive/Patient Self-Determination Act (PSDA)

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

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

The Advance Directive Notification Form should be completed by the patient. Aetna recommends that each patient return this form to their primary care physician so that it may be placed in their medical file.

Aetna encourages you to discuss advance directives with your patients.

Discrimination

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information or source of payment.

All participating physicians should have a documented policy regarding non-discrimination.

Providers may not discriminate against enrollees based on their payment status, e.g., QMB. Specifically, providers may not refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program.

All participating physicians or health care professionals may also have an obligation under the federal Americans with Disabilities Act to provide physical access to their offices and reasonable accommodations for patients and employees with disabilities. All participating physicians or health care professionals that are covered entities under the Section 1557 Nondiscrimination in Health Programs and Activities Final Rule must also provide access to medical services, including diagnostic services, to an individual with a disability.

Participating physicians or health care professionals may use different types of accessible medical diagnostic equipment. Or ensure they have enough staff to help transfer the patient, as may be needed, to comply. Note: The Patient Self-Determination Act impacts all Aetna members over the age of 18.

Informed consent

All participating physicians and other health care professionals should understand and comply with applicable legal requirements regarding patient informed consent, and adhere to the policies of the medical community in which they practice and/or hospitals where they have admitting privileges. In general, it is the participating physician's duty to give patients adequate information and be reasonably sure the patient understands this information before proceeding to treat the patient.

Consents to release medical information

Provider will obtain from members, any necessary consents or authorizations to the release of information and records to Company, Payers, their agents and representatives. In performing this covenant, provider will comply with any applicable Federal and state laws and regulations.

Member Rights and responsibilities: Aetna Better Health of Ohio Dual Preferred (HMO SNP)

As a provider in the Aetna Better Health of Ohio Dual Preferred plan, please be aware that our members have a right to:

Information

- Get information from Aetna about our plan. This includes information about how we're doing financially, and how our plan compares to other Medicare health plans.
- Get information from us about our network providers, including our network pharmacies.
- Have questions from non-English-speaking beneficiaries answered. We make individuals and translation services available, and the information

we provide about our benefits must be accessible and appropriate for people who are eligible for Medicare because of disability.

- Get an explanation from Aetna about any prescription drugs, Part C medical care or service not covered by our plan.
- Receive in writing why we will not pay for or approve a prescription drug, Part C medical care or service, and how the member can file an appeal to ask us to change this decision even if the member obtains the prescription drug, or Part C medical care or service from a pharmacy or provider not in the Aetna network.
- Receive an explanation from us about any utilization management requirements, such as step therapy or Precertification, which may apply to the member's plan.
- Make a complaint if the member has concerns or problems related to their coverage.
- Be treated fairly (that is, not be retaliated against) if the member makes a complaint.
- Get a summary of information about the appeals made by members and the plan's performance ratings, including how it's been rated by plan members and how it compares to other Medicare health plans.
- Get more information about the member's rights. If they have questions or concerns about their rights and protections, members can:
  - ◊ Call Aetna Member Services.
  - ◊ Get free help and information from your State Health Insurance Assistance Program (SHIP).
  - ◊ Visit medicare.gov to view or download the publication. It's available at: medicare.gov/publications?pubs/pdf/10112.pdf.
  - ◊ Call 1-800-Medicare (1-800-633-4227) 24 hours a day,
  - ◊ 7 days a week. TTY users should call 1-877-486-2048.
  - ◊ Call the Office for Civil Rights at 1-800-368-1019 if you think we've treated you unfairly or not respected your rights. TTY users should call 1-800-537-7697.

Access to care

As a member of Aetna Better Health of Ohio Dual Preferred (HMO SNP), members may:

- Go to a women's health specialist in our plan (such as a gynecologist) without a referral.
- Get timely access to providers. "Timely access" means that members can get services within a reasonable amount of time.
- Get their prescriptions filled within a reasonable period of time at any network pharmacy.

Freedom to make decisions

- Get full information from their health care providers when they go for medical care. This includes knowing about all of the treatment options that are recommended for a member's condition, no matter what they may cost or whether the services covered by our plan.
- Participate fully in decisions about the member's health care. A member's health care provider must explain things in a way that the member can understand. Their rights include knowing about all of the treatment options that are recommended for their condition, no matter what the treatment may cost or whether the treatment is covered by our plan.
- Know about the different medication therapy management programs we offer in which the member may participate.
- Be told about any risks involved in the member's care.
- Be told beforehand if any planned medical care or treatment is part of a research experiment. Members must be given the choice of refusing experimental treatments.
- Refuse treatment. This includes the right to leave a hospital or other medical facility, even if the member's doctor advises them not to leave. This includes the right to stop taking their medication.
- Receive a detailed explanation from Aetna if a member thinks a health care provider has denied care they believe they were entitled to receive or care they believe they should continue to receive. In these cases, members must request an initial decision, called an organization determination.
- Ask someone such as a family member or friend to help them with decisions about their health care. Members may fill out a form to give someone the legal authority to make medical decisions for them.
- Give a doctor's written instructions about how that provider want them to handle their medical care,

such as “Advanced Directives,” “Living Will,” and “Power of Attorney for Health Care,” if they become unable to make decisions for themselves. Members can contact our Member Services department to ask for the forms.

Personal rights

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

Privacy practices

Protecting our members’ health information is one of Aetna’s top priorities. To this end, we notify our members about our policy regarding the confidentiality of member information.

As a participating physician or health care professional, you should be aware that we distribute the following notice to our members:

Notice of Privacy Practices

We consider personal information to be confidential and have policies and procedures in place to protect against unlawful use and disclosure. By “personal information,” we mean information that relates to a patient’s physical or mental health or condition, the provision of health care to the patient, or payment for the provision of health care to the patient. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the patient.

When necessary or appropriate for a member’s care or treatment, the operation of our health plans or other related activities, we use personal information internally, share it with our affiliates and disclose it to health care professionals (doctors, dentists, pharmacies, hospitals and other caregivers), payers (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 their plan), other insurers, third-party administrators, vendors, consultants, government authorities and their respective agents. These parties are required to keep personal information confidential, as provided by applicable law. Participating network physicians and health care professionals are also required to give members access to their medical records within a reasonable amount of time after a member makes a request.

Ways in which personal information is used include: claims payment; utilization review and management; coverage reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; 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.

We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without patient consent. However, we recognize that many patients do not want to receive unsolicited marketing materials unrelated to their health benefits. We do not disclose personal information for these marketing purposes unless the patient consents. We also have policies addressing circumstances in which patients are unable to give consent.

For a copy of our Notice of Privacy Practices, which describes in more detail our practices concerning use and disclosure of personal information, members should call the toll-free Member Services number on the member's ID card or visit our public website.

Provider obligations to obtain consent for billing of non-covered services or benefits

Some services are not covered for members because such services are not covered under the member's plan of benefits. Typical examples are those services that are considered experimental and/or investigational (see Medical Clinical Policy Bulletins for examples). If you intend to provide non-covered services to the member, please refer to your provider agreement for information about your obligations to (1) inform the member that the services will not be covered and (2) obtain member's prior consent in writing to pay for the specified services.

