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Innovation Health Office Manual

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innovation-health.com

We created this Health Care Professional Office Manual for our participating physicians and their office staff to:

- Help facilitate timely and accurate payment
- Help facilitate hassle-free patient care
- Provide you with meaningful information

This manual is a resource to assist you in doing business with us.

We developed the office manual with you in mind.

Through insightful feedback provided to us during physician and office management focus groups, you've told us what's important to you. As a result, the office manual provides you with easily accessible information that strives to help your office do business with us.

Office manual highlights:

Before you use the office manual, take a moment to review these important highlights for participating health care professionals and their office personnel:

- **Patient advocacy** – As advocates on behalf of your patients who are Innovation Health plan members, you should review and become familiar with the member rights and responsibilities outlined here.
- **Informed consent** – You are responsible for providing your patients with all information that is relevant to their conditions. This includes all health care alternatives, including potential risks and benefits, even if their plan does not cover a specific option.
- **Patient emergencies** – If your Innovation Health patients need emergency care, they are covered 24 hours per day, 7 days a week, anywhere in the world.
- **Providing information** – By providing Innovation Health with complete and accurate medical information and diagnoses, you help us to make appropriate coverage determinations.
- **Independent contractors** – As indicated in our physician agreements, participating health care professionals are not employees or agents of Innovation Health or any of our affiliates.
- **Advice on coverage** – Consult our clinical policy bulletins online at **www.innovation-health.com** if you are unsure whether a particular service or treatment is medically necessary, experimental or investigational under a patient's plan.
- **Appeals** – You may 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.

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.

Base medical product	PCP selection	PCP referral	Phone number
HMO	Required	Required	Refer to the member identification card
EPO	Required	Required	Refer to the member identification card
POS	Required	Required	Refer to the member identification card
POS II	Encouraged	Not required	Refer to the member identification card
Network Only	See ID card	See ID card	Refer to the member identification card
Network Option	See ID card	See ID card	Refer to the member identification card
PPO	Not required	Not required	Refer to the member identification card

Plan features:

- Open = Open Access
- Plus = N/A
- Option = Out of network benefits are available
- HF = Health Fund
- HSA = Health Savings Account

For example, the product name on the member's identification card is **HSA Open HMO Option**. The plan features can change the requirements of the base medical product. For this plan it means:

- There is a Health Savings Account (HSA)
- No referrals are required for in-network services (Open)
- Out-of-network benefits are available (Option)

Open is a feature of some plans that allows patients access to all in-network services without a referral. Depending on the plan, patients may receive a higher benefits level if they choose providers in the network. For behavioral health benefits, please reference the patient's member ID card or contact our provider service center.

Plus:

This is an internal plan description and does not impact the member benefits or plan features.

Option:

Out-of-network benefits are available for members with this plan feature.

Health Fund:

The Health Fund family of products blends an employer established health fund with a deductible-based benefits plan. This means it is comprised of a fund, a deductible and a base medical benefits plan. You can find the underlying product designation on member ID cards, or through electronic member eligibility verification. For more information on PCP selection and referral requirements, refer to the base health products listed.

Key information about Health Fund:

- Patients receive highest benefits level by accessing participating providers.
- Patients receive an allocated health fund from the employer to assist with payments, deductibles and coinsurance.
- If the health fund is depleted, the patient is responsible for any applicable deductibles and coinsurance.
- Health care providers should bill us directly for all services.
- Member responsibility is listed on the Explanation of Benefits (EOB).

HSA:

Our integrated HSA product is comprised of three elements:

- An account
- A deductible
- A base medical benefits plan

This plan differs from a Health Fund because members can determine when to spend their account dollars. They may choose to use them now to cover medical expenses, or save them for future use. You can find the underlying product designation on the member ID cards, or through electronic member eligibility verification. For more information on PCP selection and referral requirements, refer to the base health products listed.

Key information about HSA:

- Patients receive highest benefits level by accessing participating providers.
- Patients in a qualified high-deductible health plan as defined by the government may enroll in an HSA on their own or through their employer. Anyone can contribute to the HSA. Patients may choose to use the funds in their HSA to assist with payments, deductibles and coinsurance or they may choose to pay for these services out-of-pocket and save their HSA funds for future retiree medical expenses.
- Patients are responsible for any applicable deductibles and coinsurance and may use their HSA to help pay for these expenses.
- Health care providers should bill us directly for all services.
- Member responsibility is listed on the EOB.

NOTICE: The term precertification used here and throughout the Health Care Professional Office Manual, means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage.

Behavioral Health

Overview

Innovation Health will be utilizing Aetna's behavioral health program for its members. Please view the behavioral health page on the secure website at **http://connect.navinet.net**.

Here you will find:

- Aetna's comprehensive Behavioral Health Manual
- Archived issues of Behavioral Health Insights™, our newsletter for participating behavioral health professionals
- Aetna's behavioral health specialty programs overview
- Clinical practice guidelines
- Depression management information and much more

Electronic solutions for provider offices

Overview

Aetna Provider eSolutions℠

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.

Working with us directly — transactions overview

If you perform transactions through another vendor, (other than NaviNet), functionality may vary.

Eligibility and benefits inquiry:

Our eligibility and benefits inquiry transaction enables you to request patient eligibility status quickly and easily.

- Verify member eligibility and demographics
- Find detailed financial information, including deductible, copayment and coinsurance for individual and family levels
- View an image of member ID card

Payment estimator:

Our payment estimator transaction enables you to request estimates for patients on or prior to date of service.

- Learn Innovation Health's estimated payment amount
- Get reliable estimates of patient copayments, coinsurance and deductibles
- Access printable information to help you initiate financial discussions with patients prior to or at time of care
- Reduce and potentially eliminate after-the-fact financial surprises for you and your patients

Precertification add and inquiry:

Our precertification add and inquiry transactions are quick, easy ways to request or check the status of a precertification.

- Availability for all Innovation Health benefit plans 24 hours a day, Monday through Saturday.
- Minimal wait time for initial responses.
- Ability to determine if medical precertification is required via precertification code search tool.
- Precertification inquiry lets you confirm whether a valid precertification is present.
- Ability to check the status of previously submitted requests.

Electronic referral add and inquiry:

The electronic referral add and referral inquiry transactions are quick, easy ways to request or check the status of a referral via a secure electronic data interchange

- Request referral authorization
- Inquire about the status of a referral
- Use for any Innovation Health plans that require a referral

Claims submission:

You can submit professional claims for free and receive reimbursement faster as compared to submitting paper claims.

- Receive an automatic acknowledgement for all submitted claims
- Ability to submit coordination of benefits claims electronically

Claim status transactions:

Our claim status transactions allow you to check on the status of submitted claims.

- Use the claim status inquiry for single member inquiries.
- Use the claim status report to review multiple claims over a designated time period.
- Request financial status as a follow-up to both claim status inquiry and report to provide additional financial details.

