## National Care Management

### Precertification Procedure

Replaces 00 100-02, NCM 906-02

**Subject**

**Originating Department**

**National Care Management**

Signed original on file in National Care Management
Date: 4/5/11

Signature Authority: James D. Cross, M.D.

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### Related Materials:

- NCM 100-01 National Care Management Precertification Policy
- NCM 200-01 National Care Management Concurrent Review and Discharge Planning Policy
- NCM 200-02 National Care Management Concurrent Review and Discharge Planning Procedure
- NCM 300-01 National Care Management Retrospective Review Policy
- NCM 300-02 National Care Management Retrospective Review Procedure
- NCM 503-01 National Care Management Medical Review Policy
- NCM 504-02 National Care Management Timeliness Standards for Coverage Decisions and Notification Procedure
- NCM 505-01 National Care Management Denial of Coverage Policy
- NCM 506-02 National Care Management Peer-to-Peer Review Procedure
- NCM 509-01 National Care Management Coordination of Benefits Policy
- NCM 520-02 National Care Management Reviewing Additional Information Received Following an Initial Determination Procedure
- NCM 903-02 National Care Management Medicare Advantage U.S. Travel Advantage Procedure
- NCM 1003-02 National Care Management Hours of Operation and After Hours Call Procedure

**National Precertification: Disaster Policy Liberalization Grid at:**

http://aetnet.aetna.com/provider_services/precert/disaster/disaster_policy_lib_grid.htm

**HCM PM Care Management Team Precertification Grids at:**

http://aetnet.aetna.com/medOps/PP/UMResources/UMResourcesMain.html

**Aetna Regional vs Medicare Advantage Unit Responsibilities at:**

http://aetnet.aetna.com/medOps/contentMgtAssets/documents/UMResources/AetnaRegionalvsMedicareUnitResponsibilities.doc

**Par/NonPar Decision Grid at:**

http://aetnet.aetna.com/medOps/contentMgtAssets/documents/UMResources/ParNonParDecisionGrid.doc

### Resources:

- NCM 503-02 National Care Management Medical Review Procedure
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**National Precertification How to Determine Member Precertification Requirements Workflow at:**


**Aetna appeal policies and procedures:**


**Electronic Total Utilization Management System (eTUMS) Performance Support Tool (PST) at:**


**Medicare Advantage – Documentation Guidelines at:**


**Aetna Participating Provider Precertification List with Codes at:**


**Aetna Behavioral Health Precertification List at:**


**National Precertification: Precertification Not Required Workflow at:**

[http://aetnet.aetna.com/provider_services/precert/wkflows/prec_natl_wkflows_prec_not_required_scripting_and_doc_temp.htm](http://aetnet.aetna.com/provider_services/precert/wkflows/prec_natl_wkflows_prec_not_required_scripting_and_doc_temp.htm)

**Patient Management/Precertification All Products Claim Scripting at:**


**National Medical Excellence Plan Sponsor Exceptions List at:**


**National Precertification Fax Back Forms at:**

[http://aetnet.aetna.com/natiprecert/prec_forms_page1.htm](http://aetnet.aetna.com/natiprecert/prec_forms_page1.htm)

**National Precertification Requests for Case Management at:**


**Automatic Claim Adjudication System/Aetna Standard Table (ACAS AST) Clinical Workflow at:**

[http://aetnet.aetna.com/provider_services/precert/wkflows/ast_acas_clin.htm](http://aetnet.aetna.com/provider_services/precert/wkflows/ast_acas_clin.htm)

**National Precertification List (NPL) Tasking Tool at:**


**Attachments:**

None Applicable
Background and Purpose:

General:
Precertification or prospective review involves collecting information prior to the provision of a service to facilitate:

- Confirmation of member eligibility;
- Determination of coverage;¹
- Assessment of medical necessity;
- An opportunity to identify members for pre-service discharge planning and to identify and refer members to Aetna Health Connections℠ specialty programs such as case management and disease management;
- Accurate and timely claims adjudication.

Medical precertification coverage requests are handled in National Precertification/Patient Management with referral to other Aetna specialty areas for review and determination as appropriate² (e.g., oral surgery coverage requests are forwarded to the Oral Maxillofacial Surgery [OMFS] Unit; transplants³ and blood clotting factor coverage requests are forwarded to the National Medical Excellence [NME] Unit; maternity home care coverage requests are forwarded to the Women’s Health Unit; coverage requests for identified medical injectables [e.g., Epogen] are forwarded to Aetna Specialty Pharmacy [ASRx]; coverage requests for medical injectables for members enrolled in an Aetna Medicare Pharmacy plan [MA-PD or PDP] are forwarded to Aetna Pharmacy Management; and, behavioral health coverage requests are referred to the appropriate Aetna Behavioral Health Care Management Center [CMC]).

Tools:
During the precertification process, Aetna staff utilizes, as applicable, the following tools to determine whether a procedure or service requires precertification and the associated level of review activity required (e.g., medical review or notification only):

- Aetna Participating Provider Precertification List (with codes);
- Aetna Behavioral Health Precertification List;
- The precertification requirements of a member's plan;
- Aetna Standard Table (AST)⁴; and,

¹ 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, or (ii) where a provider is required to comply with Aetna's utilization management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement.
² The National Accounts Dedicated Units may retain some of the listed precertification responsibilities based upon plan sponsor specific contractual obligations.
³ NME handles all precertification activities for members who have been approved for coverage of a bone marrow or solid organ transplant (with the exception of kidney transplants). Utilization management for members who have been approved for coverage of a kidney transplant follow all existing processes (all precertification, patient management and case management activities are managed by the designated National Precertification Unit/region/National Accounts Dedicated Unit) until the member is admitted for the kidney transplant surgery. NME manages the transplant admission and all subsequent precertification, patient management and case management activities until these activities are transferred back to the National Precertification Unit/region/National Accounts Dedicated Unit.
⁴ The Aetna Standard Table is utilized by National Precertification staff when reviewing coverage requests that include multiple procedures/services and one or more code requires medical review following the Aetna Participating Provider Precertification List or the terms of the member's plan (member precertification requirement).
• eTUMS Length of Stay (LOS) tables.

Coverage determinations are based upon nationally recognized guidelines/criteria (e.g., Centers for Medicare & Medicaid Services [CMS] guidelines; Milliman Care Guidelines; the American Society of Addiction Medicine Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition – Revised [ASAM-PPC-2R]; Aetna Clinical Policy Bulletins [CPBs]; the Applied Behavioral Analysis (ABA) guidelines for the treatment of autism spectrum disorders or, for mental health admissions, the Aetna Level of Care Assessment Tool [LOCAT]).

Precertification Approval Time Frames:
A precertification approval is valid for six (6) months from the date of the certification for elective medical/surgical procedures/services with the exception of OMFS procedures/services for which the certification is valid for twenty-four (24) months from the date of the certification. A precertification approval for non-elective medical and behavioral health services is valid for the specified dates of the approved services. In all instances, precertification approvals are subject to the eligibility provisions being met at the time services are provided.

• Eligibility provisions include both active coverage under the plan and the availability of plan specific benefits at the time services are provided. If the member’s plan renews prior to the date of service but within the authorization time frame, the determination of whether benefits are payable is based upon the terms of coverage in effect on the date of service.

• Verbal disclaimers are not utilized when conducting precertification activities.

Decision Making:
Non-clinical staff does not make adverse precertification coverage determinations. Clinicians are available to non-clinical staff throughout the precertification process for questions, concerns and guidance regarding how to handle a coverage request for a particular procedure or service.

When a precertification coverage request includes multiple procedures or services and all procedures/services are either medical or behavioral health in nature and one (1) or more procedure(s) or service(s) requires medical review based upon the Aetna Participating Provider Precertification List or the terms of the member’s plan (referred to as a member precertification requirement):

• All codes are accepted as part of the initial precertification intake;

• Clinical staff makes a coverage determination for all codes that require medical review or notification based upon a Precertification List or the AST.

