Provider Disclosure Form

Participating Providers Doing Business with Aetna in California

This statement contains information regarding certain notice requirements, Claim Settlement procedures, the Provider Dispute Resolution process, and Aetna Payment Policies.

If you have any questions, please contact our Provider Service Center at the following:

For Medicare HMO plans only: **1-800-624-0756**;

For all other plans (PPO and Commercial HMO plans): **1-888- MD-Aetna (632-3862)**;

Or visit the Aetna website at **www.aetna.com**.

NOTICE

Special notice for providers not accepting new patients. What to do if you're contacted by a member or potential member

If you're not accepting new patients, but are contacted by a member or a potential member who wants to become a new patient, you must tell them to contact:

- Aetna at **1-800-325-6541** for help; **and**
- The California Department of Managed Health Care at **1-888-466-2219**, or the California Department of Insurance at **1-800-927-4357**, as applicable, to report any inaccuracy with Aetna's provider directory.

CLAIM SETTLEMENTS

Clean Claim

A clean claim submitted on paper or on its electronic equivalent must be on a CMS-1500 form or a UB-04 form and must include all information and attachments listed. A claim will not be a clean claim if it is missing any of the information or attachments specified below.

Electronic Claims

An electronic claim is a HIPAA-compliant electronic submission equivalent to the UB-04 (for institutional providers), the CMS-1500 (for physicians and other professional providers), or any other format adopted by the National Uniform Billing Committee (NUBC) or National Uniform Claim Committee (NUCC) that includes all relevant information.

To submit claims electronically, please contact your Practice Management System vendor and determine whether the vendor can send claims electronically to Aetna. If you do not have a Practice Management System vendor, or if that vendor cannot accommodate the request, then please contact one of Aetna's clearinghouse vendors listed at **www.aetna.com**.

From the menu bar, click "Providers," hover over "Working with us" then click on "Claims, payment & reimbursement." On the following page, scroll to "Electronic transaction tools" then click on "Look up electronic transaction vendors."

Electronic Transaction Vendors

For information on Aetna's electronic vendors, visit **www.aetna.com**.

From the menu bar, select click "Providers," hover over "Working with us" then click on "Claims, payment & reimbursement." On the following page, scroll to "Electronic transaction tools" then click on "Look up electronic transaction vendors."

Paper Claims – HMO & PPO Products – Mail claims to:

Aetna
P.O. Box 14079
Lexington, KY 40512-4079

Claims Inquiries – To confirm the recorded date of claims receipt or to make other inquiries about claims, you may inquire electronically using your preferred electronic claim status vendor. Or you may call Aetna at **1-800-624-0756 for Medicare HMO Products** / **1-888-MD-Aetna (632-3862) for All Other Products** or contact your clearinghouse vendor.

CMS-1500 Form

Required Data Elements, Clean Claim Elements, and Attachments for Emergency Services and Care Providers, Physicians and Other Professional Providers

The Form CMS-1500 is the standard claim form used by health care professionals and suppliers. The (NUCC) maintains the Form CMS-1500.

A sample copy of the CMS-1500 Form is available for review at:

http://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2019_07-v7.pdf

A clean claim submitted on paper or on its electronic equivalent must be on a CMS-1500 form and must include all information and attachments listed. A claim will not be a clean claim if it is missing any of the information or attachments below.

1. Insured's I.D Number	2. Patient's Name		
3. Insured's Name			
4. Patient's Street Address or P.O Box			
4a. City		4b. State	4c. ZIP Code
8. Patient's Relationship to Insured			
9. Insured's Address or P.O. Box			
9a. City		9b. State	9c. ZIP Code
10. Reserved for NUCC Use			
11. Other Insured's Name *(If the provider does not have the cap ability to submit this information electronically, then Aetna requires the billing entity to attach an Explanation of Benefits form from the additional payer.)*			
12. Insurance Plan Name or Program Name			
13. Is Patient's Condition Related To:			
13a. Employment ☐ Yes ☐ No	13.b Auto Accident ☐ Yes ☐ No	13c. State	13d. Other Accident
14. Insured's Policy, Group, or FECA Number	15. Insured's Date of Birth (MM/DD/YYYY) / /		16. Insured's Sex
17. Insurance Plan Name or Program Name	18. Is there another Health Benefit Plan?		
19. Insured's or Authorized Person's Signature			
20. Date of Current Illness, Injury, or Pregnancy (LMP) (MM/DD/YYYY) and defined QUALIFIER code *This field is required when the Emergency indicator is 'Y' (Box 27). This is the date of first symptoms of illness or injury. It may be either prior to or on the current date of service.* / /			
21. Other Date and defined QUALIFIER code (MM/DD/YYYY) / /			
22. Name of Referring Provider or Other Source and defined QUALIFIER code			
23. Hospitalization Dates Related to Current Services *Required for inpatient claims. Must be a valid date and may not be greater than the current billing date.* / / / /			
/ / / /			