Electronic Funds Transfer (EFT):

EFTs allow 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 be notified via e-mail when payments have been transmitted to your bank.

Online claim explanation of benefits (EOBs):

Through our **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 file or print EOBs.
- Receive notification when EOBs become available.
- EOB activity page allows multiple EOB 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.

NOTICE: The term precertification used here and throughout the Health Care Professional Office Manual, means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage.

Working through clearinghouse vendors – transactions by vendor

Aetna administers ERA/EFT enrollment function. To learn more about various electronic transactions, connectivity options, web-enabled products or to enroll in ERA/EFT, visit us at: **www.aetna.com/healthcare-professionals/claims-administration**

View a listing of our electronic vendors and the transactions they support at: **www.aetna.com/provider/vendor**

Key contacts

Department	Contact Info
Provider Services	**Please see member ID card**
Patient management/precertification	
All plans	**Please see member ID card**
Pharmacy management precertification	Pharmacy management precertification **1-800-414-2386** Fax: **1-800-408-2386** Specialty drug precertification online **www.navinet.net/provider-physician-solutions/drug-authorizations** **1-866-503-0857** Fax: **1-888-267-3277**
Aetna Specialty Pharmacy℠ for ordering self-injectable medications	**1-866-782-2779** **www.AetnaSpecialtyPharmacy.com**
Aetna Health Connections℠ (Medical management)	**1-866-269-4500**
Breast Cancer Case Management Program	**1-888-322-8742**
BRCA Genetic Testing Program (Genetic Testing for Breast and Ovarian Cancers)	**1-877-794-8720**
National Infertility Unit	**1-800-575-5999**
National Medical Excellence Program® (Transplants)	**1-877-212-8811**
Informed Health® Line	**1-800-556-1555**
Behavioral health	**1-800-999-5698**
Preferred lab	Visit our national, preferred lab, Quest Diagnostics®. It's easy for you and your patients to find a close location and make an appointment. You can even get testing reminders. Visit **www.questdiagnostics.com**. Or call **1-888-277-8772**. Looking for a list of labs in your area? Visit our DocFind® online provider directory at **www.innovation-health.com**.

Department	Contact Info
Enhanced clinical review **Your will need to preauthorize your patients for the following procedures:** ▸ Elective outpatient stress test with an echocardiogram ▸ Elective outpatient diagnostic catheterization of the heart ▸ Elective outpatient imaging and nuclear cardiology ▸ On-site sleep studies ▸ Elective pacemaker implants	Do you need to preauthorize a test or service? Call, e-mail or visit MedSolutions at: **www.medsolutionsonline.com** **Phone: 1-888-693-3211** **Fax: 1-888-693-3210**
Non-participating provider and special services requests.	
Paper claims address:	Innovation Health PO Box 981106 El Paso, TX 79998-1106
How to submit a dispute:	
Write to the PO Box listed on the EOB and the denial letter related to the issue being disputed. Please include the reasons for the disagreement.	Refer to member ID card or visit **www.innovation-health.com** and click on the "Physicians & Providers" tab
Innovation Health electronic payer ID number	40025

Website	Link
Innovation Health	**www.innovation-health.com**
Innovation Health secure provider website	**http://connect.navinet.net**
Aetna InteliHealth®	**www.intelihealth.com**
DocFind® for physicians (Find a Doctor)	**www.innovation-health.com**
Formulary search engine	**www.innovation-health.com/physicians-and-providers/**
Aetna Compassionate Care℠	**www.aetnacompassionatecare.com/EOL/**
Council for Affordable Quality Healthcare (CAQH)	**http://caqh.org/**

Member programs and resources

Compassionate Care

The goal of the our 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, visit **www.AetnaCompassionateCare.com**.

Aetna Health Connections℠ (medical management)

Aetna Health Connections is the name of our medical management philosophy that features a suite of programs designed to help our members achieve their optimal health. Within the portfolio of programs are the following programs:

- Disease management program
- Enhanced case management program
- National Medical Excellence program
- Integrated clinical programs for behavioral health, disability and pharmacy
- An expanding suite of wellness programs

You can get more information online.

Aetna Health Connections (disease management program)

Our disease management program is designed to help your patients work with their doctors to effectively manage ongoing health conditions and improve outcomes. The program supports more than 35 diseases and conditions.

Participants have access to 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 a nurse, who acts as their personal health coach.
- Personalized information about their current health conditions and issues.
- Educational information about multiple aspects of their medical conditions, treatment options and medications.
- Support in making lifestyle changes to achieve and maintain optimal health.

Our disease management program is included in many Innovation Health medical plans. It is also available to self-funded plan sponsors who can include it in their benefits offering. For additional information or to refer your patients call the Member Services telephone number on the member's ID card.

Informed Health® Line

Informed Health Line puts members in touch with registered nurses 24 hours a day, 7 days a week. The nurses can provide information on:

- Health issues
- Medical procedures
- Treatment options

The nurses may also offer members suggestions for communicating more effectively with their doctors as needed.

When members call, nurses can provide them with a video link to help promote further education and support of 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 2–3 minutes long. This video library replaces the audio library that we used in the past. Research shows that well-designed videos are more effective in delivering instructions.

Our video library is from the Healthwise® award-winning production, animation and user experience team. Each one 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 (IHL) nurse.
2. The nurse e-mails the member a link to the video library.
3. Members can visit the link and watch the video as often as they want.

There is no limit to the number of times member may access the video. There is also no limit to the number of video links a member may receive from the IHL nurse. There is no charge for access to the videos.

The video library helps to:

- Provide further education and 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
- Connect members to information in an easy way

Institutes of Excellence™

Institutes of Excellence (IOE) is our network of participating facilities for the following services:

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

Institutes of Quality®

Institutes of Quality (IOQ) facilities — IOQ is a designation facilities can achieve for certain clinical services, for example, bariatric surgery, selected orthopedic and cardiac procedures. We base this designation on our evaluation of their processes and outcomes, for example, mortality rates and readmission rates, for these procedures.

Member rights and responsibilities

Advance directives/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 him or her 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 patient should complete the Advance Directive Notification form. Each patient should return this form to his or her primary care physician (PCP) for his or her medical file.

We encourage you to discuss advance directives with your patients.

Note: The Patient Self Determination Act impacts all our members over the age of 18.

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
- Source of payment

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

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
- Reasonable accommodations for patients and employees with disabilities

Informed consent

All participating physicians and other health care professionals should:

- Understand and comply with applicable legal requirements regarding patient informed consent
- Adhere to the policies of the medical community in which they practice and 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.

Rights and responsibilities commercial plan members

The following sections detail the rights and responsibilities information we provide to our members.