When a precertification coverage request involves a mixed service, the area with primary utilization management responsibility refers providers requesting coverage for additional procedures/services not included within the mixed service diagnosis to the appropriate intake area for response. (For example, if a member is admitted to a behavioral health facility for treatment of an eating disorder and a consulting provider requests coverage for an abdominoplasty, the consultant is referred by behavioral health staff to National Precertification for intake of the surgical coverage request.)

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5 The National Accounts Dedicated Units utilize Milliman Care Guidelines (MCG) Goal Length of Stay (GLOS) or Benchmark Length of Stay (BLOS) in place of the eTUMS ELOS table.
6 Codes requiring medical review or notification are defined for purposes of this procedure as codes included on the Participating Provider Precertification List, codes requiring precertification based upon a member’s plan and codes identified by the AST as potentially cosmetic, experimental/investigational or non-efficacious.
7 Oral surgery precertification coverage requests requiring medical review that are accompanied by additional procedural/service codes not requiring precertification are routed to the Oral Surgery Claim Unit for processing as a predetermination.
Aetna Behavioral Health staff follows the same procedural steps that are listed below when behavioral health benefits are included in the Aetna plan of benefits and managed by Aetna (not "carved out" of the plan to another insurer or delegated to another behavioral health contractor) except where specifically described otherwise.

Precertification coverage determinations and notifications are communicated to the member or the member authorized representative and the treating provider in compliance with the time frames identified in (NCM 504-01) National Care Management Timeliness Standards for Coverage Decisions and Notification Policy.

- The submission of missing pre-requisite procedure/service(s) to the precertification department is considered a new precertification request when the missing pre-requisite procedure/service(s) are performed after the date of the denial letter and the initial adverse precertification coverage determination is based upon a failure to meet clinical criteria/guidelines because all required clinical information was not submitted. The missing pre-requisite procedure/service(s) must be performed within six (6) months of the date of the original denial letter in order to be considered with the previously submitted clinical information as a new precertification request.
  - For example, a breast reduction coverage request that is received by the precertification department for a woman over age 40 who is enrolled in a commercial plan is considered a new precertification request when the initial denial was based upon the lack of a mammogram within one (1) year of the planned surgery and a mammogram is completed within six (6) months of the date of the denial letter.
  - For members enrolled in Medicare Advantage plans, the submission of the missing pre-requisite procedure/service is considered a new precertification request when the missing pre-requisite procedure/service is performed after the date of the denial letter and is submitted to the precertification department more than 60 calendar days but less than six (6) months of the date of the initial denial letter.

- The submission of missing pre-requisite procedure/service(s) is considered within the following processes when the missing pre-requisite procedure/service(s) are performed prior to the initial coverage denial determination but are not included with the initial coverage request and the initial adverse precertification coverage determination is based upon a failure to meet clinical criteria/guidelines because all required clinical information was not submitted:
  - Through the peer-to-peer review process when the information is submitted by the treating practitioner within fourteen (14) calendar days of the written denial determination following (NCM 506-01) National Care Management Peer-to-Peer Review Policy.

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8 For precertification, concurrent and retrospective reviews, an individual must satisfy at least one of the following requirements in order to be considered an Authorized Representative of a member:

- The member has given express written or verbal consent for the individual to represent the member's interests. A member can appoint an attorney to represent them.
- The individual is authorized by law to provide substituted consent for a member (e.g.-parent of a minor, legal guardian, foster parent, power of attorney); or
- For pre-service, urgent care or concurrent claims only, the individual is an immediate family member of the member (e.g.- spouse, parent, child, sibling); or
- For pre-service, urgent care or concurrent care claims only, the individual is a primary caregiver of the member; or
- For pre-service, urgent care or urgent concurrent care claims only, the individual is a health care professional with knowledge of the member's medical condition (e.g.- the treating physician).
Through the review of additional information process following *(NCM 520-01) National Care Management Reviewing Additional Information Received Following an Initial Determination Policy* when the information is submitted by a provider within fourteen (14) calendar days of the written denial determination;

- Through the *applicable Aetna Appeal policy* when the information is submitted more than fourteen (14) calendar days from the date of the written denial determination.

More stringent *state amendments* may supersede the requirements of this procedure. Check the *eTUMS Controlling State field* to determine if state requirements apply.

### Required Documentation:

eTUMS is utilized for documentation of all services requiring precertification following the guidelines outlined in the *eTUMS PST*.

### Considerations specific to Medicare Advantage members:

#### A. Organization Determinations:

An organization determination is the notification in response to an oral or written coverage request by a Medicare Advantage member, their representative, or a physician (either contracted or non-contracted). There are two types of organization determinations; standard and expedited. In the absence of a request to expedite the determination, coverage requests are handled as a standard organization determination.

1. **Expedited Organization Determinations:**

   Expedited organization determination time frames may be applied to pre-service coverage requests when the member, the member’s representative, or a physician (either contracted or non-contracted) believes the member’s health, life, or ability to regain maximum function could be jeopardized by waiting for a decision within the standard time frame. Expedited organization coverage determinations are not limited to procedures/services requiring precertification but are available for any coverage request made by, or on behalf of, a Medicare Advantage member by the member’s authorized representative or a physician for a coverage decision (organization determination).

   Requests are automatically accepted as expedited if:

   - The request is made by a physician or,
   - The request is accompanied by physician documentation stating that the request is urgent and that the standard time frame may result in one of the above adverse outcomes.

   All other requests for an expedited pre-service coverage determination must be sent to an Aetna Medical Director to determine if the request meets the definition of an expedited organization determination. When the request to expedite the review has been denied, the coverage request must be processed in accordance with the standard organization determination timeliness and notification standards.

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9 Note: *(NCM 520-01) National Care Management Reviewing Additional Information Received Following an Initial Determination Policy* does not apply to the submission of additional information by members. Upon receipt of a member request to consider additional information, staff refers the member to the applicable appeal process included in the initial coverage denial letter.

10 A provider is defined within *(NCM 520-01) National Care Management Reviewing Additional Information Received Following an Initial Determination Policy* as facility based utilization review staff or practitioner/provider office staff.
After Hours Telephonic Call Handling:

Telephonic expedited review requests are accepted 24 hours a day, seven (7) days a week. During normal business hours, requests are initially received through the toll free number on the member’s Aetna Identification Card and are forwarded for handling as appropriate.

- Expedited requests that are received after business hours are handled no later than the next business day with the exception of requests received during a company holiday which are handled no later than the below time frames:
  
  o When either Friday or Monday is a company holiday, calls are routed for centralized after hours handling following (NCM 1003-01) National Care Management Hours of Operation and After Hours Call Policy for the initial 24 hours of the holiday weekend.
    - If the holiday falls on a Monday, the designated centralized after hours unit handles requests received from Friday 5PM (regional time) to Saturday 5PM (regional time).
    - If the holiday falls on a Friday, the designated centralized after hours unit handles requests received from Thursday 5PM (regional time) to Friday 5PM (regional time).
  
  o If the holiday weekend is extended to 4 days (e.g., Thursday and Friday consecutive holidays), the designated centralized after hours unit handles requests received during the initial 72 hrs (e.g., from Wednesday 5PM [regional time] to Saturday 5PM [regional time]).

Expedited requests received after business hours that require forwarding to the assigned on-call Medical Director by the designated centralized after hours unit include:

- Requests that do not meet the definition of an expedited organization coverage determination; and,

- Requests that the on-call clinician is unable to approve.

The on-call clinician provides all required Medicare Advantage member verbal notifications as outlined below.

**Expedited Notification Requirements:**

**Expedited Handling of the Coverage Request - Approved:**

If the coverage request is accepted for expedited review, the decision to expedite the request does not require notification; instead, the member is notified of the final coverage decision.