CMS-15000 Form continued the next page.

CMS-1500 Form

24. Diagnosis or Nature of Illness or Injury ☐ 9 ICD-9-CM ☐ 0 ICD-10-CM			
24a. Diagnosis code	24b. Diagnosis code	24c. Diagnosis code	24d. Diagnosis code
24e. Diagnosis code	24f. Diagnosis code	24g. Diagnosis code	24h. Diagnosis code
24i. Diagnosis code	24j. Diagnosis code	24k. Diagnosis code	24l. Diagnosis code

25. Date(s) of Service [lines 1–6]	26. Place of Service [lines 1–6]	27. EMG [lines 1–6]	28. Procedures, Services, or Supplies [lines 1–6]
1. / / 2. / / 3. / / 4. / / 5. / / 6. / / *This field must meet standard date edit and must not be greater than the current date. (MM/DD/YYYY)*	1. 2. 3. 4. 5. 6.	1. 2. 3. 4. 5. 6.	1. 2. 3. 4. 5. 6. *CPT Code(s), HCPC Code(s) any Appropriate Modifiers and Anesthesia Time (in minutes)*

29. Diagnosis Pointer [lines 1–6]	30. Charges $ [lines 1–6]	31. Days or Units [lines 1–6]	32. Rendering Provider ID # [lines 1–6]
1. 2. 3. 4. 5. 6.	1. 2. 3. 4. 5. 6.	1. 2. 3. 4. 5. 6.	1. 2. 3. 4. 5. 6.

33. Federal Tax ID Number	
34. Total Charge	35. Amount Paid *The total amount the patient and/or other payers paid on the covered services only.*
36. Reserved for NUCC Use	
37. Signature of Physician or Supplier	
38. Service Facility Location Information	

39. Billing Provider Info		
39a. Provider Billing Name	39b. Address	39c. Phone Number

40. Remarks

The Remarks field is designed for use in those limited situations where Aetna requires supplementary data, that is, data in addition to the information entered in the Boxes identified above. Note: The electronic definition of this field is established by vendors and may vary.

Additional information for the CMS 1500 form is available at the **CMS.gov** website, please use the link provided to access:

In order for a claim to be a clean claim, the following additional documents are required.

1. Modifiers

There are situations in which a claim must be submitted using a CPT modifier. The use of modifiers can indicate an unusual event occurred or that the procedure or service was altered in some way. When billing with certain CPT modifiers you must provide a complete description of the service performed including supporting documentation such as operative report, or anesthesia notes. Relevant information should include adequate description of the nature and events that occurred during the procedure or at the time of service.

Modifier-22 - Unusual Procedural Service
Submit complete description of the procedure including operative report

Modifier-23 - Unusual Anesthesia
Submit complete description of the procedure including operative report and anesthesia notes Aetna Modifier policies are available to all providers for review and reference in **Availity**, a secure external vendor for healthcare networking and communications. Visit **Availity.com** to register and log-in.

2. All Unlisted/Unspecified Codes

Include a complete written description of the procedure and written report for all unlisted/unspecified codes. See the requirements below for the following specific codes.

All Unlisted Anesthesia Codes / All Unlisted Surgical Procedures / All Unlisted Laboratory Procedures
For example: CPT 01999-Unlisted anesthesia procedure or CPT 19499-Unlisted procedure, breast or CPT 84999-Unlisted chemistry procedure Submit complete description of the procedure including operative report.

All Unlisted Radiology/Imaging Procedures
For example: CPT 78799-Unlisted genitourinary procedure, diagnostic nuclear medicine Submit complete description of the procedure including imaging report

All Unlisted Medical Procedures & Supplies
For example: CPT 93799-Unlisted cardiovascular service or procedure; CPT 99070-Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided). Submit complete description of procedure including office notes and report.