As a member, you have a right to the following:

Information:

- Know the names and qualifications of health care professionals involved in your medical treatment.
- Get up-to-date information about the services covered or not covered by your plan and any limitations or exclusions.
- Know how your plan decides what services are covered.
- Get information about copayments and fees that you must pay.
- Get up-to-date information about the health care professionals, hospitals and other providers that participate in the plan.
- Find out how to file a complaint or appeal with the plan.
- Learn how the plan pays network health care professionals for providing services to you.
- Receive information from health care professionals about your medications, including what the medications are, how to take them and possible side effects.
- Receive from health care professionals as much information about any proposed treatment or procedure as you may need in order to consent to or refuse a course of treatment. Except in an emergency, this information should include:
  - A description of the proposed procedure or treatment.
  - The potential risks and benefits involved.
  - Any alternate course of treatment (even if not covered) or non-treatment and the risks involved in each.
  - The name of the health care professional who will carry out the procedure or treatment.
- Participating health care providers will inform you about continuing health care requirements after your discharge from inpatient or outpatient facilities.
- Be informed if a health care professional plans to use an experimental treatment or procedure in your

care. You have the right to refuse to participate in research projects.

- Receive an explanation about non-covered services.
- Receive a prompt reply when you ask the plan questions or request information.
- Receive a copy of the plan's member rights and responsibilities statement.

Access to care

- Obtain primary and preventive care from the primary care physician you chose from the plan's network.
- Change your PCP to another available PCP who participates in the plan.
- Get necessary care from participating network specialists, hospitals and other health care providers.
- Be referred to participating network specialists who are experienced in treating your chronic illness.
- Be told by your health care professionals how to schedule appointments and get health care during and after office hours. This includes continuity of care.
- Be told how to get in touch with your PCP or a back-up physician 24 hours a day, every day.
- Call 911 (or any available emergency response service) or go to the nearest emergency facility when you have a medical condition with symptoms that are severe enough that a person who has average knowledge of health and medicine could reasonably expect the lack of immediate medical attention to result in serious danger to the person's health.
- Receive urgently needed medically necessary care.

The freedom to make decisions

- Use these rights regardless of your:
  - Race
  - Physical or mental disability
  - Ethnicity
  - Gender
  - Sexual orientation
  - Creed
  - Age
  - Religion
  - National origin
  - Cultural or educational background
  - Economic or health status
  - English proficiency
  - Reading skills
  - Genetic information
  - Source of payment for your care
- Have any person who has legal responsibility to make medical care decisions for you make use of these rights on your behalf.
- Refuse treatment or leave a medical facility, even against the advice of doctors (providing you accept responsibility and the consequences of the decision).
- Complete an advance directive, living will or other directive and give it to your health care professionals.
- There is no penalty to you or your health care professional for filing a complaint or appeal.

Personal rights

- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when permitted by law or with your approval.
- Be involved in deciding on the kind of care you do or do not want.

Input

- Have your health care professional's help when you have to make decisions about the need for services and if you are involved in the complaint process.
- Suggest changes in the plan's policies and services, including our member rights and responsibilities policy.

As a member, you have a responsibility to:

Exercise your rights

- Choose a primary care physician from the plan's network and form an ongoing patient-physician relationship.
- Help your health care professional make decisions about your health care.

Follow instructions

- Read and understand your plan and benefits.
- Know your copayments and what services are covered and what services are not covered.
- Follow the directions and advice you and your health care professionals have agreed upon.
- See the specialists your primary care physician refers you to.
- Make sure you have the correct authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Show your member ID card to health care professionals before getting care from them.
- Pay the copayments required by your plan.
- Promptly follow your plan's complaint procedures if you believe you need to submit a complaint.
- Treat doctors and all providers, their staff and the staff of the plan with respect.
- Not be involved in dishonest activity directed to the plan or any health care provider.

Member rights and responsibilities (continued)

Communicate

- Tell your health care professionals if you do not understand the treatment you receive and to ask if you do not understand how to care for your illness.
- Tell your health care professional promptly when you have unexpected problems or symptoms.
- Consult with your primary care physician for referrals to non-emergency covered specialist or hospital care.
- Understand that network doctors and other health care professionals who care for you are not employees of Innovation Health and that we do not control them.
- Call our Member Services department about your plan if you do not understand how to use your benefits.
- Give correct and complete information to doctors and other health care professionals who care for you.
- Tell us about other medical insurance coverage you or your family members may have.
- Ask your treating doctor about all treatment options, and how the doctor is paid by us.

You may have additional rights and responsibilities depending upon any state law applicable to your plan.

Physician-member communications policy

Our contracts for participating providers do not contain gag clauses. Nothing about the contract should be interpreted as preventing the physician or other health care professional from discussing issues openly with his or her patients.* In 1996, we began including language in our contracts to promote open physician-patient communication.

At that time, physicians and other health care professionals were informed of our policy. Our policy is designed to give our members the comfort of knowing their physicians and other health care professionals have the right and the obligation to speak freely with them.

Our contracts contain positive communication language. They read that physician shall have the right and is encouraged to discuss with his or her patients pertinent details regarding the diagnosis of the patient's conditions, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment and any reasonable alternatives to such recommended treatment.

If you have questions regarding this issue, contact your local Innovation Health office.

We recently revised our physician contracts making them easier to understand. The new contracts are being filed with the applicable regulatory agencies and implemented across the country. These contracts also contain other new language, including notice requirements on the part of Innovation Health and Prudent Layperson.

Privacy practices

Protecting our members' health information is one of our 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 your care or treatment, the operation of our health plans or other related activities, we use personal information internally and share it with our affiliates and disclose it to health care professionals like:

- Doctors
- Dentists
- Pharmacies
- Hospitals
- Other caregivers

Payers like:

- Health care provider organizations
- Employers who sponsor self-funded health plans
- Those who share responsibility for the payment of benefits
- Others who may be financially responsible for payment for the services or benefits you receive under your 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 you access to your medical records within a reasonable amount of time after you make a request.

*To the extent any older agreements may still include any such clauses; we are not enforcing these provisions.

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
- 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
- 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 that describes in more detail our practices concerning use and disclosure of personal information, call the toll-free Member Services number on the member's ID card.

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 experiment 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
2. Obtain member's prior consent in writing to pay for the specified services

Office management

Participating practitioner medical record criteria

Organization:

A. Each page has the member's name or ID number on it:
   - The member's name or ID number should be recorded on each page of the medical record. For example on all notes, lab reports and consult reports) (1 point)

B. The member's personal data of gender, date of birth, address, occupation, home and work phone numbers and marital status is documented.
   - Each record must contain appropriate biographical and 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)
   - (Prenatal only) – A centralized medical record for the provision of prenatal care and all other services must be maintained (1 point)

*C. All entries in the record contain the author's signature, 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, for example, MD, DO and DPM. Examples of acceptable physician signatures are:
     - Handwritten signature or initials
     - Electronic signature with authentication by the respective provider
     - 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)

*D. All entries are dated. (1 point)

*E. 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)

*F. Medications including dosages and 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)

*G. 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)

*H. 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 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-9 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)

*I. Past medical history is completed (for members seen three or more times) and is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to 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 documented (1 point)

*J. History and physical (H&P) documents have subjective and objective information for the 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)

*Indicates items assessed for Medical Record Keeping Practices based on National Committee for Quality Assurance (NCQA), CMS, regulatory and our guidelines.