- **For approvals**, the member is notified in writing of the final coverage decision within 72 hours of receipt of the coverage request or before the end of the extension time frame (not to exceed 17 calendar days from receipt of the coverage request). **If the member is notified verbally** of the final coverage decision within 72 hours of receipt of the coverage request or before the end of the extension time frame (not to exceed 17 calendar days from receipt of the coverage request), follow-up written notification of the decision is provided to the member within three (3) calendar days of the verbal notice. All expedited organization determinations require member and provider verbal notification of the coverage decision to ensure compliance with notification requirements.

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11 Normal business hours for each office (with the exception of the Aetna Behavioral Health CMCs and the Beginning Right program) are, at a minimum, 8am-5pm in the time zone where the office is located, Monday through Friday, except company holidays. The Aetna Behavioral Health CMCs and the Beginning Right program define normal business hours as 8am-6pm in the time zone where the office is located Monday through Friday, except company holidays.
When unable to verbally notify the member due to administrative reasons (e.g., no answer at the member’s phone number; the member’s phone number has been disconnected; the member’s phone number is no longer valid; the member has a designated power of attorney for health care, legal representative, or other authorized representative) or clinical reasons (e.g., the member’s clinical condition prevents notification [confusion, acute psychiatric condition, clinically unstable, unresponsive]), staff follows the Medicare Advantage - Documentation Guidelines. In all instances, written notification of the coverage determination is required.

- **For denials**, the member is notified in writing of the final coverage decision within 72 hours of receipt of the coverage request or before the end of the extension time frame (*not to exceed 17 calendar days from receipt of the coverage request*). If the member is notified verbally of the final coverage decision within 72 hours of receipt of the coverage request or before the end of the extension time frame (*not to exceed 17 calendar days from receipt of the coverage request*), follow-up written notification of the decision is provided to the member within three (3) calendar days of the verbal notice. All expedited organization determinations require member and provider verbal notification of the coverage decision to ensure compliance with notification requirements.

- When unable to verbally notify the member due to an administrative reason as defined above, staff follows the Medicare Advantage - Documentation Guidelines. In all instances, written notification of the coverage determination is required.

**Extensions:**

The Medicare Advantage member, the member’s representative, a physician, or Aetna may request that the time frame for notifying the member of the final coverage decision be extended up to fourteen (14) calendar days from the date the extension is granted (*not to exceed 17 calendar days from receipt of an expedited coverage request*), if it can be demonstrated that the delay is in the interest of the member.

- If an extension is granted, the member and provider are notified in writing within 72 hours of receipt of the coverage request. In order to meet the 72 hour time frame for the receipt of written notification, Aetna staff completes the eTUMS 14 day extension letter within 24 hours of receipt of the expedited request.

The written notification must inform the Medicare Advantage member of:

- The reasons for the delay; and,
- The member’s right to file an expedited grievance (oral or written) if in disagreement with the decision to grant an extension.

If additional medical records are required for processing of the coverage request, the records are requested from the provider within 24 hours of receipt of the initial request in order to allow sufficient time for notification of an extension, if needed.

**Expedited Handling of the Coverage Request – Not Approved:**

If the coverage request is not accepted for expedited review based upon consultation with the Medical Director, the member is notified verbally of this decision within 72 hours of receipt of the coverage request. Follow-up written notification of the decision not to expedite the request is provided to the member within three (3) calendar days of the verbal notification.

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12 Refer to page 2 of the Documentation Guidelines.
The verbal and written notification must inform the Medicare Advantage member of the following:

- The coverage request will be processed within fourteen (14) calendar days from receipt of the request as a standard organization determination;
- The right of the member to resubmit the expedited request with physician supporting documentation;
- The right of the member to file an expedited grievance if in disagreement with Aetna’s decision not to process the request as an expedited determination; and,
- The instructions regarding the expedited grievance process and applicable time frames.

Notification of the final coverage decision must be provided in accordance with the standard organization determination standards.

2. **Standard Organization Determinations**

Standard organization determination time frames are applied to pre-service coverage requests when Aetna has not received a specific request to expedite the coverage decision or the request to expedite has not been approved. **Standard organization coverage determinations are not limited to procedures/services requiring precertification but are available for any coverage request made by, or on behalf of, a Medicare Advantage member by the member’s authorized representative or a physician for a coverage decision.**

**Standard Notification Requirements:**

**Extensions:**

The Medicare Advantage member, the member’s representative, a physician, or Aetna may request that the time frame for notifying the member of the final coverage decision be extended up to fourteen (14) calendar days from the date the extension is granted (not to exceed 28 calendar days from receipt of a standard coverage request), if it can be demonstrated that the delay is in the interest of the member.

- If an extension is granted, the member and provider are notified in writing within fourteen (14) calendar days of receipt of the coverage request. In order to meet the fourteen (14) calendar day time frame for the receipt of written notification, Aetna staff completes the eTUMS 14 day extension letter within five (5) calendar days of receipt of the standard request.

The written notification must inform the Medicare Advantage member of:

- The reasons for the delay; and,
- The member’s right to file an expedited grievance (oral or written) if in disagreement with the decision to grant an extension.

If additional medical records are required for processing of the coverage request, the records are requested from the provider within five (5) calendar days of receipt of the initial request in order to allow sufficient time for notification of an extension, if needed.

**Standard Handling of the Coverage Request:**

For all standard organization determinations, the member is notified of the final coverage decision.

- **For approvals,** CMS requires member notification either verbally or in writing\(^\text{13}\) of the final coverage decision within fourteen (14) calendar days of receipt of the coverage request or before the end of the extension time frame (not to exceed 28 calendar days from receipt of the coverage request). Aetna has adopted a written member notification requirement.

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\(^{13}\) eTUMS edit requires written notification when an approval determination has been entered.
For denials, the member and provider are notified in writing of the final coverage decision within fourteen (14) calendar days of receipt of the coverage request or before the end of the extension time frame (not to exceed 28 calendar days from receipt of the coverage request). Verbal notification is not required.

B. Medicare Advantage Products and Precertification:

Medicare Advantage HMO members: Generally, all services are rendered by a contracted provider within the defined service area.

- Coverage at the in-network benefit level for care or services from providers outside the Medicare Advantage HMO plan’s defined service area may be precertified when it has been determined that utilization of the out-of-area provider is consistent with patterns of care for individuals residing in the same geographic area. The out-of-area provider may be either non-participating or may participate in an adjacent Aetna Medicare HMO service area. Pre-service coverage requests for out-of-area providers for members enrolled in a Medicare Advantage HMO plan are handled in accordance with (NCM 512-01 & 02) National Care Management Non-Participating Provider Policy and Procedure.

- Medicare Advantage HMO members temporarily traveling out of the assigned service area have access to covered benefits through the U.S. Travel Advantage Program and are able to access eligible services as described in (NCM 903-01) National Care Management Medicare Advantage U.S. Travel Advantage Policy.

Medicare Advantage PPO members: Members may access covered services from both contracted and non-contracted providers both within and outside of the defined service area.