All Unclassified Drug Codes
For example: HCPCS J3490-Unlisted drugs State the NDC code, name of drug, manufacturer's name, dose, number of doses and number of doses administered. Submit complete description of the service including itemized invoice.

All Other Unlisted, Non-specific HCPCS Codes
For example: HCPCS A0999-Unlisted ambulance service or HCPC E1399-Durable medical equipment, miscellaneous or HCPC A4649-Surgical supply, miscellaneous. Submit complete description of the service, including itemized invoice.

All Non-specific ICD-10 Codes
For Example: ICD-10 R94.8 Abnormal results of function studies of organs and systems. Submit complete description of the diagnosis, including office notes and history and physical

3. Coordination of Benefits (COB)

If indicating "yes" to Other Insured's Name in Box 11, the other carrier's payment and allowed amount must be submitted in the HIPAA 837 format **or** attached to the claim.

Precertification
Precertification occurs before inpatient admissions and select ambulatory procedures and services. Use our online tools to help you determine if precertification is required for a particular procedure. Then, submit precertification requests for those services.
Precertification Code Search tool - allows you to enter up to five Current Procedural Terminology (CPT®) codes at a time to determine whether a medical precertification is required for your patient.
Online Precertification transaction - allows you to add a precertification request for those services that require it and inquire to see if a precertification has been approved.
You can submit a precertification by electronic data interchange (EDI), through our provider website or by phone, using the number on the member's ID card. Based on historical experience, we may sometimes allow particular providers to follow a streamlined precertification process for certain services.
Visit our website for more information on precertification procedures and Coverage Policy Bulletins at http://aetna.com/health-care-professionals/precertification.html

eviCore Healthcare (formerly **MedSolutions**) is Aetna's preferred national vendor that reviews preauthorization requests for services for Aetna members who live in and/or receive covered services in states/markets that have the Enhanced Clinical Review (ECR) Program implemented.

Providers can contact eviCore healthcare to register for their online portal at: **https://www.evicore.com/.**

Enhanced Clinical Review Program
Note: This program is currently only applicable to Commercial PPO and Medicare plans in California. For HMO-based plans, physicians affiliated with a Medical Group/IPA should follow the precertification and ordering process for services established by their Medical Group/IPA.

Aetna has implemented the Enhanced Clinical Review Program (ECR) as a comprehensive approach to both quality and utilization management for a variety of services including high tech radiology services – magnetic resonance imaging (MRI)/magnetic resonance angiogram (MRA), computed tomography (CT)/computed tomography angiogram (CTA), positron emission tomography (PET) scans, nuclear cardiology, outpatient stress echocardiography, diagnostic left heart catheterization, and diagnostic right heart catheterization, preauthorization of cardiac rhythm implantable procedures/devices, attended sleep studies performed in a healthcare facility, interventional pain management, musculoskeletal (large joint hip and knee arthroplasties), Radiation therapy: complex and 3D conformal, stereotactic radiosurgery (SRS), stereotactic body radiation therapy (SBRT), brachytherapy, hyperthermia, intensity-modulated radiation therapy (IMRT), image-guided radiation therapy (IGRT), proton beam therapy, neutron beam therapy and radiopharmaceuticals.

Aetna's ECR vendors, **CareCore** National (CCN) and **MedSolutions**, Inc. (MSI), have rebranded to become **eviCore healthcare**. Providers can click on the vendor name links for additional information and overview tutorials.

UB-04 Form

Required Data Elements, Clean Claim Elements, and Attachments for Institutional Providers and Emergency Services and Care Providers

The UB-04, also known as the Form CMS-1450, is the uniform institutional provider claim form suitable for use in billing multiple third-party payers. The 837 Institutional electronic claim format is the electronic version of the form and is in use by providers who submit claims electronically.

A Fact Sheet containing information for electronic & paper UB-04 submissions and Education & Learning tools is available at the CMS.gov website; please use the link to access:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf.

A sample copy of the UB-04 form including field descriptions is available at the CMS.gov website; please use the link to access:

http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms Items/CMS1196256.html?DLPage=1&DLFilter=1450&DLSort=0&DLSortDir=ascending.