K. 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, ask about substance abuse history).
   - For members 14 years and older, a score of 1 requires a response to an inquiry concerning alcohol, smoking or substance abuse history as part of risk screening. This is in support of preventative health. For members under the age of 14 years, the score will be N/A (1 point)

L. 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)

M. An immunization record has been initiated for children and history for adults.
   - An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults). Member reported data is acceptable (1 point)

*N. Preventive screenings and services offered according to our guidelines.
   - There is evidence that preventive screenings and services are offered in accordance with the organization's practice guidelines. Preventive screenings specific to member's age, gender or illness. For example, mammography, immunizations, HA1C and LDL are documented (1 point)

*O. 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)

*P. Treatment plan is documented.
   - There is documentation of clinical findings and evaluation for each visit (1 point):
     - Presenting complaints
     - Diagnosis
     - Treatment plan
     - Prescription
     - Referral authorization
     - Studies
     - Instructions

*Q. 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)

*R. No evidence that the 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:

S. Blood pressure, weight, weight BMI percentile and height are measured and recorded at least annually (1 point)

Studies:

T. Lab and other studies are ordered are 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 like lab tests or X-rays should be documented. (1 point)

U. Evidence that the physician has reviewed labs, X-rays or biopsy results (signed or initialed reports) and member has been notified of results before filing record.
   - There is evidence that the physician reviewed lab tests, X-rays, 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:

*V. Documentation of communications contact with referred specialist.
   - The PCP or managing practitioner coordinates and manages the care of the member. If a consultation or referral is made to a specialist, there is documentation of communication between the specialist and the PCP. This must include notation that the physician has seen it. There must also be 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)

*W. Documentation indicating the patient's preferred language (CA only).

*X. Documentation of offer of a qualified interpreter and the enrollee's refusal, if interpretation services are declined (CA only).

*Indicates items assessed for Medical Record Keeping Practices based on National Committee for Quality Assurance (NCQA), CMS, regulatory and our guidelines.

Office management (continued)

Innovation Health's benefits plans

Innovation Health benefit products booklet

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

- How to interpret our member ID cards
- PCP selection and referral requirements
- Precertification instructions
- Laboratory and radiology services

You can access the Innovation Health benefit products booklet on **www.innovation-health.com**.

NOTICE: The term precertification used here and throughout the Health Care Professional Office Manual, means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage.

Coordination of benefits

Coordination of benefits (COB) is a plan provision that establishes a uniform order of benefit 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.

There are two primary ways to calculate benefits*:

- **100% 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:
    1. What it would have paid had it been primary, or
    2. What it would have paid less the primary plan's payment

Note: 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.

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

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

Primary plan contract with physician:	Innovation Health contract with physician:
$1,500.00 billed charges **$1,000.00 primary plan's negotiated fee** **x 80% coinsurance rate** **$ 800.00 primary plan's payment**	$1,500.00 billed charges $1,200.00 Innovation Health 's negotiated fee x80% coinsurance rate $960.00 Innovation Health's normal benefit -800.00 primary plan's payment $160.00 Innovation Health's payment.

*State mandates may apply.

Birthday rule:

We follow 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. For example, the plan of the father is primary. And 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. We will contact the other carrier to discuss an agreed payment arrangement

Motor vehicle accident (MVA):

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 Innovation Health. If automobile insurance is not available to the patient and our policies, procedures and programs were followed, we 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 us over their automobile insurance company, we will require proof that the insured has elected us as primary insurer at the time the accident occurred. All procedures must be covered services and referred by the patient's PCP, excluding emergency procedures. All our policies, procedures and programs must be followed for benefits consideration.

Patients who have an MVA and whose Innovation Health coverage is secondary to PIP should still have all care coordinated through the PCP, if applicable. The PCP should issue referrals to participating physicians and health care professionals and place the information in the patient's file.

ICD-10 and 5010

The 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 the Health Insurance Portability and Accountability Act (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 take effect on October 1, 2015

For more information on ICD-10 and our conversion status, visit: **www.innovation-health.com** and click on the Physicians & Providers tab. The information is located in the "Practice Resources" section under "Physicians & Providers Tools."

Office management (continued)

Medical record documentation — standards and criteria

In accordance with their contract with us and applicable laws and regulations, participating physicians and other health care professionals are required to treat personal health information (PHI) as confidential.

PHI includes:

- Identity of the individual
- The relationship of the individual with us
- Physical or behavioral health status or condition
- Payment information for the provision of health care

We have established medical record criteria to provide a guideline for fundamental elements of:

- Organization
- Documentation of diagnostic procedures and treatment
- Communication
- Storage of medical records

These criteria are applicable to all benefits plans. We establish performance goals to assess the quality of medical record-keeping practices and conduct audits no less than every two years. Our performance goal is 85 percent compliance.

In their provider agreements with us, participating physicians and other health care professionals agree to maintain medical records in a manner that is:

- Current, detailed, organized and comprehensive
- 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.

We have the right to access confidential medical records of our members for the purposes of:

- Claims payment
- Assessing quality of care, including medical evaluations and audits
- Performing utilization management functions

Medical records may be requested as a part of our participation in HEDIS. HIPAA privacy regulations allow for sharing of personal health information (PHI) for purposes of making decisions around treatment, payment or health plan operations.

Member identification and verification of eligibility

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

Member ID cards:

- 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
- Members can access and print some of the information that appears on their ID card via the Instant Eligibility feature on their Plan Benefits Navigator℠ member website powered by Aetna Navigator®, including:
  - Member ID number
  - Member name
  - Group number
  - Member Services telephone numbers
  - Claims address

Note: A paper version of the member's information can be accepted in lieu of an actual member ID card.

Group enrollment form

- Members may present a copy of a group enrollment form to your office. This 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 Innovation Health primary care office number is designated. If the incorrect doctor or office is listed the 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.

Newborn enrollment

This policy applies to most plans, excluding Medicare Advantage plans. Contact Member Services for additional information on newborn enrollment. Members are instructed to contact their Human Resources department to find out their employer's rule for the time frame to enroll a newborn.

Members are required to list the selected primary care office for the newborn on the newborn's enrollment form.

Note: Federal Employees Health Benefits Program (FEHBP) members under FEHBP guidelines do not need to complete an enrollment form if they are currently enrolled for family' coverage. FEHBP members should call Member Services to add additional members to a family contract.