- Benefit payment level is based upon whether the provider is contracted or, if accessing services from a non-contracted provider, whether prior approval at the in-network benefit level has been issued.
### Procedure:

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| 1. Receive request for coverage. | A. Access the member in eTUMS.  
  1. Review eTUMS edits to verify that the call has been received by the correct unit (Dedicated Unit vs National Precertification).  
     a. Transfer misdirected callers to the correct intake phone number when indicated by an eTUMS edit following the National Precertification: Misdirected Calls Behavioral Health/Pharmacy workflow.  
  B. Verify the member’s eligibility utilizing Aetna Strategic Desktop (ASD).  
     1. Proceed to activity C of this step of the procedure for members enrolled in a commercial plan.  
     2. Proceed to the Medicare Advantage Plans section of this procedure for members enrolled in a Medicare Advantage plan.  
  C. Determine the provider’s status (participating vs non-participating) utilizing ASD through either the “Provider View”, Provider Search screen or the “Member View”, Find Provider tab.  
     1. For oral surgery coverage requests, confirm the provider status under the medical plan rather than under the dental plan. **Note:** Include consideration of the Oral Surgery Referral Waiver policy.  
  D. Review the coverage request to determine whether precertification is required and proceed accordingly.  
     1. For behavioral health services:  
        a. Validate precertification requirements by consulting the Aetna Behavioral Health Precertification List and the Plan Sponsor Tool to identify member precertification requirements.  
           1). If precertification is not required:  
              a). Notify the requestor following the Precertification Not Required workflow.  
              b). Document the call with response in eTUMS Member Notes or ASD. **Note:** This ends the precertification/notification process.  
           2). If precertification is required:  
              a). For inpatient coverage requests:  
                 (1). Verify whether the member has already been discharged.  
                 (a). If no, proceed to activity D1a2a(2) of this step of the procedure.  
                 (b). If yes, verify the discharge date and consider the request based upon a comparison with the admission notification date. | Inbound Queue Associate  
  Precertification Care Management Associate  
  Case Manager  
  Utilization Management Nurse Associate  
  Utilization Management Nurse Consultant  
  Behavioral Health Customer Service Representative |
## COMMERCIAL PLANS

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| 1. Receive request for coverage (con’t). | i. If notification is within three (3) business days of the discharge, the inpatient stay was less than seven (7) days and the facility has the clinical information available at the time of the notification:  
   i). Proceed to activity D1a2)a)(2) of this step of the procedure.  
   ii. If any of the conditions within activity D1a2)a)(1)(b)i of this step are not met, notify the requestor to submit the claim and the appropriate medical records.  
   i). Document the call and the response in the eTUMS Member Notes tab or alternatively, within ASD Contact Event Notes. | Inbound Queue Associate  
Precertification Care Management Associate  
Case Manager  
Utilization Management Nurse Associate  
Utilization Management Nurse Consultant  
Behavioral Health Customer Service Representative |
| | (2). Review the eTUMS Event History tab for a previous inpatient event with a documented discharge within one (1) calendar day of the admission.  
(a). If an eTUMS inpatient event is located:  
   i. Review the last eTUMS event note for documentation of “DRG hospitalization.”  
   (i). Follow the DRG Readmissions workflow if the documentation is present.  
   (ii). Proceed to step 2 of this procedure if the documentation is not present.  
(b). If an eTUMS inpatient event is not located:  
   i. Proceed to step 2 of this procedure.  
   b). For ambulatory coverage requests:  
      (1). Proceed to step 2 of this procedure. | |
| 2. For medical/surgical services:  
   a. Validate precertification requirements following the How to Determine Member Precertification Requirements workflow. | 1). If precertification is not required:  
   a). Notify the requestor following the Precertification Not Required workflow.  
   b). Document the call with response in eTUMS Member Notes or ASD.  
   c). Follow the Requests for Case Management workflow when the coverage request is accompanied by a request for case management. | |
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<tr>
<th>STEPS</th>
<th>ACTIVITIES</th>
<th>RESPONSIBLE PARTY</th>
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</thead>
<tbody>
<tr>
<td>1. Receive request for coverage (con’t).</td>
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<td></td>
</tr>
<tr>
<td>2). If precertification is required:</td>
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<td></td>
</tr>
<tr>
<td>a). Review the member’s eTUMS event history for a previously denied precertification coverage request that includes the same ICD-9 and/or CPT codes.</td>
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<tr>
<td>(1). If a denial determination is located, follow the Additional Clinical Received following an Adverse Determination workflow.</td>
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<tr>
<td>(2). If a denial determination is not located:</td>
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<td></td>
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<tr>
<td>(a). For inpatient coverage requests:</td>
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<td></td>
</tr>
<tr>
<td>i. Verify whether the member has already been discharged.</td>
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<td></td>
</tr>
<tr>
<td>i). If no, follow activities D1a2)a)(2)(a) or (b) of this procedure as appropriate.</td>
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<tr>
<td>ii). If yes, verify the discharge date and consider the request based upon a comparison with the admission notification date.</td>
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<td></td>
</tr>
<tr>
<td>i. If notification is within two (2) business days of the actual day of admission (e.g., member admitted on Friday, discharged on Sunday, and notification received by Aetna on Monday):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i). Follow activity D1a2)a)(2)(a) or (b) of this procedure as appropriate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. If notification is greater than two (2) business days from the date of the actual admission, notify the requestor to submit the claim and the appropriate medical records.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i). Document the call and the response in the eTUMS Member Notes tab or alternatively, within ASD Contact Event Notes.</td>
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<td></td>
</tr>
<tr>
<td>(b). For ambulatory coverage requests:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Proceed to step 2 of this procedure.</td>
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Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
## COMMERCIAL PLANS

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<tr>
<th>STEPS</th>
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<th>RESPONSIBLE PARTY</th>
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</table>
| 2. Identify if notification or medical review is required and task for follow-up accordingly. | A. Initiate an eTUMS event following the eTUMS PST.  
1. Enter an initial place holder date (i.e., 12/31/2099) as the date of service if the coverage request does not include an actual date.  
B. Request information about other insurance coverage, document response, and initiate COB verification request (when applicable) following (NCM 509-02) National Care Management Coordination of Benefits Procedure.  
C. Determine if the coverage request requires “notification” (data entry) or “medical review” (clinical coverage determination required).  
1. For behavioral health services:  
a. Pend the coverage request and task the eTUMS case to the appropriate clinical team.  
b. The Behavioral Health Care Manager proceeds to step 3 of this procedure.  
2. For medical/surgical services listed on the Aetna Participating Provider Precertification List with Codes,  
a. If medical review is required:  
1). Pend the coverage request and task the eTUMS case to the appropriate clinical team using the NPL Tasking Tool or Dedicated Unit plan sponsor assignment in order to complete the remainder of the precertification process.  
2). Proceed to step 3 of this procedure.  
b. If notification only is required, perform the following:  
1). Complete eTUMS documentation.  
a). Enter the actual date of service if included with the coverage request or a place holder date six months from the date of the eTUMS data entry if not previously documented.  
(1). Inform the requestor to notify Aetna of the actual date of service once confirmed, as applicable.  
b) Utilize the Patient Management/Precertification All Products Claim Scripting guidelines as applicable to communicate with Claims for services such as unspecified procedure codes.  
2). Verify plan exclusions and limitations using ASD; and as needed; the Plan Sponsor Tool based upon the member’s plan type; and the member’s Certificate of Coverage (COC) or Summary Plan Description (SPD) using the Benefit Document Locator at: https://www.aetna.com/epublishing/ and following the Benefit Document Locator PST. | Inbound Queue Associate  
Precertification Care Management Associate  
Case Manager  
Utilization Management Nurse Associate  
Utilization Management Nurse Consultant  
Behavioral Health Customer Service Representative |
### COMMERCIAL PLANS

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</table>
| 2. Identify if notification or medical review is required and task for follow-up accordingly (con’t). | a). If plan documents are not available within the Benefit Document Locator, obtain a copy of the plan documents following the process outlined within Microsoft Outlook public folders/all public folders/Aetna/DOL Plan Documents. Refer to “Process for Accessing Plan Documents.” (1). For plan exclusions:  
   a) Pend the coverage request and task the eTUMS case to the appropriate clinical team using the NPL Tasking Tool or Dedicated Unit plan sponsor assignment.  
   (2) For plan limitations:  
   a) Inform the requestor of the benefit terms and provisions as stated in ASD.  
   b) Pend the coverage request and task the eTUMS case to the appropriate clinical team using the NPL Tasking Tool or Dedicated Unit plan sponsor assignment.  
   c) If the coverage request does not clearly exceed benefit limitations, proceed to activity C2b3 of this step of the procedure directly below. | Inbound Queue Associate  
Precertification Care Management Associate  
Case Manager  
Utilization Management Nurse Associate  
Utilization Management Nurse Consultant |