A clean claim submitted on paper or on its electronic equivalent must be on a UB-04 form and must include all information and attachments listed. A claim will not be a clean claim if it is missing any of the information or attachments below.

1. Billing Provider Name					
2. Billing Provider's Street Address or P.O Box					
2a. City			2b. State	2c. ZIP Code	2d. Phone Number
3. Type of Bill	4. Federal Tax Number		5. Statement Covers Period (From-Through) / / - / / *From-date may not be earlier than admission date. Through-date may not be earlier than from-date. Through-date may not be later than from processing date.*		
6. Patient's Name					
7. Patient's Address or P.O Box					
7a. City			7b. State	7c. ZIP Code	7d. Country Code
8. Patient's Birthdate / /	9. Insured's Sex	10. Admission Date / /	11. Admission Hour	12. Type of Admission	13. Source of Admission
14. Discharge Hour *(Applicable only if the patient was admitted as an inpatient or was admitted for outpatient observation.)*		15. Discharge Status	17. Occurrence Span Code and Dates / / *(Applicable only if the UB-04 manual contains an occurrence span code appropriate to the patient's condition.)*		
18. Occurrence Span Codes and Dates *(Applicable only if the UB-04 manual contains an occurrence span code appropriate to the patient's condition.)*					
18a. / /	18b. / /		18c. / /	18d. / /	
19. Reserved for Assignment by the NUBC					
20. Value Codes and Amounts *This field must be used when submitting DRG codes. Electronic transmission specifications vary so please contact your vendor to ensure correct placement. For example, one submission format requires that a ZZ value be present in block 39 in order for the DRG to be transmitted; likewise, it requires that DRG be present if the ZZ value exists.*					
20a. $.	20b. $.		20c. $.		
21. Revenue Code *A code that identifies a specific accommodation, ancillary service or billing calculation of the related service(s) provided. This is required for all claims. Please follow the guidelines specified in the National Uniform Billing Data Element Specifications or St. Anthony's UB-04 editor for code values. Note: For outpatient services, most revenue codes will require a HCPCS code attachment.*					22. Revenue Description

UB-04 Form continued the next page.

UB-04 Form

23. HCPCS/Accommodation Rates/HIPPS Rate Codes *This field must be valued when reimbursement is based on HCPCS codes.*		24. Service Date / / *For HMO claims, the service date is required for all outpatient claims when the statement covers period from and through dates are not equal.*	
25. Service Units	26. Total Charges $	27. Prior Payments *(Applicable only if payment has been made to the provider.)*	
28. Payer's Name		29. Insured's Name	
30. Patient's Relationship to Insured	31. Insured's Unique Identifier	32. Insured's Insurance Group Number *The identification number, control number, or code assigned by the carrier administrator to identify the group for which the individual is covered.*	
33. Principal Diagnosis Code *Other Diagnosis Codes (Applicable only if there are diagnoses other than the principal diagnosis.)*			
33a. Diagnosis code	33b. Diagnosis code	33c. Diagnosis code	33d. Diagnosis code
33e. Diagnosis code	33f. Diagnosis code	33g. Diagnosis code	33h. Diagnosis code
33i. Diagnosis code	33j. Diagnosis code	33k. Diagnosis code	33l. Diagnosis code
33m. Diagnosis code	33n. Diagnosis code	33o. Diagnosis code	33p. Diagnosis code

34. Admitting Diagnosis Code	35. DRG Code	36. Attending Physician ID Number
37. Principal Procedure Code and Date / / *(Applicable only if the patient has undergone a surgical procedure.)*	38. Other Procedure Codes and Dates / / / / / / *(Applicable only if additional surgical procedures were performed.)*	

39. Remarks

This field is designated for use in limited situations when supplementary data is required from health care providers that the format and data set do not provide for them.

Additional information documenting UB-04 form changes and updates is available through the National Uniform Billing Committee (NUBC) website; please use the link to access: **http://www.nubc.org/**.

In order for a claim to be a clean claim, the following additional documents are required.

1. **Modifiers**
   Modifier information is available for review on Page 3 of this document. Click on the subject line above to review.

2. **All Unlisted/Unspecified Codes**
   Unlisted/Unspecified Code information is available for review on Page 4 of this document. Click on the subject line above to review.