It may take several weeks to process the newborn's member ID card once the newborn is enrolled. In the interim, use the mother's or father's member ID card when administering care to the newborn. If the newborn does not receive his/her own member ID card after the appropriate time frame, either your office or the subscriber should check with the appropriate Member Services number on the subscriber's ID card. If the subscriber does not enroll the child as a dependent within the appropriate time frame, the subscriber must wait until his or her next open enrollment period to enroll the child and the child will not be eligible for coverage in the interim.

For primary care physicians (PCPs) – If your office provided routine newborn hospital care, submit your bill electronically or on a CMS-1500 form to us. If a referral is necessary for a newborn not yet appearing on the primary office member list, use the mother's or father's member ID number.

Physician accessibility standards

Primary care physicians (PCPs):

Our established standards for member access to primary care services are included in the participation criteria that are a part of each participating physician contract. Each primary care practitioner is required to have appointment availability within the following time frames:

- Routine care: within 7 days†
- Routine preventive care: within 8 weeks†
- Symptomatic care/non-urgent acute complaint, for example, a sore throat: within 3 days
- Urgent complaint: same day or within 24 hours

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

- For the states of California, Texas and North Carolina the above standards also apply to specialists

Specialists:

Please refer to your contract for access standards specific to your state and specialty.

†Note: State mandates take precedence over our standards.

Physician-requested member transfer

Circumstances may necessitate a participating physician to ask their patient to leave his or her practice when persistent problems prevent an effective physician-patient relationship. Such requests cannot be based solely on:

- The filing of a grievance
- The filing of an appeal
- A request for external review or other action by the patient related to coverage
- High utilization of resources by the patient
- 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 reasons for the termination. A copy of this letter must also be sent to your local network manager. For the mailing address, call your local Innovation Health office or refer to the number on the member's ID card. The physician's letter to the member should be sent by certified mail.
- In the case of a primary care physician, we will send the a letter to the member providing information that he or she must select a new PCP. We will also provide instructions on how to select another PCP.
- 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 and within thirty (30) days of the initial request by the physician, the physician shall both:

- Provide resources or recommendations to the patient to help him or her locate another participating physician.
- Offer to transfer records to the new physician upon receipt of a signed patient authorization.

Provider identification numbers

To comply with the HIPAA regulations, providers who are required to have a National Provider Identifier (NPI) should include their NPIs on HIPAA standard transactions.

The HIPAA standard transactions initiated by medical providers are:

- Claims
- Encounter
- Eligibility and benefit inquiry
- Claim status inquiry
- Precertification add
- Referral add

In addition to an NPI, claims must also include the billing provider's tax ID number.

Share your NPI now

If you are a provider who is required to have an NPI, make sure you share your NPI with us. Visit our secure website and select:

1. NPI Resources
2. Share your NPI

In addition, share your NPI with other providers who may need it to conduct electronic claims, referrals or precertification requests.

Innovation Health Provider Identification Number (PIN):

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

Note: Your Innovation Health PIN will be the same as your Aetna PIN.

The NPI should be used in electronic transactions for purposes of identifying yourself as a provider. You can use your PIN or tax identification number or TIN to identify yourself when contacting us by other means.

NOTICE: The term precertification used here means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage.

Primary care physician (PCP) office panel status changes

Follow this procedure to change the enrollment status of a primary care office.

- Send a letter to your local Innovation Health office notifying us of your request. For the mailing address, call your local Innovation Health office or refer to the number on the member's ID card.
- Indicate the status you are requesting for your office:
  - **Open:** Your office is open and accepting all Innovation Health patients.
  - **Accepting current patients only:** Your office is not accepting any new Innovation Health members unless the member is currently a patient in your practice.
  - **Frozen:** Your office is not accepting any new Innovation Health members as patients even if the patient is currently a patient in your practice under another type of coverage.

We require 90-day advance written notice of a change in the enrollment status of an office.

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 re-assess 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?

Simply call the credentialing customer service department at **1-800-353-1232.**

Adding a new provider to your group?

To start the application process, visit **www.innovation-health.com** and click on the "Physicians & Providers" tab.

OrthoNet Prepay Audit Program

We use OrthoNet to review our members' medical records before their claims are processed. When a claim is selected for review, we'll ask the provider for copies of the patient's medical records. OrthoNet will compare the claim coding to the services provided.

Affected specialties:

- Orthopedic surgery
- Neurosurgery
- Hand surgery
- Podiatry
- Plastic surgery
- ENT
- Neurology
- Physiatry
- Sports medicine
- Pain management
- Dermatology
- Urology

Where to send Aetna records

If your office is asked to send records to Aetna you can:

- Fax to **1-859-455-8650** (Aetna central fax)
- Mail to Aetna, PO Box 14079, Lexington, KY 40512-4079

When faxing or mailing records, be sure to include a coversheet with "**CODE: ONET**" at the top of the page. We'll also need the following information:

- Aetna member ID
- Date of service
- Servicing provider name

Servicing provider Tax ID number and/or Aetna provider ID #

†State variations may exist.

Patient management and acute care

Overview

Our patient management and acute care model integrates available programs and services across the member's health continuum. This includes:

- Case management
- Disease management
- Other 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 targeted for patient management activity with:

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

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.
- Providers may contact patient management staff during normal business hours of 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 will 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 are located on **www.innovation-health.com**.

Select:

1. Physicians & Providers, then
2. Precertification Search Tool

These policies include:

- Precertification
- Concurrent Review
- Discharge planning
- Retrospective Review

How we determine coverage:

Our medical directors make all coverage denial decisions that involve clinical issues. Denial decisions for reasons related to medical necessity are made only by our licensed:

- Medical directors
- Dentists (oral and maxillofacial surgeons)
- Psychiatrists/psychologists
- Pharmacists

Licensed dentists, pharmacists and psychologists review coverage requests as permitted by state regulations. Where state law mandates, utilization review coverage denials are made 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
- Retrospective review

*For these purposes, coverage means either the determination of:

(i) whether or not the particular service or treatment is a covered benefit pursuant to the terms of the particular member's benefits plan.

(ii) where a provider is required to comply with our utilization management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement.

**All continental US time zones. Hours of operation may differ based on state regulations.

Staff use the following criteria as guides in making coverage determinations that are based on information about the specific member's clinical condition:

- MCG (formerly Milliman Care Guidelines)
- Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and Medicare Benefit Policy Manual
- **Level of Care Assessment Tool® (LOCAT)**
- **Applied Behavioral Analysis (ABA) Medical Necessity Guidelines for the treatment of Autism Spectrum Disorders**
- American Society of Addiction Medicine Patient Placement Criteria for Addictive, Substance-Related and Co-Occurring Conditions
  Note: For treatment provided in Texas, Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers (28 TAC §§3.8001-3.8030) are utilized in place of ASAM for Texas members.
- Internally developed guidelines and our Clinical or Pharmacy Policy Bulletins (CPBs) (based on peer-reviewed published medical literature)

Participating physicians may ask for the criteria that were used to make a determination by contacting us in writing or by phone.