Office Management

Participating practitioner medical record criteria

Organization

- Each page has member's name and date of birth on it.
  - ◊ The member's name and date of birth should be recorded on each page of the medical record (e.g., all notes, lab reports and consult reports). (1 point)
- Member's personal data (gender, date of birth, address, occupation, home/work phone numbers, marital status) is documented.
  - ◊ Each record must contain appropriate biographical/ personal data including age, sex, race, address, employer, home and work telephone numbers, ICE contact and marital status.
  - ◊ All members must have their own chart — no family charts. (1 point)
  - ◊ A centralized medical record for the provision of prenatal care and all other services must be maintained (prenatal only). (1 point)
- All entries in the record contain author's signature or initials or electronic identifier (stamped signatures are not acceptable).*
  - ◊ The provider of service for face-to-face encounters must be appropriately identified on medical records via their signature and physician specialty credentials (e.g., MD, DO, DPM, etc.). Examples of acceptable physician signatures are: handwritten signature or initials; electronic signature with authentication by the respective provider; or facsimiles of original written or electronic signatures. This means that the credentials for the provider of services must be somewhere on the medical record — either next to the provider's signature or preprinted with the provider's name on the group practice's stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider. (1 point)
- All entries are dated. (1 point) *
- All entries are legible to someone other than the writer. *
  - ◊ The medical record should be complete and legible. Illegible medical record entries can lead to misunderstanding and serious patient injury. (1 point)
- Medications noted, including dosages and dated status of prescription (active or discontinued) or date of initial or refill prescription. *
  - ◊ Evidence of prescribed medications, including dosages and dates of initial or refill prescriptions must be present in the record. This list should be updated each visit. (1 point)
- Medication allergy and adverse reactions or lack thereof prominently noted. *
  - ◊ Allergies and adverse reactions to medications are prominently noted in chart or the lack thereof is noted as NKA (no known allergies) or NKDA (no known drug allergies). (1 point)
- Up-to-date problem list is completed including significant illnesses and medical and psychological conditions. *
  - ◊ A problem list recorded with notations must be present and include any significant illness or medical and/or psychological condition found in the history or in previous encounters. The problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-10 diagnosis code on the date of service. A problem list should be either a classical separate listing of problems or an updated summary of problems in the progress note section (usually a periodic health exam). The latter type list should be updated at least annually and should include health maintenance. A repetitive listing of problems within progress notes is acceptable. A blank problem list receives a score of 0. (1 point)
- Past medical history is completed (for members seen three or more times) and is easily identified and includes dates of serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to dates of prenatal care, birth, operations and childhood illnesses.*
  - ◊ Past history including experiences with illnesses, operations, injuries and treatments must be documented. Family history including a review of medical event, diseases and hereditary conditions that may place the member at risk must be

**This is assessed for Medical Record Keeping Practices based on CMS, regulatory and Aetna guidelines.*

documented. (1 point)

- History and Physical (H&P) documents have subjective/objective information for presenting problem. *
  - ◊ Past medical history including physical examinations, necessary treatments and possible risk factors for the member relevant to the particular treatment are noted. (1 point)
- For members 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for members seen three or more times, query substance abuse history).
  - ◊ For members 14 years and older, a score of 1 requires a response to an inquiry concerning alcohol, smoking and/or substance abuse history as part of risk screening in support of preventative health. For members under the age of 14 years, the score will be N/A. (1 point)
  - ◊ Note regarding follow-up care, calls and visits. Specific time of return is noted in weeks, months or as needed.
  - ◊ Encounter forms or notes have a notation regarding follow-up care, calls or visits when indicated. The specific time of return is noted in weeks, months or as needed (i.e., PRN). (1 point)
- An immunization record has been initiated for children and history for adults.
  - ◊ An immunization record (for children) which includes the name of the vaccine and date of administration or disease (e.g., chickenpox) is up to date or an appropriate history has been made in the medical record (for adults). Member reported data is acceptable. (1 point)
- Preventive screenings and services offered according to Aetna guidelines. *
  - ◊ There is evidence that preventive screenings and services are offered in accordance with the organization's practice guidelines. Preventive screenings specific to member age/gender/illness (e.g., mammography, immunizations, Pap/HPV tests, BMI value for adults, BMI percentiles for ages 15 and under, colorectal cancer screening, diabetic eye exams) are documented. Documentation should include screening date and result. (1 point)
  - ◊ For children and adolescents there should be documentation of counseling for nutrition and physical activity.
- Documentation about advance directives (whether executed or not) is in a prominent place in the member's record (except for under age 18).*
  - ◊ There is evidence of advance directives noted in a prominent place in the record (1 point) and whether or not the advance directive has been executed in the chart for members over 18 years of age. (1 point)
- Treatment Plan is documented. *
  - ◊ There is documentation of clinical findings and evaluation for each visit (presenting complaints, pain management, Diagnosis and Treatment Plan, prescription, referral authorization, studies, instructions). (1 point)
- Working diagnoses are consistent with findings. *
  - ◊ There is a documented reason for the visit. The progress note contains appropriate subjective and objective information pertinent to the member's presenting complaints for each visit. (1 point)
- No evidence member is at inappropriate risk. Possible risk factors for member relevant to particular treatment are noted. *
  - ◊ There is no evidence that the member is placed at inappropriate risk by a diagnostic or therapeutic procedure. Diagnostic and therapeutic procedures are appropriate for the member's diagnosis and risk factors. Examples: a) Member has complaint of right hip pain and an X-ray of the right hip is ordered. b) Abnormal lab and imaging study results do not have an explicit note regarding follow-up plans. (1 point)

Examination

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

Studies

- Lab and other studies are ordered, as appropriate.
  - ◊ If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, for

**This is assessed for Medical Record Keeping Practices based on CMS, regulatory and Aetna guidelines.*

example, lab or X-ray should be documented. (1 point)

- Evidence that physician has reviewed lab, X-ray or biopsy results (signed or initialed reports) and member has been notified of results before filing in the record.
  - ◊ There is evidence of physician review of lab, X-ray or biopsy results or other studies by either signing or initialing reports or documentation of the results in the progress notes. Abnormal lab and imaging study results have an explicit note regarding follow-up plans. (1 point)

Communication

- Documentation of communications contact with referred specialist. *
  - ◊ The PCP or managing practitioner coordinates and manages the care of the member. If a consultation/referral is made to a specialist, there is documentation of communication between the specialist and the PCP with notation that physician has seen it. And there is evidence of discharge summaries from hospitals, HHAs and SNFs, if applicable. If there is no evidence of referral or other facility services, mark N/A. (1 point)
- Documentation indicating the patient's preferred language (California only). *
- Documentation of offer of a qualified interpreter, and the enrollee's refusal, if interpretation services are declined (California only). *

Aetna's benefits plans

Aetna Benefit Products booklet

An easy-to-use tool that puts basic Aetna benefits product information at your fingertips. It provides clear, concise information about our plans:

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

You can access the Aetna Benefit s Products booklet (ABP) on our public website.

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

Coordination of benefits

Coordination of benefits (COB) is a plan provision that establishes a uniform order of benefits determination under which plans pay claims. It reduces duplication of benefits and provides greater efficiency in the processing of claims when a person is covered under more than one plan.