3. **Coordination of Benefits (COB)**
   Coordination of benefits (COB) information is available for review on Page 4 of this document. Click on the subject line above to review.

Precertification
Precertification information is available for review on Page 5 of this document. Click on the subject line above to review.

Enhanced Clinical Review Program
The Enhanced Clinical Review Program Precertification information is available for review on Page 5 of this document. Click on the subject line above to review.

PROVIDER DISPUTE RESOLUTION PROCESS

Definition of Provider Dispute -Contracted Provider Dispute
A contracted provider's written notice to Aetna or to Aetna's capitated provider:

- Challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested
- Seeking resolution of a billing determination or other contract dispute (or a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered)
- Disputing a request for reimbursement of an overpayment of a claim.

Contents of Written Notice: You must include a completed Practitioner and Provider Complaint and Appeal Request Form (Provider Disclosure Form, PDR) with your written dispute. To obtain a Practitioner and Provider Complaint and Appeal Request Form or for additional information, call the appropriate number listed below or visit **http://www.aetna.com/healthcare-professionals/documents-forms/provider-complaint-appeal request.pdf.** The written notice must contain the following information:

- Aetna's Practitioner and Provider Complaint and Appeal Request Form available at **http://www.aetna.com/healthcare-professionals/documents-forms/provider-complaint-appeal-request.pdf.**
- Provider's name
- Provider's identification number/Tax ID Number
- Provider's contact information
- For claims issues:
  - Clear identification of the disputed item;
  - Date of Service;
  - Clear explanation of the basis upon which the provider believes that the plan's action is incorrect regarding the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contested/denied/adjusted claim.
- For non-claims issues, a clear explanation of the issue and the provider's position.
- For issues involving enrollees:
  - The name and identification number(s) of the enrollee(s);
  - Clear explanation of the disputed item;
  - Date of service;
  - Provider's position.
- For filing substantially similar multiple disputes (claims, billing, contractual, or other) in batches:
  - Sort provider disputes by similar issue
  - Provide a cover sheet for each batch
  - Number each cover sheet
  - Provide a Practitioner and Provider Complaint and Appeal Request Form for the entire submission describing each provider dispute with references to the number cover sheets.

For HMO Members Only:

- **Deadline to Submit Provider Disputes:** Provider must submit a dispute for an HMO-based claim within three hundred sixty-five (365) calendar days from the date of Aetna's last action on the claim, billing, or contractual issue. For PPO-based claims, Provider must submit a dispute within one hundred eighty (180) calendar days from the date of Aetna's last action on the claim, billing, or contractual issue.
- **Incomplete Disputes:** Incomplete disputes will be returned to the provider for completion within thirty (30) working days.
- **Acknowledgement:** Aetna will acknowledge receipt of the dispute within fifteen (15) working days, unless the dispute is resolved within that timeframe.
- **Resolution:** Provider disputes will be resolved within forty-five (45) working days after receipt of the complete written dispute.

Provider Disputes – HMO Products:

Provider Resolution Team
P.O. Box 24019
Fresno, CA 93779-4019

Provider Disputes – PPO Products:

TRAD: Provider Resolution Team
P.O. Box 14020
Lexington, KY 40512

For Medicare Products Provider Dispute Inquiries HMO plans only: Contact the Provider Service Center at **1-800-624-0756.**

For all other Products' Provider Dispute Inquiries (PPO and Commercial HMO plans): Contact the Provider Service Center at **1-888-MD-Aetna (632-3862).**

Additional information and Aetna policies for provider disputes, appeals, and reconsiderations are available on the Aetna.com website, in the "Health Care Professionals" section. Please use the link to access: **https://www.aetna.com/health-care-professionals/disputes-appeals/disputes-appeals-overview.html.**

MEDICAL COST TRANSPARENCY*

Aetna has several tools to assist members with insurance cost sharing and payment estimates. The Member Payment Estimator tool delivers an estimate of what a member can expect to pay for a service, based on the provider the member chooses and the member's own benefits. It can show a member estimates for certain in-network and out-of-network non-emergency services.

The Medical Procedure by Facility Cost Tool is a guide that helps estimate a member's costs for certain medical procedures and treatments. It allows a member to compare costs by facilities within a specified area. Actual cost ranges depend upon the plan selected. Cost ranges (average-low to average-high) are based upon claim data for the past two (2) years and are subject to change.