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.

We don't make employment decisions or 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 under and over utilization of services.

Admissions protocol

In the case of referred care, the admitting physician must electronically submit or contact us for preadmission precertification.* In the case of self-referred care, the member must contact us. 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 an expected length of stay (ELOS). This determines when a review will start. For other cases, we give specific guidelines with the admission precertification. The ELOS determination is primarily based on MCG.

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

Failure to meet this notification timeframe may reduce your payment

It's 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 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.

*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 Medicare Advantage plan members if they do not get precertification.

Patient management and acute care (continued)

All-Products Precertification List

Precertification* is the process of collecting information prior to inpatient admissions and selected ambulatory procedures and services. The process facilitates:

- Communicating a coverage decision to the treating practitioner and member before the procedure, service or supply
- Identifying members for pre-service discharge planning
- Identifying and registering members for our covered specialty programs, such as:
  - Aetna Health Connections℠ case management and disease management programs
  - Behavioral health programs
  - National Medical Excellence programs

You can find more information about our precertification policy at **www.innovation-health.com**.

Select:

1. Physicians & Providers, then
2. Precertification Code Search Tool

NOTICE: The term precertification used here and throughout the Health Care Professional Office Manual, means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage.

Case management services

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

Our case managers review and coordinate services for:

- Members with multiple and complex needs. For example, cardiac care, complex pediatric care, complex behavioral health care, medical psychiatric coordination and oncology.
- 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.

Once we decide that a member is right for case management and the member agrees, we make an individualized plan. We work with the member, the member's family, physicians and other health care professionals.

During the assessment process, we make a case management plan to meet 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 to achieve his or her health goals and they resolve any 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 it accordingly. Once the member meets the stated goals and objectives, the member is discharged from case management. This is usually within an average of 30-90 days.

†Case Management Society of America

Clinical practice guidelines

We adopt evidence-based clinical practice guidelines from nationally-recognized sources. We use these guidelines to promote consistent application of evidence-based treatment methodologies. We make them available to practitioners to facilitate improvement of health care and reduce unnecessary variations in care. We review the CPGs every two years or more frequently if national guidelines change within the two-year period.

The CPGs are provided for informational purposes only and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider's clinical judgment regarding the appropriate treatment of a patient in any given case.

CPGs that have been formally adopted can be accessed through the links below:

- **Attention-Deficit/Hyperactivity Disorder: Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment in Children and Adolescents**
- Behavioral health
  - Diagnosis, Evaluation and Treatment of ADHD in Children and Adolescents
  - **Helping patients who drink too much**
  - **Treating patients with major depressive disorder**
- Diabetes
  - Treating patients with diabetes
- Heart disease
  - Treating patients with coronary artery disease

You can access all the clinical guidelines listed above on our **secure provider website**.

Once on the site, go to **Plan Central > Aetna Health Plan > Support Center > Clinical Resources**. This website also provides access to the nationally recognized sources to download full content of the guidelines directly. For assistance in obtaining hard copies from the nationally recognized sources, call the Member Services or Provider Services numbers below:

- Middle Market – **1-888-877-0943**
- Small Group – **1-855-330-4545**
- National Accounts – **1-855-337-2212**
- Innovation Health IVL – **1-855-330-4546**

Coordination of care

The importance of collaboration:

We monitor and seek to improve coordination and collaboration between treating providers of care. Results from annual physician practice surveys show 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 PCPs 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.

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

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

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

Patient management and acute care (continued)

Preventive services guidelines

We adopt nationally accepted evidence-based preventive services guidelines from:

- The U.S. Preventive Services Task Force (USPSTF)
- The Centers for Disease Control and Prevention (CDC)

Where there is a lack of sufficient evidence to recommend for or against a service by these sources, or conflicting interpretation of evidence, we may adopt recommendations from other nationally recognized sources. You can find information about preventive services guidelines and links to locate guideline content on our secure provider website **(http://connect.navinet.net)** at **www.innovation-health.com**.

Once logged in, select:

1. Plan Central, then
2. Aetna Health Plan
3. Choose Aetna Support Center, then
4. Clinical Resources

For assistance in obtaining hard copies from the nationally recognized sources, call the Member Services and Provider Services numbers below:

- Middle Market – **1-888-877-0943**
- Small Group – **1-855-330-4545**
- National Accounts – **1-855-337-2212**
- Innovation Health IVL – **1-855-330-4546**

We review guidelines every two years unless updates from recognized sources warrant more frequent review.

Transition of care

Transition-of-care guidelines are for members who are engaged in an active course of covered treatment with a provider who falls under one of these categories:

- Not a contracted provider in the member's plan
- Not included within a plan sponsor-specific network

Additionally, to be eligible for the transition of care process the treating provider must be either:

- An individual practitioner. For example, a specialist, physical therapist, speech therapist.
- A home care agency.

Transition of care does not apply to non-participating facilities, DME vendors or pharmacy vendors. It is also limited to a fixed period of time. Transition-of-care also applies to members who are engaged in an active course of covered treatment upon a physician's or other health care professional's termination of participation in the our 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. For example, a surgical follow-up visit.

Procedures for requesting transition of care:

1. 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 non-participating treating physician.
2. The member or non-participating treating physician faxes the completed form to the designated fax number listed on the form.
3. We then review the information. When necessary, our medical director evaluates the treatment program and may also contact the treating physician or health care professional.
4. We send a letter about the coverage decision to the member and the nonparticipating treating physician or health care professional. If approved for coverage, the letter advises the length of time the transition benefits apply. We also send a letter to the member's PCP.

†State variations may exist.

Performance programs

We use practitioner/provider performance data to improve the quality of service and clinical care our members receive. Accrediting agencies require that you let us use your performance data for this purpose.

Bridges to Excellence®

Through our agreement with Health Care Incentives Improvement Institute, Inc. (HCI3), formerly Bridges to Excellence (BTE), physicians may be eligible for bonus payments. Payments are based per patient, per year for performance in one or more of their BTE programs. HCI3 is a non-profit company. Their mission is to create significant leaps in the quality of health care. HCI3 recognizes and financially rewards physicians and other health care providers who demonstrate that they're following recognized standards of care for their patients.

Physician pay for performance (P4P)

Participation is through a direct contract. It's available in all markets to all providers that include PCPs. It's executed via a signed amendment to their current participation agreement.

Our nationally available physician performance incentive programs combine the strengths of our data collection and national data archives to local-market efforts. This allows for customized measures and goals.

Annual goals are:

- Negotiated agreements between the provider group and us
- 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 (IPAs)
- Physician-hospital organizations (PHOs)
- 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 towards their targeted performance results
- Maintain their high-performing levels of achievement

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

Broadly speaking, we believe that performance incentive program success requires:

- Clear and specific understanding between payers and providers. On the understanding of 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. For example, 95 percent performance and above. Replace those measures 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. Recognize that when physicians improve their practices, all patients benefit.