The goal of COB is to make sure that the combined payments of all plans do not add up to more than the covered health care expenses.

There are two primary ways to calculate benefits**:

- 100 Percent Allowable (Standard Allowable Calculation)
  - ◊ The benefits paid by both plans will equal no more than the allowable expense.
  - ◊ An allowable expense is defined as any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom the claim is made.
- Maintenance of Benefits (MOB)
  - ◊ Under MOB, a secondary plan may reduce its benefits to the lesser of:

What it would have paid had it been primary, or what it would have paid less the primary plan's payment.

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

**This is assessed for Medical Record Keeping Practices based on CMS, regulatory and Aetna guidelines.*
***State mandates may apply*

Aetna is respnonsible for coordinating benefits based on the member's benefits plan and its cotnract with the physician or other health care professional. The primary carrier's negotiated fee is not used to determine Aetna's normal benefits. See the following example:

Primary plan contract with physician	Aetna contract with physician
$1,500 billed charges	$1,500 billed charges
$1,000 primary plan's negotiated fee	$1,200 Aetna's negotiated fee
x80% coinsurance rate	x80% coinsurance rate
$800 primary plan's payment	$960 Aetna's normal benefit -$800 primary plan's payment $160 Aetna's payment

Birthday Rule

Aetna follows the Birthday Rule for all employer groups and provider contracts regarding dependent children of parents not separated or divorced:

• The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year.
• If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
• If the other plan does not follow the Birthday Rule COB provision, but instead has a Gender Rule (e.g., the plan of the father is primary) and if, as a result, the plans do not agree on the order of benefits, both carriers must come to an agreement on the benefit each plan pays. (Aetna will contact the other carrier to discuss an agreed payment arrangement.)

Medicare Secondary Payer

Medicare Secondary Payer (MSP) is the term used by Medicare when Medicare is not responsible for paying claims first. Under MSP, active employee group plans with 20 employees or more are the primary payers of benefits when individuals are covered by both employer plans and Medicare because of age (but are actively working), disability or renal disease (during the ESRD coordination period).

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

Medicare/Medicaid dual eligibles

"Dual eligibles" are individuals who are entitled to Medicare Part A and/or Part B and who are also eligible for some form of Medicaid benefit. Members of Aetna Better Health of Ohio Dual Preferred (HMO-SNP) are considered dual eligible.

Medicare/Medicaid relationship

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

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

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

Providers and suppliers, including pharmacies, must refrain from collecting Medicare cost sharing for covered Parts A and B services from individuals enrolled in the Qualified Medicare Beneficiary Program (QMB) program, a dual eligible program which exempts individuals from Medicare cost-sharing liability.

Aetna Medicare Advantage

Dual eligibles receive their prescription drug benefit (Part D) through Medicare. Dual eligibles may enroll in

Note*: State mandates take precedence over Aetna standards.*

stand-alone Medicare prescription drug plans (PDPs) or Aetna Medicare Advantage (MA) plans that incorporate a prescription drug benefit (MA-PDs). Aetna offers both types of insurance products to Medicare-eligible beneficiaries.

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

Medicare Part D plans

To the extent that an individual is covered under both a Medicare prescription drug plan offered under Part D of the Medicare program ("Medicare Part D") and another health plan that provide prescription drug coverage or financial assistance to Medicare Part D-eligible individuals (including non-Medigap individual market insurance policies), covered benefits must be coordinated between such plans in accordance with CMS requirements and any subsequent guidance from CMS.

Working aged

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

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

Motor vehicle accident

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

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

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

ICD-10 and 5010

ICD-10 conversion

Two rules will help the nation transition to an electronic health care environment. They were released by the Department of Health and Human Services (HHS), under the Administrative Simplification Provision of HIPAA on January 15, 2009.

They are:

- Updated standards for electronic health care and pharmacy transactions (5010/D.0). These took effect on January 1, 2012.
- New diagnosis and procedure coding standards (ICD-10 Clinical Modification [CM] and ICD-10 Procedure Coding System [PCS]). These took effect on October 1, 2015.

More information on ICD-10 is available on our public website.

Medical record documentation: Standards and criteria

Our participation agreements require you to treat personal health information (PHI) as confidential. PHI includes: identity of the individual; the relationship of the individual with Aetna; physical or behavioral health status or condition; and payment information for the provision of health care.

Note*: State mandates take precedence over Aetna standards.*

Aetna established medical record criteria to provide a guideline for fundamental elements of organization, documentation of diagnostic procedures and treatment, communication and storage of medical records. These criteria are applicable to all benefits plans. Performance goals are established to assess the quality of medical record-keeping practices, and audits are conducted no less than every two years. Aetna's performance goal is 85 percent compliance.

Our participation agreements require you to maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards. This requirement survives the termination of the contract, regardless of the cause for termination. You must keep our members' information confidential and stored securely. You must also ensure your staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

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

Maintenance of information and records requirements

Provider agrees:
a) to maintain information and records in a current, detailed, organized and comprehensive, accurate and timely manner and according to customary medical practice, applicable Federal and state laws, and accreditation standards;

b) that all member medical records and confidential information will be treated as confidential and according to applicable laws, including but not limited to, the requirements set forth in 42 C.F.R. §§ 422.118 and 423.136; and

c) to maintain the information and records for the longer of six (6) years after the last date provider services were provided to member, or the period required by applicable law.

This requirement survives the termination of your agreement, regardless of the cause of the termination.

Member identification and verification of eligibility

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

Digital ID cards

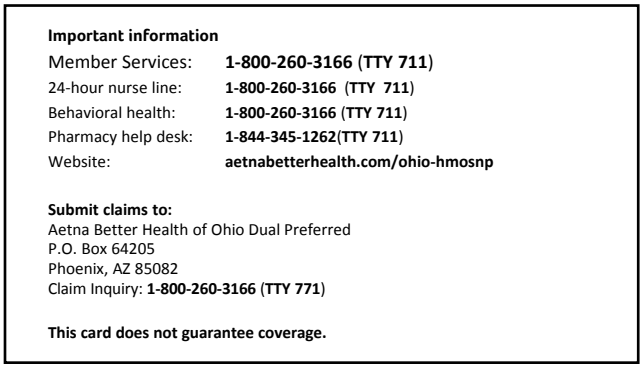
Members can access and view their digital ID cards within 24 hours after the effective date using the Aetna Mobile app, their Aetna Navigator® member website, aetna.com. Members can easily print replacement ID cards from Aetna Navigator. Digital ID cards are identical to plastic ID cards.

Member ID cards

To see a sample of our Aetna Better Health of Ohio Dual Preferred (HMO SNP) or Aetna Medicare Rx plan member ID cards, refer to the Medicare product page on our secure provider website.