3). Determine if the site of service is inpatient or ambulatory:  
a). For ambulatory services:  
   (1). Authorize the request and provide the caller with the eTUMS reference number.  
   (2). Initiate specialty program referrals as indicated by eTUMS edits.  
b). For inpatient surgical procedures, apply the eTUMS Length of Stay (LOS) table and compare the results with the coverage request.  
   (1). If the requested site of service (inpatient) does not match (e.g., eTUMS estimated length of stay table results = 0 or NF), pend the coverage request and task the eTUMS case to the clinical Precertification Team to complete the precertification process using the NPL Tasking Tool or Dedicated Unit plan sponsor assignment;  
   (2). If the requested site of service (inpatient) matches established criteria (e.g., eTUMS estimated length of stay table results > 0), certify the site of service;  
   (3). If the requested length of stay is equal to or less than the established criteria, certify the length of stay; |

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14 The National Accounts Dedicated Units utilize MCG GLOS or BLOS in place of the eTUMS ELOS table.
### COMMERCIAL PLANS

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<tr>
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</thead>
<tbody>
<tr>
<td>2. Identify if notification or medical review is required and task for follow-up accordingly (con’t).</td>
<td>(4). If the requested length of stay is greater than the established criteria, approve the system generated ELOS and advise the caller that any additional days will be subject to medical review at the time of hospitalization; (5). If multiple procedure codes are submitted with varying eTUMS estimated length of stay table results, assign the lowest ELOS result that is greater than 0; (6). Initiate specialty program referrals as indicated by eTUMS edits; (7). Task all approved inpatient coverage requests not requiring additional clinical precertification review to the appropriate Care Management Team on the day of the receipt of the request using the current date to populate the “Follow up Date” field. Task using the NPL Tasking Tool or Dedicated Unit plan sponsor assignment.</td>
<td>Inbound Queue Associate Precertification Care Management Associate Case Manager Utilization Management Nurse Associate Utilization Management Nurse Consultant</td>
</tr>
<tr>
<td>3. Determine if plan exclusion or limitations apply for coverage requests referred from Precertification intake staff and for procedures/services requiring medical review.</td>
<td>A. Determine if the requested benefit is a plan exclusion, plan carve out, or limitation reviewing the following, as applicable: 1. Utilize ASD; and as needed; the Plan Sponsor Tool based upon the member’s plan type to confirm benefits and, if not done previously, whether the requested services are carved out to another carrier/vendor. a. Refer the requestor to the contact number designated in ASD if the service is a plan carve out. 2. Review the member’s plan documents as needed to confirm benefits using the Benefit Document Locator at: <a href="https://www.aetna.com/epublishing">https://www.aetna.com/epublishing</a> and following the Benefit Document Locator PST. a. If plan documents are not available within the Benefit Document Locator, obtain a copy of the plan documents following the process outlined within Microsoft Outlook public folders/all public folders/Aetna/DOL Plan Documents. Refer to “Process for Accessing Plan Documents.” 3. National Medical Excellence Plan Sponsor Exceptions List. B. Determine if the requested limited benefit is exhausted. 1. Check the eTUMS event history for previous authorizations. 2. Issue an administrative denial if the benefit is specifically excluded or a limited benefit is exhausted under the terms of the plan following (NCM 505-02) National Care Management Denial of Coverage Procedure. a. Proceed to step 6 of this procedure.</td>
<td>Utilization Management Nurse Associate Utilization Management Nurse Consultant Case Manager OMFS Unit Behavioral Health Care Manager</td>
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</table>
## Precertification Procedure

### COMMERCIAL PLANS

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<th>RESPONSIBLE PARTY</th>
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<tbody>
<tr>
<td>4. Gather required information and forward for review.</td>
<td>A. Gather required information (as appropriate) for evaluation by a clinical reviewer within established time frames according to (NCM 504-01) National Care Management Timeliness Standards for Coverage Decisions and Notification Policy.</td>
<td>Precertification Care Management Associate Utilization Management Nurse Associate Utilization Management Nurse Consultant Case Manager OMFS Unit Behavioral Health Care Manager</td>
</tr>
<tr>
<td></td>
<td>1. Utilize the appropriate Fax Back Form when applicable, for medical/surgical precertification coverage requests to request additional information.</td>
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<td>2. Complete and send an eTUMS “Request for Additional Information Letter” to the attending practitioner when the coverage request is incomplete upon receipt.</td>
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<tr>
<td>5. Conduct clinical review.</td>
<td>A. Conduct clinical review for:</td>
<td>Utilization Management Nurse Associate Utilization Management Nurse Consultant Case Manager Care Manager OMFS Unit Behavioral Health Care Manager</td>
</tr>
<tr>
<td></td>
<td>1. Inpatient procedures/services pended for site of service match with established criteria;</td>
<td></td>
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<td></td>
<td>2. Inpatient procedures/services pended for length of stay greater than established criteria;</td>
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<td></td>
<td>3. Ambulatory procedures/services requiring a clinical coverage determination;</td>
<td></td>
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<tr>
<td></td>
<td>4. Coverage requests involving multiple procedures/services when at least one (1) code is included on the Aetna Participating Provider Precertification List with Codes or is a member precertification requirement;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. National Precertification staff utilizes the ACAS AST Clinical Workflow to determine review requirements for codes identified by the AST as potentially experimental, investigational, cosmetic, or non-efficacious.</td>
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<td></td>
<td>b. Care Management staff alternatively utilizes Aetna Clinical Policy Bulletins to conduct clinical review for codes not included on a Precertification List when accompanied by a code requiring medical review.</td>
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<td></td>
<td>5. Pharmacy injectables requiring pre-certification;</td>
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<td>6. Procedures and services listed on the Aetna Behavioral Health Precertification List.</td>
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<td>B. Refer the following coverage requests (as applicable) to an Aetna physician Medical Director, dentist (Oral and Maxillofacial Surgeon), psychiatrist or psychologist for review:</td>
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</table>
# Commercial Plans

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<tr>
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<tbody>
<tr>
<td>5. Conduct clinical review (con’t).</td>
<td>1. Requests unable to be certified based on coverage criteria/guidelines; and, &lt;br&gt; 2. Requests for medical/surgical services listed on the <a href="#">Aetna Participating Provider Precertification List with Codes</a> as always requiring Medical Director review.</td>
<td>Utilization Management Nurse Associate&lt;br&gt; Utilization Management Nurse Consultant&lt;br&gt; Case Manager&lt;br&gt; Care Manager&lt;br&gt; OMFS Unit&lt;br&gt; Behavioral Health Care Manager</td>
</tr>
<tr>
<td></td>
<td>C. Update eTUMS with the coverage determination following the <a href="#">eTUMS PST</a>.&lt;br&gt; 1. Enter the actual date of service if included with the coverage request or enter a place holder date six (6) months from the date of the decision (or, for OMFS procedures/services a place holder date twenty four [24] months from the date of the decision).&lt;br&gt; a. For approvals, inform the requestor to notify Aetna of the actual date of service once confirmed, as appropriate.</td>
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<td></td>
<td>D. Task approved inpatient medical/surgical eTUMS events to the Care Team on the date of the decision using the <a href="#">NPL Tasking Tool</a> or Dedicated Unit plan sponsor assignment.</td>
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<tr>
<td>6. Communicate determination.</td>
<td>A. Provide verbal/written notification of the coverage decision following (<a href="#">NCM 503-02</a> National Care Management Medical Review Procedure).&lt;br&gt; 1. Send an approval letter for all approved bariatric surgery coverage requests.&lt;br&gt; 2. Notify the provider verbally and/or in writing according to the time frames established in (<a href="#">NCM 504-01</a> National Care Management Timeliness Standards for Coverage Decisions and Notification Policy Attachment A).&lt;br&gt; 3. For coverage approvals, notify the practitioner of the preferred vendor or preferred alternate setting as appropriate.&lt;br&gt; a. Document provider notification in the eTUMS event note.</td>
<td>Inbound Queue Associate&lt;br&gt; Care Management Associate&lt;br&gt; OMFS Unit&lt;br&gt; Case Manager&lt;br&gt; Utilization Management Nurse Associate&lt;br&gt; Utilization Management Nurse Consultant&lt;br&gt; Behavioral Health Care Manager</td>
</tr>
<tr>
<td></td>
<td>B. Update eTUMS following the <a href="#">eTUMS PST</a>.&lt;br&gt; 1. Task all approved and denied requests for injectable drugs to “Pharmacy Eligibility Medical Auth” Group List after the case is closed.</td>
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16 Note: Utilize the experimental/investigational plan language (along with the clinical denial reason identified by the Medical Director) through selection of the experimental/investigational eTUMS Informational Remark when issuing a written denial of coverage determination for coverage requests determined to be experimental/investigational by the Medical Director. Do not utilize the medical necessity Informational Remark for experimental/investigational coverage determinations.
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<th>COMMERCIAL PLANS</th>
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<tbody>
<tr>
<td>STEPS</td>
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<tr>
<td>7. Review for appropriateness of referral to Aetna Health Connections specialty programs (e.g., Case Management, Disease Management, Behavioral Health).</td>
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_April 2011 For Aetna Use Only_
# Precertification Procedure