Pharmacy management

Overview – Pharmacy Plan drug list (formulary)

Our pharmacy benefits plans use a Pharmacy Plan drug list or formulary to help maintain access to quality, affordable prescription drug benefits for your patients. You'll find current preferred drug list information on our website at **www.innovation-health.com/physicians-and-providers/**. Many drugs, including drugs on the formulary are subject to manufacturer rebate arrangements between us and the manufacturers of those drugs.

Coverage is not limited to drugs on the list. In some benefits plans, certain nonpreferred drugs are excluded from coverage, unless a medical exception is first obtained. These drugs are on our formulary exclusions list that is also available at **www.innovation-health.com/physicians-and-providers/**. It's important to note that not all members with our medical benefits have our pharmacy benefits.

Aetna Rx Home Delivery® mail order pharmacy

Aetna Rx Home Delivery is our affiliated mail order pharmacy. It provides maintenance medications for chronic conditions such as arthritis, asthma, diabetes, high cholesterol and heart conditions. Aetna Rx Home Delivery can send members up to a 3-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. The Aetna Rx Home Delivery 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 –** Depending on the Innovation Health pharmacy benefits plan, members can save money by using Aetna Rx Home Delivery mail order pharmacy. Standard shipping is always free.

Aetna Specialty Pharmacy®

Aetna Specialty Pharmacy is our 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.

Specialty medications are often expensive. They may also require refrigeration, special storage and handling and fast delivery. In addition, they may not be readily available at retail pharmacies.

Our specialty pharmacy's health care team helps your 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 our 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.

Our 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 and 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:
  - Needles
  - Syringes
  - Alcohol swabs
  - Adhesive bandages
  - Sharps containers for needle waste

Our specialty pharmacy supports a wide variety of complex diseases.

Aetna Specialty Pharmacy dispenses specialty medications to treat many disease states. Many of these medications are available only through limited distribution networks.

Our 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 at **www.AetnaSpecialtyPharmacy.com**

Send it to us by fax or mail:

By fax to: **1-866-FAX-ASRX (1-866-329-2779)**

By mail to:
Aetna Specialty Pharmacy
503 Sunport Lane
Orlando, FL 32809

Electronic prescribing:

Physicians use e-prescribing technology to input prescriptions through an electronic medical record (EMR) using a tablet, smartphone or desktop computer. Physicians can send orders electronically to the patient's pharmacy. This eliminates 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 Considerations℠ 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. It's included free of charge as part of our pharmacy benefits plan coverage.

Learn more about e-prescribing products and services at:

www.aetna.com/provider/pharmacy/resource_pharmacy/business_pharmacy/ePrescribe.html

Pharmacy management (continued)

Pharmacy clinical policy bulletins (PCPBs)

PCPBs are used as a guide to determine coverage for members with benefits plans that cover outpatient prescription drugs. These bulletins also describe the medical exception clinical coverage criteria for drugs on our:

- Formulary Exclusions List
- Precertification List
- Step-Therapy List
- Quantity Limits List

You can find all PCPBs on our website at **www.innovation-health.com**.

Precertification, step therapy and quantity limits

Precertification

Most members with our pharmacy benefits may have a plan that includes 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
- Cost and manufacturer rebate arrangements

To determine which medications may require precertification, refer to **www.innovation-health.com/physicians-and-providers/**. Call us at **1-800-AETNA RX (1-800-238-6279)** if you have questions.

Step-therapy

Some members may have a plan that includes 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
- Cost and manufacturer rebate arrangements.

You'll find current step-therapy requirements **www.innovation-health.com/physicians-and-providers/**. If you have questions, call us at **1-800-AETNA RX (1-800-238-6279)**.

Note: If it is 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 a medical exception. The drugs requiring step-therapy are subject to change.

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. To do so, contact the Aetna Pharmacy Management Precertification Unit. Refer to the medical exception and precertification information on how to access this unit.

Medical exceptions and precertification

Physicians, patients or a person appointed to manage the patient's care can contact our pharmacy management precertification unit to:

- Ask for a medical exception for coverage of drugs on the formulary exclusions list or the step-therapy list
- Request prior authorization or exceptions about quantity limits

Aetna Pharmacy Management precertification unit contact information:	Fax	E-mail/web link
1-800-414-2386	**1-800-408-2386** (Use the Medical Exception/ Precertification Request **Form** located in this section)	**www.innovation-health.com** (Through our secure provider website link)

Contact information for precertification for specialty drugs on the Innovation Health National Precertification List:

Phone	Fax	E-mail/web link
1-866-503-0857	**1-888-267-3277**	**www.innovation-health.com** (Through our secure provider website link)

Policies

Complaints and appeals

We have developed a formal complaint and appeals policy* for physicians, health care professionals and facilities. The complaint and appeal process has:

- Two levels of appeal for physicians and health care professionals
- One level of appeal for facilities

Physician, health care professional and facility appeals involve payment decisions or claims. They do not include dissatisfaction with pre-service or concurrent medical necessity decisions. Those decisions are handled through the member appeal process.

Physician and health care professional post-service appeals are classified as payment appeals and are not considered on behalf of the member unless both of the following apply:

- The appeal explicitly states on behalf of the member
- The physician or health care professional submits specific written authorization from the member

Note: The process may vary due to state-specific requirements. For more information on complaints or appeals, contact your local Innovation Health office.

Visit **www.innovation-health.com** to view more information on our appeal process. You'll find several documents on the "Physicians & Providers" tab.

Medical Clinical Policy Bulletins (CPBs)

CPBs are 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
- Not medically necessary

Note: 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. We conduct these reviews to determine whether and how such technologies will be considered medically necessary or not experimental or 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. This includes reviews by the U.S. Food and Drug Administration (FDA) and the Centers for Medicare & Medicaid Services (CMS) coverage policies.

We develop our CPBs from a review of relevant information regarding a particular technology. Our CPBs are published on our website **www.innovation-health.com** for public reference.

*Medicare Advantage plans must comply with CMS requirements and timeframes when processing appeals and grievances received from Medicare Advantage plan members. Please refer to the Medicare section of the Office Manual for further information.

Medical emergencies

If patients require emergency care, they are 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 our service areas.

- Call the local emergency hotline. For example, 911. Or go to the nearest emergency facility. If a delay would not harm the patient's health, call the PCP.
- After assessing and stabilizing the patient's condition, the emergency facility should contact the PCP. The PCP can then 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 PCP or us as soon as possible.
- All follow-up medical care should be coordinated by the PCP.

We cover members who travel outside their service area or students who are away at school for emergency and urgent care. Members may obtain urgent care from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility.

We consider certain conditions, such as severe vomiting, earaches, sore throats or fever, as urgent care outside our service area. We cover these conditions in any of the above settings. We do not cover preventive care services and other routine treatment for conditions such as minor colds and flu outside our service area.