Card front

Card back



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

Group enrollment form

- Members may present a copy of a group enrollment form to your office, which should be accepted as a temporary ID until their member ID card is received. This temporary form is valid for 30 days after the effective date specified on the form.
- Federal Employees Health Benefits Program (FEHBP) members may present to your office a copy of the Federal Form 2809 Enrollment Form or an electronic confirmation of their enrollment from Employee Express or Annuitant Express.
- When accepting this temporary form of identification, note the following:
  - ◊ Primary care physicians should check the form to ensure their Aetna primary care office number is designated (if applicable for plan). If the incorrect doctor or office is listed, claims may be denied or payments may be misdirected.
  - ◊ Examine the form to verify the correct copayment.
  - ◊ Verify the plan sponsor's signature is present on the bottom of the form.
  - ◊ With the EZenroll® online enrollment option, members may enroll with Aetna via the Internet. Members fill out the application online and send it to their employer, who submits it electronically to Aetna. As proof of enrollment, members should present an enrollment validation form printed from their personal printer. The EZenroll option is not available to Aetna Medicare Plan (HMO) members or in certain states.

Provider accessibility standards

Primary care provider responsibilities
Each primary care provider (PCP), if any, providing covered services under your agreement will comply with the following:

PCPs will arrange and coordinate the overall provision of covered services to members under the terms and conditions of the applicable plan. PCPs will provide or arrange for the provision of covered services, including, without limitation, urgently needed services or emergency services, regardless of whether the PCPs has previously seen or treated the member.

Aetna has established standards for member access to primary care services. Each primary care practitioner is required to have appointment availability within the following time frames:

- Regular or routine care: within 7 days
- Urgent complaint: same day or within 24 hours

In addition, all participating primary care physicians must have a reliable 24/7 answering service or paging system. A recorded message or answering service that refers the member to the emergency room is not acceptable.

Specialty care provider responsibilities
Aetna has established standards for member access to specialty care services. Each specialty care practitioner is required to have appointments available with the following time frames:

- Routine care: within 30 calendar days
- Urgent complaint: same day or within 24 hours

In addition, all participating specialty care physicians must have a reliable 24/7 answering service or machine with a beeper or paging system. A recorded message or

Note: *HMO members are not required to select a primary care physician. However, members are encouraged to select a primary care physician so they can take advantage of certain programs that require members to access care through their primary care physician.*

answering service that refers members to emergency rooms is not acceptable. More stringent state requirements supersede these accessibility standards.

Physician-requested member transfer

Circumstances may necessitate a participating physician to ask an Aetna member to leave their practice when persistent problems prevent an effective physician–patient relationship. Such requests cannot be based solely on the filing of a grievance, an appeal, a request for external review or other action by the patient related to coverage, high utilization of resources by the patient, or any reason that is not permissible under applicable law.

The following steps must be taken when requesting a specific physician–patient relationship be terminated:

- The physician must send the patient/member a letter informing him or her of the termination and the reason(s) for the termination. A copy of this letter must also be sent to your local Aetna network manager. For the mailing address, call your local Aetna office at 800-260-3166. The physician's letter to the member should be sent by certified mail.
- In the case of a primary care physician, Aetna will send the member a letter informing the member that he or she must select a new primary care physician and providing instructions on how to select another primary care physician.
- Consistent with the American Medical Association Code of Medical Ethics, Opinion 8.115, the physician must support continuity of care for their patient by giving the patient sufficient notice and opportunity to make other arrangements for care.

In addition, upon request, within 30 days of initial request by the physician, the physician shall provide resources or recommendations to the patient to help locate another participating physician, and offer to transfer records to the new physician upon receipt of a signed patient authorization.

Primary care provider responsibilities

Each primary care provider (PCP), if any, providing covered services under your agreement will comply with the following:

- PCPs will arrange and coordinate the overall provision of covered services to members under the terms and conditions of the applicable plan.
- PCPs will provide or arrange for the provision of covered services, including, without limitation, urgently needed services or emergency services, regardless of whether the PCP has previously seen or treated the member.

Provider office panel status changes

Follow this procedure to change the enrollment status of your office:

- Send a letter to your local Aetna office notifying us of your request. For the mailing address, call your local Aetna office at 800-260-3166. There are two exceptions to this rule:
- Indicate the status you are requesting for your office:
  - ◊ **Open**: Your office is open and accepting all Aetna patients.
  - ◊ **Accepting current patients only**: Your office is not accepting any new Aetna members unless the member is currently a patient in your practice.
  - ◊ **Frozen**: Your office is not accepting any new Aetna members as patients even if the patient is currently a patient in your practice under another type of coverage.

Provider capacity

Provider will give notice, at the earliest possible time, to Company of any significant changes in the capacity of group or group providers to provide or arrange for the provision of covered services to members as contemplated by your agreement, including, but not limited to, any material reduction in the number of group providers.

Closed panel

Provider and Company agree that a broad selection of physicians is important to members and that members expect physicians listed in Company's directories to be available. Therefore, only upon at least ninety (90) days prior written notice with good cause acceptable to Company, provider or any group provider may prospectively decline to accept new members as patients. To prevent discrimination against Company or its members, for such time as provider or a group provider declines to accept new members as patients, the provider or group provider will not accept as patients additional members from any insurer, entity or organization which competes with Company.

Requirements:

- We require 90-day advance written notice of a change in the enrollment status of an office.
- To prevent discrimination against Company or its Members, for such time as Provider or a Group Provider declines to accept new Members as patients, such Provider or Group Provider shall not accept as patients additional members from any insurer, entity or organization which competes with Company.
- Provider shall provide, at the earliest possible time, notice to Company of any significant changes in the capacity of Group or Group Providers to provide or arrange for the provision of Covered Services to Members as contemplated by this Agreement, including, but not limited to, any material reduction in the number of Group Providers.

Provider identification numbers

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

The HIPAA standard transactions initiated by medical providers are:

- Claims
- Encounter
- Eligibility and benefits inquiry
- Claims status inquiry
- Precertification add
- Referral add

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

Share your NPI

If you're a provider who's required to have an NPI, make sure you share your NPI with us. In addition, share your NPI with other providers who may need it to conduct electronic claims, referrals or precertification requests.

Aetna provider identification number (PIN)

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

Although the NPI should be used in electronic transactions for purposes of identifying yourself as a provider, you can use your PIN or TIN to identify yourself when contacting us by other means.

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

Recredentialing

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

Our recredentialing process

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

We'll send providers (whose applications aren't complete within CAQH) three reminder letters. The letters will ask them to update their recredentialing data. If they don't respond to the letters, we'll call them.

How can I check the status of my recredentialing application?

Call our Provider Services Service department at 800-260-3166.

Case management and acute care

Overview

Aetna's Case Management and Acute Care model integrates available programs and services. This includes case management, disease management and specialty areas such as behavioral health.

Our role is to help coordinate health care and to encourage members to be informed participants in health care decision making.