**Medicare Advantage Plans**

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<tr>
<th>STEPS</th>
<th>ACTIVITIES</th>
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</table>
| 1. Receive request for coverage. | A. Determine the provider’s status (participating vs non-participating) utilizing Aetna Strategic Desktop (ASD) through either the “Provider View”, Provider Search screen or the “Member View”, Find Provider tab.  
   1. For oral surgery coverage requests, confirm the provider status under the medical plan rather than under the dental plan. **Note**: Include consideration of the Oral Surgery Referral Waiver policy.  
   B. Review the coverage request to determine whether precertification is required and proceed accordingly.  
   1. For behavioral health services:  
      a. Validate precertification requirements by consulting the Aetna Behavioral Health Precertification List and the Plan Sponsor Tool to identify member precertification requirements.  
      1). If precertification is not required:  
         a). Notify the requestor that precertification is not required and determine whether the call is an inquiry or a request for coverage utilizing the How to Determine Member Precertification Requirements Medicare scripting.  
         (1). For inquiries:  
            (a). Document the call with response in eTUMS Member Notes or alternatively, within ASD Contact Event Notes.  
            (2). For coverage requests, proceed to step 2 of this procedure.  
      2). If precertification is required:  
         a). For inpatient coverage requests:  
            (1). Verify whether the member has already been discharged.  
            (a). If no, proceed to activity B1a2a)(2) of this step of the procedure.  
            (b). If yes, verify the discharge date and consider the request based upon a comparison with the admission notification date.  
            i. If notification is within three (3) business days of the discharge, the inpatient stay was less than seven (7) days and the facility has the clinical information available at the time of the notification:  
               i). Proceed to activity B1a2a)(2) of this step of the procedure.  
            ii. If any of the conditions within activity B1a2a)(1)(b)i of this step are not met, notify the requestor to submit the claim and the appropriate medical records. | Inbound Queue Associate  
Precertification Care Management Associate  
Case Manager  
Utilization Management Nurse Associate  
Utilization Management Nurse Consultant  
Behavioral Health Customer Service Representative |
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<th>STEPS</th>
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<tbody>
<tr>
<td>1. Receive request for coverage (con’t).</td>
<td>i). Document the call and the response in the eTUMS Member Notes tab or alternatively, within ASD Contact Event Notes. (2). Review the eTUMS Event History tab for a previous inpatient event with a documented discharge within one (1) calendar day of the admission. (a). If an eTUMS inpatient event is located: i. Review the last eTUMS event note for documentation of “DRG hospitalization.” (i). Follow the DRG Readmissions workflow if the documentation is present. (ii). Proceed to step 2 of this procedure if the documentation is not present. (b). If an eTUMS inpatient event is not located: i. Proceed to step 2 of this procedure. b). For ambulatory coverage requests: (1). Proceed to step 2 of this procedure.</td>
<td>Inbound Queue Associate Precertification Care Management Associate Case Manager Utilization Management Nurse Associate Utilization Management Nurse Consultant Behavioral Health Customer Service Representative</td>
</tr>
<tr>
<td>2. For medical/surgical services:</td>
<td>a. Validate precertification requirements following the How to Determine Member Precertification Requirements workflow. 1). If precertification is not required: a). Notify the requestor that precertification is not required and determine whether the call is an inquiry or a request for coverage utilizing the How to Determine Member Precertification Requirements Medicare scripting. (1). For inquiries: (a). Document the call with response in eTUMS Member Notes or alternatively, within ASD Contact Event Notes. (b). Follow the Requests for Case Management workflow when the coverage request is accompanied by a request for case management. (2). For coverage requests, proceed to step 2 of this procedure. 2). If precertification is required: a). Review the member’s eTUMS event history for a previously denied precertification coverage request that includes the same ICD-9 and/or CPT codes.</td>
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### Medicare Advantage Plans

<table>
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<tr>
<th>Steps</th>
<th>Activities</th>
<th>Responsible Party</th>
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</table>
| 1. Receive request for coverage (cont). | (1). If a denial determination is located, follow the Additional Clinical Received following an Adverse Determination workflow.  
(2). If a denial determination is not located:  
(a). For inpatient coverage requests:  
   i. Verify whether the member has already been discharged.  
      i). If no, follow activities B1a2)a)(2)(a) or (b) of this procedure as appropriate.  
      ii). If yes, verify the discharge date and consider the request based upon a comparison with the admission notification date.  
         i. If notification is within two (2) business days of the actual day of admission (e.g., member admitted on Friday, discharged on Sunday, and notification received by Aetna on Monday):  
            i). Follow activities B1a2)a)(2)(a) or (b) of this procedure as appropriate.  
            ii). If notification is greater than two (2) business days from the date of the actual admission, notify the requestor to submit the claim and the appropriate medical records.  
               i). Document the call and the response in the eTUMS Member Notes tab or alternatively, within ASD Contact Event Notes.  
(b). For ambulatory coverage requests:  
   i. Proceed to step 2 of this procedure. | Inbound Queue Associate  
Precertification Care Management Associate  
Case Manager Utilization Management Nurse Consultant  
Behavioral Health Customer Service Representative |
| 2. Identify if notification or medical review is required and task for follow-up accordingly. | A. Initiate an eTUMS event following the eTUMS PST.  
**Note:** When the caller has specifically requested an expedited (fast) time frame, complete the Service Request Tab with "Expedited Req Provider" or "Expedited Req Member", as appropriate.  
1. Enter an initial place holder date (i.e., 12/31/2099) as the date of service if the coverage request does not include an actual date.  
B. Request information about other insurance coverage, document response, and initiate COB verification request (when applicable) following (NCM 509-02) National Care Management Coordination of Benefits Procedure. | Inbound Queue Associate  
Behavioral Health Customer Service Representative  
Case Manager (con’t next page) |
### MEDICARE ADVANTAGE PLANS