Note: 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.

State mandates may apply.

When claims submitted to us by the provider who supplied care do not appear to meet the standards for emergency or urgent care, we may need 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. We will also notify the member of the request. If the member wishes, he or she may provide additional information to us by phone or mail regarding the visit.

Follow-up care after emergencies:

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

We require precertification before we can cover any out-of-network follow-up care. This applies to care either inside or outside our service area. You can obtain precertification electronically or by calling the toll-free number on your patient's member ID card.

Examples of follow-up care include:

- Suture removal
- Cast removal
- X-rays
- Clinic and emergency room revisits

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

Pharmacy Clinical Policy Bulletins (PCPBs)

We use PCPBs as a guide to determine coverage for members with benefits plans covering outpatient prescription drugs. These bulletins also describe the medical exception clinical coverage criteria for drugs on the formulary exclusions list, precertification list and step-therapy list. All PCPBs are accessible on our website at **www.innovation-health.com**.

Policies (continued)

Referral policies

In benefits plans that require referrals for specialist care, the PCP 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 PCP must request a referral prior to the patient's visit to the specialist. The referral must be for covered benefits under the plan.

Please submit an inquiry by an eligibility transaction or call the number on your patient's member ID card to confirm covered benefits.

Depending on his or her plan type, if your patient visits a specialist without a referral, the patient may be responsible for payment for all services rendered. Or for paying a deductible and coinsurance. After a patient receives care he or she should not return to the PCP to request a referral. PCPs should not issue retroactive referrals.

In our products that do not require a referral, a patient may self-refer to either a participating or nonparticipating physician or health care professional. The patient is responsible for paying any applicable copay, deductible or coinsurance for self-referred benefits. See the patient management and acute care section for rules regarding preauthorization for certain services.

In our Open plans, referrals are not necessary. A patient may self-refer to any participating physician or health care professional.

We require that PCPs review every referral issued by their practice. In addition, we recommend that the initial consultative referral be authorized for one visit, except when either:

- The patient is known to have a predicted need for more visits
- The patient is involved in an ongoing process of care

This encourages communication from the specialist to the PCP.

Following an initial consultation, additional referrals from the PCP 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 PCP.
- 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 PCP can consider the appropriate course of treatment. For example, referrals for additional services or follow-up care.

Referrals may be authorized for consultation and treatment (C&T) using CPT code 99499. In most areas, C&T referrals don't need to specify the procedures to be performed by the specialist. We reimburse specialists for any associated covered procedure performed in an office setting. This is in accordance with current claims processing guidelines.

Please note that referrals don't permit specialists to refer members to another specialist for care. If this is necessary, patients must get a referral from their PCP to see another specialist. This referral is not a guarantee of payment. Payment is subject to:

- Eligibility on date of service
- Plan benefits
- Limitations and exclusions
- Pre-existing condition limitations
- Patient liability under the plan

Maryland Universal Consultation Referral Form

To follow Maryland Insurance Code 31.10.12.06, we provide the Maryland Universal Consultation Referral Form for use by Primary Care:

http://www.dsd.state.md.us/comar/comarhtml/31/31.10.12.06.htm

Referrals

You should issue electronic referrals for all plans that require referrals (see our benefits products). For information on submitting electronic referrals, see the eSolutions for provider offices section.

See the patient management and acute care section for those services requiring precertification.

Note: Physicians or other health care professionals who participate with us through an independent practice association (IPA), physician medical group (PMG) or physician hospital organization (PHO) should consult their IPA, PMG or PHO on all plan policies and procedures. Some of these referral guidelines may not apply to physicians or health care professionals participating with us through these groups.

*For benefits plans that require the issuance of referrals for specialist care in the Southern New Jersey, Pennsylvania, Maryland, Virginia and the District of Columbia, the member should be directed to his/her PCP for referrals for laboratory and radiology services.

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.

These programs include:

Program	Telephone
Nurse case management and education for women with breast cancer	**1-888-322-8742**
BRCA Genetic Testing Program (genetic testing for breast and ovarian cancers)	**1-877-794-8720**
National Infertility Unit* to help members and physicians throughout infertility care	**1 800-575-5999**

Female members† have direct access to participating obstetricians and gynecologists for routine and preventive care like breast exams, mammograms and Pap tests. These doctors can authorize referrals for related specialty care.

Obstetric enhancement programs* overview

We developed three programs that give enhanced reimbursement to obstetricians who perform ultrasound studies and fetal non-stress tests (NSTs) in their offices. All programs have eligibility requirements and apply to obstetric ultrasounds and NSTs for our members enrolled in Innovation Health plans. Participation in these programs eliminates referrals and billing for individual procedures.

- **Complete Obstetric Ultrasound Program.** Physicians who participate in the Complete Ultrasound Program:
  - Perform all necessary obstetric ultrasounds in the office
  - Get an enhancement to the global obstetric fee, regardless of the number of ultrasounds they perform
- **Limited Obstetric Ultrasound Program.** Physicians who participate in the Limited Ultrasound Program:
  - Perform all necessary limited ultrasounds in the office
  - Get an enhancement to the global obstetric fee, regardless of the number of limited ultrasounds they perform
- **Fetal non-stress test (NST) enhancement program.** Physicians who participate in this program:
  - Perform all fetal NSTs in the office
  - Get an enhancement to the global obstetric fee, regardless of the number of fetal NSTs they perform

Call Provider Services at the number on your member's ID card for more information about these programs. Please specify that you are asking about our obstetric ultrasound enhancement programs.

†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.

*Not available in all service areas. Texas and Oklahoma — refer to local network information.

This material is for information only and is not an offer or invitation to contract. Health insurance plans contain exclusions, limitations and benefit maximums. Providers are independent contractors and are not agents of Aetna or Innovation Health. Provider participation may change without notice. Aetna or Innovation Health does not provide care or guarantee access to health services. Aetna and its affiliates provide certain management services for Innovation Health. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional.

The Plan Benefits Navigator℠ is powered by Aetna Navigator®. The availability of Plan Benefits Navigator's key features may vary by plan. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional.

This information is not meant to be either a recommendation for medical treatment or a diagnosis of medical condition. Please consult your health care provider for the advice and care appropriate for your specific medical needs. The availability of a program may vary by geographic service area and by plan design. While only your doctor can diagnose, prescribe or give medical advice, the Informed Health nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs. While this material is believed to be accurate as of this date, it is subject to change. These programs are not insured benefits. Aetna and its affiliates provide certain management services for Innovation Health.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy providing prescription services by mail. Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. Aetna's Preferred Drug List is subject to change. Medications on the precertification, step-therapy and quantity limits lists are subject to change.

NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or who conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DISTRICT OF COLUMBIA (DC) NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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Information is believed to be accurate as of the production date; however, it is subject to change.

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