We provide hospitalized members who are identified for patient management activity with:

- Focused discharge planning to help their transition to the next level of care
- Targeted concurrent review to evaluate and determine the appropriate level of coverage* for medical services

Utilization management and standards

Aetna Better Health of Ohio Dual Preferred (HMO SNP) uses systems of utilization review/quality improvement/ peer review to promote adherence to accepted medical treatment standards. And, to encourage participating physicians to minimize unnecessary medical costs consistent with sound medical judgment. Furthermore, provider agrees, consistent with sound medical judgment to:

a) participate, as requested, and to abide by Aetna Better Health of Ohio Dual Preferred (HMO SNP)'s utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) and decisions with respect to all members;

b) regularly interact and cooperate with Aetna Better Health of Ohio Dual Preferred (HMO SNP)'s nurse case managers;

c) abide by all Aetna Better Health of Ohio Dual Preferred (HMO SNP)'s participation criteria and procedures, including site visits and medical chart reviews, and to submit to these processes biannually, annually, or otherwise, when applicable;

d) obtain advance authorization from Aetna Better Health of Ohio Dual Preferred (HMO SNP) prior to any non-emergency admission. And, in cases where a member requires an emergency hospital admission, to notify Company, both according to the Company's rules, policies and procedures in effect; and

e) the extent required by the terms of the applicable plan, provider will refer or admit members only to participating providers for covered services, and will furnish such participating providers with complete information on treatment procedures and diagnostic tests performed prior to such referral or admission.

For those members who require services under a specialty program, provider agrees to work with Aetna Better Health of Ohio Dual Preferred (HMO SNP) in transferring the member's care to a specialty program provider.

How to contact us for specific utilization management issues

- Patient Management and Acute Care staff, including medical directors, are available 24 hours a day through toll-free telephone numbers for provider and member inquiries.
- Health care providers may contact Patient Management staff during normal business hours (8 a.m. to 5 p.m., Monday through Friday) by calling the toll-free precertification number on the member ID card.
- When only a Member Services number is on the card, you'll be directed to the Precertification Unit through a phone prompt or a Member Services representative.
- On weekends, company holidays and after normal business hours, use these same toll-free phone numbers to contact Patient Management staff.

Utilization review policies

Utilization Review policies including precertification, concurrent review, discharge planning, and retrospective review are located on our public website.

**For these purposes, "coverage" means either the determination of (1) whether or not the particular service or treatment is a covered benefit pursuant to the terms of the particular member's benefits plan, or (2) where a provider is required to comply with Aetna's utilization management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement.*

How we determine coverage

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

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

- MCG™ guidelines
- Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and the Medicare Benefit Policy Manual
- Level of Care Assessment Tool (LOCAT)
- Applied Behavioral Analysis (ABA) Guidelines for the treatment of Autism Spectrum Disorder then accept the terms to view the ABA Guidelines.
- American Society of Addiction Medicine Patient Placement Criteria for Addictive, Substance-Related and Co-Occurring Conditions
- American Society of Addiction Medicine (ASAM) Third Edition Criteria are copyrighted but can be purchased by contacting:

  American Society of Addiction Medicine
  4601 North Park Ave
  Upper Arcade Suite 101
  Chevy Chase, MD 20815
  Telephone: 301-656-3920
  Fax: 301-656-3815
  Contact ASAM at email@asam.org.
- Internally developed guidelines and Aetna's Clinical or Pharmacy Policy Bulletins (CPB) (based on peer-reviewed published medical literature)

Participating physicians may ask for a hard copy of the criteria that were used to make a determination by contacting our Provider Service Center at 800-260-3166.

We base decisions on the appropriateness of care and service. We review coverage requests to determine if the requested service is a covered benefit under the terms of the member's plan and is being delivered consistent with established guidelines. If we deny a request for coverage, the member (or a physician acting on the member's behalf) may appeal this decision through the complaint and appeal process. Depending on the specific circumstances, the appeal may be made to a government agency, the plan sponsor or an external utilization review organization that uses independent physician reviewers, as applicable.

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

Admissions protocol

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

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

Notify us of hospital admissions within one business day

We need notice of all inpatient admissions, including those through the emergency department, within one business day of the admission. If a patient is unable to provide coverage information, you must contact us as soon as you become aware of their Aetna coverage.

You must also explain any extenuating situation. You may contact us by telephone (call the number on the patient's member ID card) or through electronic data interchange (EDI).

Failure to meet this notification time frame may reduce your payment

It is very important that you let us know of an admission within one business day. Late notification may result in denying payment for the portion of the stay before we were notified. Failure to inform us of the stay at all (or until after discharge) may result in denying the entire hospital stay. This denial is not based on medical necessity. Like other denials of this type, you cannot bill the patient for these denied services.

All-products precertification list

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

The process facilitates:

- Communicating a coverage decision to the treating practitioner and/or member before the procedure, service or supply
- Identifying members for pre-service discharge planning
- Identifying and registering members for covered Aetna specialty programs, such as case management and disease management, behavioral health, the National Medical Excellence Program and the Beginning Right maternity program.

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

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

You can also access an updated list of ser vices requiring precertification on our public website.

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

Case management services

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

Our case managers review and coordinate services for members with multiple and complex needs (e.g., cardiaccare, complex pediatric care, complex behavioral health care, medical psychiatric coordination, oncology), and for members who are at risk for high cost or high utilization. We welcome referrals from treating physicians to our case management program. You can submit a referral through the toll-free phone number on the member ID card or via EDI transactions. Once we decide that a member is right for case management and the member or caregiver agrees to it, we make an individualized plan. We work with the member, the member's family, physician(s), and other health care professional(s).

The assessment process leads to the development of a case management plan that meets the member's specific needs. The plan includes member-specific deficits, goals and objectives. There are targeted activities to meet these goals and objectives. The case manager helps the member achieve his or her health goals, and they work to resolve any identified issues or barriers. We regularly reassess the plan to determine the member's progress in meeting the goals and objectives. As the member's condition progresses or regresses, we modify the plan accordingly. Once the stated goals and objectives are met, the member is discharged from case management. This is usually within an average of 30 to 90 days.

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

Coordination of care

Importance of collaboration

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

Sharing patient information

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

To this end, we strongly encourage you to send progress notes and discharge summaries to your patients' other treating practitioners. Forms are available on our provider website and include the following:

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

Accessing communication forms

You can access these forms through the Health Care Professional Forms on our public website.

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

Health insurance marketplace quality improvement strategy

The Affordable Care Act (ACA) authorizes the creation of Health Insurance Marketplaces (Marketplaces) to help individuals and small employers shop for, select, and enroll in high quality, affordable private health plans. Only qualified health plans (QHPs) may be offered within the Marketplaces. As part of the ACA, QHPs must implement a quality improvement strategy (QIS) if the issuer has been participating in a Marketplace for two or more consecutive years and meets the membership threshold. A QIS is designed to improving health outcomes of plan enrollees and must address improving health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, implement wellness and health promotion activities or reduce health and health care disparities.

Transition of care

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

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

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

[2]*Kinchen, KS, Cooper, LA., Levine, D., Wang, NY., Powe, NR. Referral of Patients to Specialists: factors Affecting Choice of Specialist by Primary care Physicians. Annuals of Family Medicine. May/June 2004;2(3), 245-252.*

member's plan

- Not included within a plan sponsor-specific network Additionally, the treating provider must be an individual practitioner (e.g., a specialist, physical therapist, speech therapist) or home care agency in order to be eligible for the transition-of-care process.

Transition of care does not apply to nonparticipating DME vendors or pharmacy vendors. Transition of care does not apply to nonparticipating facilities, with the exception of facilities in which the Aetna contract has terminated (for reasons other than quality issues) and a treating participating practitioner only temporarily has privileges only at the nonparticipating facility.