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<tbody>
<tr>
<td>2. Identify if notification or medical review is required and task for follow-up accordingly (con’t).</td>
<td>C. Determine if the coverage request requires “medical review” (clinical coverage determination required) or “notification” (data entry).</td>
<td>Precertification Care Management Associate</td>
</tr>
<tr>
<td></td>
<td>1. For behavioral health services:</td>
<td>Utilization Management Nurse Associate</td>
</tr>
<tr>
<td></td>
<td>a. Pend the coverage request and task the eTUMS case to the appropriate clinical team.</td>
<td>Utilization Management Nurse Consultant</td>
</tr>
<tr>
<td></td>
<td>b. The Behavioral Health Care Manager proceeds to step 3 of this procedure.</td>
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<tr>
<td></td>
<td>2. For medical/surgical services not listed on the Aetna Participating Provider Precertification List with Codes:</td>
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<tr>
<td></td>
<td>a. Pend the coverage request and task the eTUMS case to the appropriate regional Medicare Unit.</td>
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<td></td>
<td>3. For medical/surgical services listed on the Aetna Participating Provider Precertification List with Codes:</td>
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</tr>
<tr>
<td></td>
<td>a. If medical review is required:</td>
<td></td>
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<tr>
<td></td>
<td>1). Pend the coverage request and task the eTUMS case to the appropriate clinical team using the NPL Tasking Tool in order to complete the remainder of the precertification process.</td>
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<tr>
<td></td>
<td>b. If notification only is required, perform the following:</td>
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<tr>
<td></td>
<td>1). Complete eTUMS documentation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a). Enter the actual date of service if included with the coverage request or a place holder date six months from the date of the eTUMS data entry if not previously documented.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(1) Inform the requestor to notify Aetna of the actual date of service once confirmed, as applicable.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b). Utilize the Patient Management/Precertification All Products Claim Scripting guidelines as applicable to communicate with Claims for services such as unspecified procedure codes.</td>
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<tr>
<td></td>
<td>2). Verify plan exclusions and limitations using and as needed; the Medicare Advantage Plan Sponsor Tool (for Medicare Advantage group plan members only); and the member’s plan documents.</td>
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<tr>
<td></td>
<td>a). Review ASD or the eTUMS Demographics tab to determine if the member is enrolled in a Medicare Advantage group or individual plan.</td>
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<tr>
<td></td>
<td>(1). For group plan members:</td>
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### MEDICARE ADVANTAGE PLANS

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</table>
| 2. Identify if notification or medical review is required and task for follow-up accordingly (con’t). | (a). Obtain a copy of the plan documents using the Benefit Document Locator at: https://www.aetna.com/epublishing and following the Benefit Document Locator PST for coverage requests not clearly addressed in ASD or the Medicare Plan Sponsor Tool.  
   i. If plan documents are not available within the Benefit Document Locator, obtain a copy of the plan documents following the process outlined within the Microsoft Outlook public folders/all public folders/Aetna/DOL Plan Documents. Refer to “Process for Accessing Plan Documents.”  
   (2). For individual plan members:  
      (a). Access the current year EOC (evidence of coverage) and SOB (summary of benefits) at www.aetnamedicare.com.  
      (b). Select “Help and Resources” and then “Downloadable Forms.”  
   b). For plan exclusions:  
      (1) Pend the coverage request and task the eTUMS case to the appropriate clinical team using the NPL Tasking Tool.  
   c). For plan limitations:  
      (1). Inform the requestor of the benefit terms and provisions as stated in ASD.  
      (2). Pend the coverage request and task the eTUMS case to the appropriate clinical team using the NPL Tasking Tool.  
      (3). If the coverage request does not clearly exceed benefit limitations, proceed to activity C3b3) of this step of the procedure. | Inbound Queue Associate  
Precertification Care Management Associate  
Case Manager  
Utilization Management Nurse Associate  
Utilization Management Nurse Consultant |
| 3). Determine if the site of service is inpatient or ambulatory: | a). For ambulatory services:  
   (1) Authorize the request and provide the caller with the eTUMS reference number.  
   (2) Initiate specialty program referrals as indicated by eTUMS edits.  
   b). For inpatient surgical procedures, apply the eTUMS Length of Stay (LOS) table and compare the results with the coverage request. |
## MEDICARE ADVANTAGE PLANS

<table>
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<tr>
<th>STEPS</th>
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<tbody>
<tr>
<td>2. Identify if notification or medical review is required and task for follow-up accordingly (con’t).</td>
<td>(1). If the requested site of service (inpatient) does not match (e.g., eTUMS estimated length of stay table results = 0 or NF), pend the coverage request and task the eTUMS case using the NPL Tasking Tool to complete the precertification process;</td>
<td>Inbound Queue Associate</td>
</tr>
<tr>
<td></td>
<td>(2). If the requested site of service (inpatient) matches established criteria (e.g., eTUMS estimated length of stay table results &gt; 0), certify the site of service;</td>
<td>Precertification Care Management Associate</td>
</tr>
<tr>
<td></td>
<td>(3). If the requested length of stay is equal to or less than the established criteria, certify the length of stay;</td>
<td>Case Manager</td>
</tr>
<tr>
<td></td>
<td>(4). If the requested length of stay is greater than the established criteria, approve the system generated ELOS and advise the caller that any additional days will be subject to medical review at the time of hospitalization;</td>
<td>Utilization Management Nurse Associate</td>
</tr>
<tr>
<td></td>
<td>(5). If multiple procedure codes are submitted with varying eTUMS estimated length of stay table results, assign the lowest ELOS result that is greater than 0;</td>
<td>Utilization Management Nurse Consultant</td>
</tr>
<tr>
<td></td>
<td>(6). Initiate specialty program referrals as indicated by eTUMS edits;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(7). Task all approved inpatient coverage requests not requiring additional clinical precertification review to the appropriate Care Management Team on the day of the receipt of the request using the current date to populate the “Follow up Date” field using the NPL Tasking Tool.</td>
<td></td>
</tr>
<tr>
<td>3. Determine if plan exclusion or limitations apply for coverage requests referred from the Precertification intake staff and for procedures/services requiring medical review.</td>
<td>A. Determine if the requested benefit is a plan exclusion, plan carve out, or limitation reviewing the following, as applicable:</td>
<td>Case Manager</td>
</tr>
<tr>
<td></td>
<td>1. Review ASD or the eTUMS Demographics tab to determine if the member is enrolled in a Medicare Advantage group or individual plan.</td>
<td>Utilization Management Nurse Associate</td>
</tr>
<tr>
<td></td>
<td>2. Utilize ASD; and as needed; the Medicare Advantage Plan Sponsor Tool (for Medicare Advantage group plan members only); to confirm benefits and, if not done previously, whether the requested services are carved out to another carrier/vendor.</td>
<td>Utilization Management Nurse Consultant</td>
</tr>
<tr>
<td></td>
<td>a. Refer the requestor to the contact number designated in ASD if the service is a plan carve out.</td>
<td>Behavioral Health Care Manager</td>
</tr>
<tr>
<td></td>
<td>3. Review the member’s plan documents as needed to confirm benefits:</td>
<td>OMFS Unit</td>
</tr>
<tr>
<td></td>
<td>a. For group plan members:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1). Obtain a copy of the plan documents using the Benefit Document Locator at: <a href="https://www.aetna.com/epublishing">https://www.aetna.com/epublishing</a> and following the Benefit Document Locator PST for coverage requests not clearly addressed in ASD or the Medicare Plan Sponsor Tool.</td>
<td></td>
</tr>
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Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
### MEDICARE ADVANTAGE PLANS