The transition-of-care process applies to all benefits plans except Traditional Choice. It is also limited to a fixed period of time. Transition of care also applies to members who are in an active course of covered treatment when a physician's/health care professional terminates participation in the Aetna network.

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

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

Procedures for requesting transition of care
The member asks for a Transition Coverage Request Form from Member Services or his or her employer. The member completes the form with help, as needed, from the nonparticipating treating physician.

- The member or nonparticipating treating physician faxes the completed form to the Aetna fax number on the form.
- We review the information and, when necessary, an Aetna medical director evaluates the treatment program and may also contact the treating physician or health care professional.
- We send a letter about the coverage decision to the member and the nonparticipating treating physician or health care professional and, if approved for coverage, the length of time the transition benefits apply. We also send a letter to the member's primary care physician, as applicable.

Depression in Primary Care Program

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

Our Depression in Primary Care Program is designed to support the screening for and treatment of depression at the primary care level.Our program offers your primary care practice:

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

To participate you just need to be a participating primary care provider, use the PHQ-9 tool to screen your patients and submit claims with the following billing combination: CPT code 99420 (administration and interpretation of a health risk assessment) in conjunction with diagnosis code Z13.89 (screening for depression). Click here to learn more.

Alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) program

Our SBIRT program is designed to support primary care physicians in screening patients for alcohol abuse, providing brief intervention and referring individuals to treatment. Overall, the program aims to improve both the quality of care for patients with substance abuse conditions, as well as outcomes for patients, families and communities. Our goal is to help increase the adoption of alcohol screening, brief intervention and the referral to treatment process in primary care physician practices.

The program incorporates the evidence-based protocol established by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). We reimburse you for screening and brief intervention. This program is open

to Aetna participating primary care physicians treating any patient who is 18 years old or older and has Aetna medical benefits. Click here to get started.

Patient-centered medical home (PCMH)

PCP practices can participate as a PCMH in three ways:

- Direct contract via an amendment to a physician/ group agreement
- Aetna's external PCMH recognition program
- Multi-health plan collaborative

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

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

These two requirements encompass many requirements and standards such as:

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

The purpose of these types of arrangements are to:

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

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

These are currently the states of Arizona, Colorado, Connecticut, Delaware, Maryland, Massachusetts, New Jersey, New York, Virginia, Washington and West Virginia, and the cities of Jacksonville and Tampa, Florida, and Cleveland and Columbus, Ohio.

Multi-health plan collaboratives include:

- Those promoted by CMS (i.e., MAPCP, CPCI)
- Others where there is local market interest among providers, payers, plan sponsors, and other interested parties, and these parties collectively agree on an arrangement

Aetna currently participates in collaboratives in Colorado; Maine; Hudson Valley, New York; Southeastern Pennsylvania; Maryland/Washington, D.C./Virginia; Cincinnati, Ohio; and Washington state.

Physician pay for performance (P4P)

Participation is through a direct contract. It's available in all markets to PCPs who meet panel size requirements. It's executed via a signed amendment to their current participation agreement.

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

Annual goals are:

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

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

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

- Independent practice associations (IPA)

**State variations may exist*

- Physician-hospital organizations (PHO)
- Physician groups

We incorporate group and physician-level data into our online and other tools. This provides actionable, patient-level information to physicians. Physicians earn reward payments only when they either:

- Improve toward their targeted performance results
- Maintain their high-performing levels of achievement

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

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

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

Pharmacy management

Overview: Pharmacy Plan Drug List (formulary)

Aetna Medicare Advantage plans
Our prescription drug formulary can be found at the following links:

- Drug Formulary

CVS Caremark Mail Service Pharmacy

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

With this service, your patients will enjoy these benefits:

- **Convenience**: Reorder only once every three months. And CVS Caremark Mail Service Pharmacy's website and automated telephone service allow members to order refills, track orders and more.
- **Privacy**: Prescriptions are discreetly packaged.
- **Peace of mind**: Pharmacists are available 24 hours a day, every day, to answer members' questions.
- **Savings**: Members may save money by using CVS Caremark Mail Service Pharmacy, and standard shipping is always available at no additional cost.

How your patients can learn more
To learn more, encourage members to visit our Aetna portal secure member website.

Aetna Specialty Pharmacy

Aetna Specialty Pharmacy is Aetna's "affiliated" specialty medication pharmacy. It provides specialty medications including injectable, infused and select oral therapies.

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

Aetna Specialty Pharmacy's team helps patients manage their therapy
Specialty medications usually carry a risk for side effects, and a risk that members may have trouble complying with their prescribed therapy schedule. For these reasons, the use of specialty medications must be consistently monitored.

With Aetna Specialty Pharmacy, your patients get a personal care plan and ongoing support:

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

Aetna Specialty Pharmacy offers other helpful services, including:

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

Flexible payment options for out-of-pocket costs, when necessary
- Free injection supplies, such as needles, syringes, alcohol swabs, adhesive bandages and Sharps containers for needle waste, if needed

Aetna Specialty Pharmacy dispenses specialty medications to treat many complex diseases
Many of these medications are available only through limited distribution networks. Aetna Specialty Pharmacy also works hard to monitor the FDA's pipeline to get access to new specialty therapies as they come to market. If Aetna Specialty Pharmacy gets a prescription order for one of the few therapies they don't have access to, we respond without delay. An Aetna Specialty

Pharmacy representative will forward the prescription to the appropriate contracted specialty pharmacy, along with a letter.

Ordering through Aetna Specialty Pharmacy is easy

- Print and complete a Medication Request Form.
- Fax it to 1-866-FAX-ASRX (1-866-329-2779).
- Or mail it to:

  Aetna Specialty Pharmacy, 503 Sunport Lane, Orlando, FL 32809.

Electronic prescribing

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

- Reduce paperwork and result in faster, more accurate information
- Simplify the prescribing process for physicians and patients
- Lessen the number of phone calls that physicians get from pharmacies trying to understand their handwriting
- Reduce medication errors resulting from unreadable, handwritten prescriptions

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

Opioid Overdose Risk Screening Program

In effort to address the rising opioid epidemic, we have implemented a screening program to identify members at risk for opioid overdose. Our clinicians screen behavioral health members to identify patients who can benefit from this program. Any patient receiving a diagnosis of opioid dependence is considered to be at risk.

We recommend that practitioners and members consider naloxone, a rescue medication that reverses the effects of an opioid overdose, as part of the patient's ongoing treatment plan when opioid dependence is diagnosed. Countering the effects of overdose in the event of a relapse allows the patient to continue the recovery process. Research has shown that the availability of naloxone does not inhibit recovery by providing a "safety net" for ongoing use. Information provided to patients and their family/ support network about the signs of overdose, and how to administer naloxone as a rescue medication are other elements which support this potentially life-saving intervention. Coverage of naloxone is available under the Aetna Better Health of Ohio Dual Preferred formulary.

Precertification, step therapy and quantity limits

Precertification

Our formulary includes medications that require precertification. . These drugs require extra coverage review before they are covered.

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

Visit our website to determine which medications may require precertification. If you have questions, call us at 1-800-260-3166.

Step therapy

Our formulary includes medications that require step therapy. With step therapy, certain drugs are not covered unless members try one or more preferred alternatives first. Step therapy is based on current medical findings, FDA-approved manufacturer labeling information, FDA guidelines and cost and manufacturer rebate arrangements.

If it's medically necessary, a member can get coverage of a step-therapy drug without trying a preferred alternative first. In this case, a physician, patient or a person appointed to manage the patient's care must request coverage for a step-therapy drug as an exception. The drugs requiring step therapy are subject

to change.

You'll find current step-therapy requirements on our website. If you have questions, call us at 1-800-260-3166.

Quantity limits
We also limit coverage on the quantity of certain drugs.

Quantity limits are established using medical guidelines and FDA-approved recommendations from drug manufacturers. The quantity limits include:

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

You, your patient or the person appointed to manage the patient's care may request a medical exception for coverage of amounts over the allowed quantity. Contact our Pharmacy Precertification Unit.

Generic drugs

- Under Aetna' Medicare Dual Core (HMO SNP) generic drugs are generally covered.
- To control health care costs and help your patients save money, consider prescribing generic drugs when appropriate.

Medical exception and precertification

To ask for a pharmacy exception Precertification, step therapy or exception to quantity limit, physicians, patients or a person appointed to manage the patient's care can contact the Pharmacy Precertification Unit by:

Phone	Fax
1-800-260-3166	1-844-807-8452

Policies

Appeals & Disputes

Aetna has developed a formal appeals and disputes policy* for physicians, health care professionals and facilities. The appeal process should be used for claim reconsiderations for non-participating providers. The dispute process should be used for claim reconsiderations for participating providers. Please ensure you are using the correct process based on your status of either participating or non-participating:

Non-Participating Provider: Claim Appeal process

Physician, health care professional and facility appeals for non-participating providers involve payment decisions (claims) but don't include dissatisfaction with pre-service or concurrent medical necessity decisions, which are handled through the member appeal process.

Physician/health care professional post-service appeals are classified as payment appeals and are not considered "on behalf of the member."

Providers who are non-participating with the Aetna Better Health of Ohio Dual Preferred (HMO SNP) and wish to have a claim reconsidered will be required to follow our Appeal process. Please follow the instructions on our Non-Par Provider Appeal Form. Non-Participating providers will also be required to fill out and submit a Waiver of Liability Statement. Both forms can be found on our website under 'For Providers', then 'Forms & Resources.'

Participating Provider: Claim Dispute process

Physician, health care professional and facility disputes for participating providers involve payment decisions (claims) but don't include dissatisfaction with pre-service or concurrent medical necessity decisions, which are handled through the member appeal process.

Physician/health care professional post-service disputes are classified as payment disputes and are not considered "on behalf of the member".

Providers who are participating with Aetna Better Health of Ohio Dual Preferred (HMO-SNP) and wish to have their claim reconsidered will be required to follow our Dispute process. Please follow the instructions on our Par Provider Dispute Form. This form can be found on our website under 'For Providers, then 'Forms& Resources'.

View more information on our website.

Medical Clinical Policy Bulletins

Contact our Precertification department at 855-870-8009 for information related to our internally developed policies that we use as a guide for determining health care coverage for our members. Our CPBs are written on selected clinical issues, especially addressing new medical technologies (devices, drugs, procedures and techniques). The CPBs are used as a tool to be interpreted in conjunction with the member's specific benefits plan and after consultation with the treating physician. Our benefits plans generally exclude from coverage medical technologies that are considered experimental and investigational, cosmetic and/or not medically necessary.

CPBs are continually reviewed and updated to reflect current information.

Because technology advances over time, we review new medical technologies and new applications of established technologies regularly to determine whether and how such technologies will be considered medically necessary and/or not experimental/ investigational under our benefits plans.

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

We consider the position statements and clinical practice guidelines of medical associations and government agencies, including the Agency for Healthcare Research and Quality (AHRQ). When applicable, we consider the regulatory status of a drug or device, including review by the U.S. Food and Drug Administration (FDA) and Centers for Medicare & Medicaid Services (CMS) coverage policies.

We develop our CPBs from a review of relevant

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

information regarding a particular technology. CPBs are published on our website for public reference.

Medical emergencies

If patients require emergency care, they're covered 24 hours a day, 7 days a week, anywhere in the world. In the event of a medical emergency, the patient should follow the guidelines below when accessing emergency care, regardless of whether the patient is in or out of one of Aetna's service areas.

- Call the local emergency hotline (e.g., 911) or go to the nearest emergency facility. If a delay would not be detrimental to the patient's health, call the primary care physician.
- After assessing and stabilizing the patient's condition, the emergency facility should contact the primary care physician so he or she can assist the treating physician by supplying information about the patient's medical history.
- If the patient is admitted to an inpatient facility, the patient, a family member or friend acting on behalf of the patient should notify the primary care physician or Aetna as soon as possible.
- All follow-up care should be coordinated by the primary care physician, where applicable (medical only).

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

Note: *State mandates may apply*.

Members traveling outside their service area or students who are away at school are covered for emergency and urgently needed care. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility.

Certain conditions, such as severe vomiting, earaches, sore throats or fever, are considered "urgent care" outside the Aetna service area and are covered in any of the above settings. Preventive care services and other routine treatment for conditions such as minor colds and flu are not covered outside the Aetna service area.

When claims submitted to us by the physician or health care professional who supplied care do not appear to meet the standards for emergency or urgent care, it may be necessary for us to review the records from the emergency visit. In this situation we will send a request to the treating facility for the records of the visit and notify the member of the request. If the member wishes, he or she may provide a Member Services representative with additional information by telephone or through correspondence regarding the circumstances of the visit.

Follow-up care after emergencies

Again, the primary care physician should coordinate all follow-up care. In all cases, the primary care physician must record all pertinent information regarding the emergency visit in the patient's chart.

Precertification is required before any out-of-network follow-up care, either inside or outside the Aetna service area, can be covered. You can obtain precertification electronically or by calling the toll-free number on your patient's member ID card.

Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.

Note: *State regulations and contractual provisions regarding emergency admissions may, in some circumstances, supersede the procedures described above.*

Assignment of benefits/obligation to submit claims

Provider represents that, where necessary, it has obtained signed assignments of benefits authorizing payment for provider services to be made directly to provider and/or group providers.

Referral policies

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

Submit an inquiry by calling the number on your patient's member ID card to confirm covered benefits.

If your patient visits a specialist without a referral, depending on his or her plan type, the patient may be responsible for payment for all services rendered or for paying a deductible and coinsurance. The patient should not return to the primary care physician to request a referral after the service is rendered; primary care physicians should not issue retroactive referrals.

In Aetna products that do not require the issuance of a referral, a patient may self-refer to either participating or nonparticipating physicians/health care professionals. The patient is responsible for paying any applicable copayment, deductible and/or coinsurance for self-referred benefits. See the Patient Management and Acute Care section for rules regarding preauthorization for certain services.