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| 3. Determine if plan exclusion or limitations apply for coverage requests referred from the Precertification intake staff and for procedures/services requiring medical review (con't). | a). If plan documents are not available within the Benefit Document Locator, obtain a copy of the plan documents following the process outlined within the Microsoft Outlook public folders/all public folders/Aetna/DOL Plan Documents. Refer to "Process for Accessing Plan Documents."  
   b. For individual plan members:  
      1). Access the current year EOC (evidence of coverage) and SOB (summary of benefits) at www.aetnamedicare.com.  
      a). Select “Help and Resources” and then "Downloadable Forms."  
| Case Manager  
Utilization Management  
Nurse Associate  
Utilization Management  
Nurse Consultant  
Behavioral Health Care Manager  
OMFS Unit |
| B. Determine if the requested limited benefit is exhausted. |  
1. Check the eTUMS event history for previous authorizations and/or, check the ASD claim inquiry for claim history.  
2. Issue an administrative denial, using the eTUMS Independent Letter System “Notice of Denial of Medical Coverage (NDMC)”, if the benefit is specifically excluded or a limited benefit is exhausted under the terms of the plan following (NCM 505-02) National Care Management Denial of Coverage Procedure.  
   a. Proceed to step 6 of this procedure.  
|  
| C. Review the information submitted with the coverage request to determine if additional information is required. |  
1. If additional information is not required, proceed to step 5 of this procedure.  
2. If additional information is required, proceed to step 4 of this procedure.  
|  
| 4. Gather required information. | A. Determine what additional information is required for review and provide notification within established time frames following (NCM 504-01) National Care Management Timeliness Standards for Coverage Decisions and Notification Policy Attachment B.  
1. Verbally notify the provider that additional information is being requested, including the submission deadline.  
2. Issue written notification to the member and provider, within 24 hours of receipt of the request for an expedited organization determination or within five (5) calendar days of receipt of the request, for a standard organization determination utilizing one of the following Medicare eTUMS Independent Letter System (ILS) letters:  
   a. 14 Day Extension for Expedited Init Determination (for expedited coverage requests).  
   b. 14 Day Extension for Std Initial Determination (for all other coverage requests).  
| Case Manager  
Utilization Management  
Nurse Associate  
Utilization Management  
Nurse Consultant  
Behavioral Health Care Manager  
OMFS Unit |
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<tr>
<td>4. Gather required information (con’t)</td>
<td>3. Pend the coverage request and task the eTUMS case to self for follow-up, using ten (10) calendar days from the date of written notification in the “Follow up Date” field.</td>
<td>Case Manager Utility Management Nurse Associate</td>
</tr>
<tr>
<td></td>
<td>B. Review the coverage request within the allotted time frame for decision making to determine whether the required documentation was submitted.</td>
<td>Utilization Management Nurse Consultant</td>
</tr>
<tr>
<td></td>
<td>1. Upon receipt of additional information, or if no additional information is received within the allotted time frame for decision making, proceed to step 5 of this procedure.</td>
<td>Behavioral Health Care Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OMFS Unit</td>
</tr>
<tr>
<td>5. Conduct clinical review.</td>
<td>A. Conduct clinical review for:</td>
<td>Case Manager Utility Management Nurse Associate</td>
</tr>
<tr>
<td></td>
<td>1. Inpatient procedures/services pended for site of service match with established criteria;</td>
<td>Utilization Management Nurse Consultant</td>
</tr>
<tr>
<td></td>
<td>2. Inpatient procedures/services pended for length of stay greater than established criteria;</td>
<td>Behavioral Health Care Manager</td>
</tr>
<tr>
<td></td>
<td>3. Ambulatory procedures/services requiring a clinical coverage determination;</td>
<td>OMFS Unit</td>
</tr>
<tr>
<td></td>
<td>4. Coverage requests involving multiple procedures/services when at least one (1) code is included on the Aetna Participating Provider Precertification List with Codes;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. National Precertification staff and Care Management staff utilize Aetna Clinical Policy Bulletins as a clinical resource for codes not included on a Precertification List in the absence of Medicare coverage criteria.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Pharmacy injectables requiring pre-certification;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Procedures and services listed on the Aetna Behavioral Health Precertification List;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Coverage requests for procedures and services not listed above in activities A1-6 of this step of the procedure.</td>
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</tr>
<tr>
<td></td>
<td>B. Refer the following coverage requests (as applicable) to an Aetna physician Medical Director, dentist (Oral and Maxillofacial Surgeon), psychiatrist or psychologist17 for review:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Requests unable to be certified based on coverage criteria/guidelines; and,</td>
<td></td>
</tr>
</tbody>
</table>

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17 A licensed psychologist reviews coverage requests that are within the psychologist’s scope of practice and for which the psychologist’s clinical experience provides sufficient experience to review the request. A licensed psychologist does not review coverage requests for inpatient care or prescription medications unless state regulations permit.
### Medicare Advantage Plans

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<tbody>
<tr>
<td>5. Conduct clinical review (con't).</td>
<td>2. Requests for medical/surgical services listed on the <a href="#">Aetna Participating Provider Precertification List with Codes</a> as always requiring Medical Director review.</td>
<td>Utilization Management Nurse Associate</td>
</tr>
<tr>
<td></td>
<td>C. Update eTUMS with the coverage determination following the <a href="#">eTUMS PST</a>.</td>
<td>Utilization Management Nurse Consultant</td>
</tr>
<tr>
<td></td>
<td>1. Enter the actual date of service if included with the coverage request or enter a place holder date six (6) months from the date of the decision (or, for OMFS procedures/services a place holder date twenty four [24] months from the date of the decision).</td>
<td>Behavioral Health Care Manager</td>
</tr>
<tr>
<td></td>
<td>a. For approvals, inform the requestor to notify Aetna of the actual date of service once confirmed, as appropriate.</td>
<td>Behavioral Health Care Manager OMFS Unit</td>
</tr>
<tr>
<td></td>
<td>D. Task approved inpatient medical/surgical eTUMS events to the Care Team on the date of the decision using the <a href="#">NPL Tasking Tool</a>.</td>
<td></td>
</tr>
<tr>
<td>6. Communicate determination.</td>
<td>A. Provide verbal/written notification of the coverage decision.</td>
<td>Inbound Queue Associate</td>
</tr>
<tr>
<td></td>
<td>1. Send an approval letter for all approved bariatric surgery coverage requests.</td>
<td>Precertification Care Management Associate</td>
</tr>
<tr>
<td></td>
<td>2. Notify the member/provider verbally and/or in writing according to the time frames established in (NCM 504-01) National Care Management Timeliness Standards for Coverage Decisions and Notification Policy Attachment B.</td>
<td>OMFS Unit</td>
</tr>
<tr>
<td></td>
<td>3. For coverage approvals, notify the practitioner of the preferred vendor or preferred alternate setting as appropriate.</td>
<td>Case Manager</td>
</tr>
<tr>
<td></td>
<td>a. Document provider notification in the eTUMS event note.</td>
<td>Behavioral Health Care Manager</td>
</tr>
<tr>
<td></td>
<td>B Update eTUMS following the <a href="#">eTUMS PST</a>.</td>
<td>Utilization Management Nurse Associate</td>
</tr>
<tr>
<td></td>
<td>1. Task all approved and denied requests for injectable drugs to “Pharmacy Eligibility Medical Auth” Group List after the case is closed.</td>
<td>Utilization Management Nurse Consultant</td>
</tr>
</tbody>
</table>

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18 Note: Utilize the experimental/investigational plan language (along with the clinical denial reason identified by the Medical Director) through selection of the experimental/investigational eTUMS Informational Remark when issuing a written denial of coverage determination for coverage requests determined to be experimental/investigational by the Medical Director. Do not utilize the medical necessity Informational Remark for experimental/investigational coverage determinations.
### MEDICARE ADVANTAGE PLANS

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<tr>
<td>7. Review for appropriateness of referral to Aetna Health Connections specialty programs (e.g., Case Management, Disease Management, Behavioral Health).</td>
<td>A. Refer eligible members to appropriate specialty programs (as applicable) if a specialty program trigger is met, following the <a href="#">Aetna Medical Management Integration PST</a>.</td>
<td>Precertification Care Management Associate Case Manager Utilization Management Nurse Associate Utilization Management Nurse Consultant Behavioral Health Care Manager</td>
</tr>
</tbody>
</table>

**Adoption:**

**National Quality Oversight Committee Review/Adoption Date:** 05/24/2011

[Signature]

Leonard J Harvey, MD
National Quality Oversight Committee Chairperson

**Aetna Behavioral Health Quality Oversight Committee Review/Adoption Date:** 05/23/2011

[Signature]

Avivah S. Goldman, MSN, MA
Aetna Behavioral Health Quality Oversight Committee Chairperson

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April 2011  
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