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

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

Requirements for utilization of non participating providers

Aetna Better Health of Ohio Dual Preferred (HMO-SNP) allows for benefits for services from providers who are not participating — if provider admits or arranges for admission to a non-participating provider (including, but not limited, to surgery centers), or refers a member to a non-participating provider, provider will document the member's written consent, and that the member has been provided with notice of the following information:

1. the hospital, facility, or provider is not a participating provider; and

2. the member's plan may, therefore, provide reduced benefits; and

3. the non-participating provider will not be restricted to seeking payment only from Company; and

4. the non-participating provider may bill the member for amounts other than deductibles, co-payments, coinsurance, and medical services not covered under the member's plan; and

5. Provider's affiliation or financial ownership interest in or with the non-participating provider, if any.

A copy of the member's written consent and the notice outlined above will be kept in the patient's file. Company will make available a form which may be used for such purpose.

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

- If the specialist wishes to provide additional services not originally requested on the referral
- If the specialist refers his or her patient to a second specialist
- If the specialty visits will exceed the number of visits initially authorized by the primary care physician
- If the specialty visits require an extension beyond the Referral Thru Date

Our standard Participating Specialist Physician Agreement requires that specialists communicate with the referring physician in a timely fashion. After receiving the consultation report from the specialist, the primary care physician can consider the appropriate course of treatment (e.g., referrals for additional services and/or follow-up care, if needed).

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

Member billing

Provider may bill or charge members only in the following situations:

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

a) applicable copayments, coinsurance and/or deductibles not collected at the time that covered services are rendered;

b) except as prohibited by law or governmental directive, if a Payer that is not a company affiliate (e.g., a self-funded plan sponsor) becomes insolvent or otherwise fails to pay provider according to applicable federal law or regulation (e.g., ERISA), provided that provider has first exhausted all reasonable efforts to obtain payment from the Payer; and

c) services that are not covered services only if:

- (i) the member's plan confirms that the specific services are not covered;
- (ii) the member was advised in writing prior to the services being rendered that the specific services may not be covered services; and
- (iii) the member agreed in writing to pay for the services after being advised

Provider agrees that it will bill or charge members at the contracted rates set forth in your agreement when provider services would be covered services but for the member's exhaustion of applicable plan benefits. Unless confirmed otherwise in writing by the plan. Provider acknowledges that denial or adjustment of payment to provider based on performance of utilization management or otherwise is not a denial of covered services under your agreement or under the terms of a plan. Provider may bill or charge individuals who were not members at the time that services were rendered.

Claims payment policy — rebundling

Provider agrees to permit rebundling to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure. And, to allow other adjustments for inappropriate billing or coding (e.g., duplicative procedures or claim submissions, mutually exclusive procedures, gender/ procedure mismatches, age/ procedure mismatches). In performing rebundling and making adjustments for inappropriate billing or coding, the plan may utilize one or more commercial software packages (as modified by the plan in the ordinary course of the plan's business) which commercial software package(s) may rely upon Medicare and/or other industry standards in the development of rebundling logic.

Reporting encounter data

For the services for which provider is compensated on a capitated basis, if any, provider agrees to provide the plan with encounter data by type of provider Service rendered to members in the form and manner as specified by the plan. There will be no restrictions on the plan's use of such encounter data. Furthermore, the plan is under no obligation to return the encounter data to provider.

Women's health

Overview

We focus on the special needs of women through programs that promote their health and well-being. We're committed to educating your patients about the lifelong benefits of preventive health care. You can find patient-focused information in our Women's Health section.

These programs include:

Program	Contact Information
Nurse case management and education for women with breast cancer	1-800-260-3166
BRCA genetic testing program (genetic testing for breast and ovarian cancers)	1-800-260-3166

Female members** have direct access to participating obstetricians and gynecologists for routine and preventive care (breast exams, mammograms and Pap tests). These doctors can authorize referrals (if applicable) for related specialty care. You can find specific policy information in the Women's Health

**Infertility benefits may vary depending on plan type and state law. You can check benefits by calling the toll-free number on the member's ID card.*

***Members whose PCP participates with us through an independent practice association (IPA), physician medical group (PMG) or physician hospital organization (PHO) may be required to use specialists within the IPA, PMG or PHO for their direct-access services.*

Programs and Policies Manual.

Radiology accreditation

To be eligible for reimbursement for the technical component of advanced diagnostic imaging procedures, the following types of providers must be accredited by the American College of Radiology (ACR), the Intersocietal Accreditation Commission (IAC), and The Joint Commission (TJC), and/or RadSite:

- Independent diagnostic testing facilities
- Freestanding imaging centers
- Office-based imaging facilities
- Physicians
- Non-physician practitioners
- Suppliers of advanced diagnostic imaging procedures

This accreditation requirement applies to the technical component of advanced diagnostic imaging procedures. For these purposes, advanced diagnostic imaging procedures exclude X-ray, ultrasound, fluoroscopy and mammography. Included are:

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Computed tomography (CT)
- Echocardiograms
- Nuclear medicine imaging, such as positron emission tomography (PET)
- Single photon emission computed tomography (SPECT)

Note the following: Providers not accredited by the ACR, IAC, TJC by January 1, 2012, and/or RadSite by September 2013, will not be eligible for payment for advanced diagnostic imaging services.

- This requirement will not apply to patients who are in the hospital or in hospital emergency departments.
- This policy will not apply to hospitals, unless they own one of the above listed providers.
- The accreditation process can take nine to twelve months.

Key term definitions

Clean claim

Unless otherwise required by law or regulation, a claim which:

a) is submitted within the proper timeframe as set forth in your agreement;

b) has:

- ◊ (i)detailed and descriptive medical and patient data;
- ◊ (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim; and
- ◊ (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-10 or its successor standard, HCPCS) as required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to member identification number, national provider identifier ("NPI"), date(s) of service, and complete and accurate breakdown of services);

c) does not involve coordination of benefits; and

d) has no defect or error (including any new procedures with no CPT code, experimental procedures or other circumstances not contemplated at the time of execution of your agreement) that prevents timely adjudication.

Confidential information

Any information that identifies a member and is related to the member's participation in a plan, the member's physical or mental health or condition, the provision of health care to the member or payment for the provision of health care to the member. Confidential information includes, without limitation, "individually identifiable health information," as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999, as amended from time to time.

Emergency services

Except as otherwise required by law or otherwise

defined in the applicable plan, the services necessary to treat 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:

a) placing the health of the individual or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus in serious jeopardy;

b) serious impairment to bodily functions; or

c) serious dysfunction of any bodily organ or part.

Medically necessary
Health care services that a physician exercising practical clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a) according to generally accepted standards of medical practice;

b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

c) not primarily for the convenience of the patient, physician or other health care provider, and not more costly than alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in (b) above.

Primary care provider
A participating provider whose area of practice and training is family practice, general medicine, internal medicine or pediatrics, or who is otherwise designated as a primary care provider by Company, and who has agreed to provide primary care services and to coordinate and manage all covered services for members who have selected or been assigned to such participating provider, if the applicable plan provides for a primary care provider. This term may also include a nurse practitioner and/or physician assistant practicing within the applicable scope of practice, provided such provider meets Company standards and Policies.

Information
All data and information obtained, created or collected by Provider related to Members and necessary for payment of claims, including without limitation confidential information.

Records
All books, records and other papers (including, but not limited to: medical and financial records, contracts and computer or other electronic systems) and information relating to this provider manual and/or the provider agreement and to those services rendered by Provider to Members.

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