The Pharmacy tool allows a member to check drug coverage and costs.

Aetna members can access information using Aetna's Member secure website at:
https://www.aetna.com/individualsfamilies/using-your-aetna-benefits/secure-member-account.html
by clicking on the "Register or log in" link to view/use the Member tools available.

*California Health & Safety Code section 1367.49 and California Insurance Code section 10133.64 information for hospitals and facilities: Hospitals/facilities will get twenty (20) days advance notice to review any methodology and data that is developed and compiled by Aetna before cost/quality information is provided to members. If a hospital/facility chooses to provide a response to the transparency information, Aetna will post a link to the hospital/facility's Internet Web site where the response may be found.

PAYMENT POLICIES

Fee Schedules

California providers: How to access your fee schedule
In accordance with the regulations issued pursuant to the Claims Settlement Practices and Dispute Mechanism Act of 2000 (CA AB 1455 for HMO) and pursuant to the expansion of the Health Care Providers Bill of Rights (Cal. Health & Safety Code § 1375.7 and Cal. Insurance Code § 10133.65) we are providing you with information about how to access your fee schedule.

- If you are a provider affiliated with an IPA, contact your IPA for a copy of your fee schedule.
- If you are a provider directly contracted with Aetna, fax your request with the desired CPT Codes to 1-859-455-8650. Contact our Provider Service Center with questions.
- If your hospital is reimbursed through Medicare Groupers, visit the Centers for Medicare and Medicaid Services (CMS) website at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/FeeScheduleGenInfo/index.html** for Medicare Fee Schedule information.

Non-physician health care professionals should call the Provider Service Center to obtain rate information.

If you have additional questions, please contact our Provider Service Center at the following:
For Medicare HMO plans only: **1-800-624-0756**; **For all other plans (PPO and Commercial HMO plans)**: **1 -888-MD-Aetna (632-3862).**

Information regarding detailed payment policies, global payment provisions, and other policies

Availity, the secure external vendor website for Physicians, Hospitals, & Health Care Professionals, provides Aetna policy and payment information including (but not limited to):

- Consolidation of multiple services or charges
- Payment adjustments due to coding changes
- Reimbursement for multiple procedures
- Assistant surgeons (Physician and Non-Physician)
- Administration of immunizations and injectable medications
- Recognition of CPT modifiers

Visit **Availity.com** to register and log-in.

PRE-PAYMENT AND POST-PAYMENT AUDITS

Inpatient Bill Review Program

Aetna authorizes CorVel Corporation to request itemized inpatient hospital bills

Aetna is contracted with CorVel Corporation to review itemized hospital and facility bills. The review applies to both contracted and non-contracted hospitals and other facilities. Aetna has authorized CorVel to request itemized bills/UB-04s directly from providers.

The Inpatient Bill Review (IBR) program focuses on inpatient hospital claims (on a prepayment basis). For contracted providers, the review occurs where contracted rates are:

- A percent of Billed Charges, or
- Meet a Stop Loss threshold that is contracted at a percent of Billed Charges.

For non-contracted providers, the review may occur (when an employer group has purchased Aetna's IBR program) where billed services are:

- Greater than $100,000 for inpatient services, or
- Greater than $50,000 for outpatient services.

How does the IBR process work?

- Aetna will continue to receive claims directly from providers.
- Aetna will identify claims that are eligible for IBR.
- Aetna will send eligible IBR claims to CorVel.
- CorVel will notify Aetna of their claims review findings.
- Aetna will process and pay the claim.

If Aetna does not already have an itemized bill/UB-04, CorVel will call the applicable hospital or facility to request one.

Facilities and hospitals will be asked to deliver the requested information to CorVel via fax, so that the itemization is obtained in a timely manner. Additionally, the facilities and hospitals that CorVel contacts are asked to submit their bills and UB-04s as soon as they are requested. CorVel will provide the fax number or mailing address for each facility and hospital to submit the requested information. Lastly, CorVel will review the claim and provide their findings to Aetna, along with any disallowed amounts.

If a provider is in disagreement with the findings and wants to appeal, appeals will follow the Provider Dispute process described previously in this document.

OrthoNet Prepay Audit Program

We use OrthoNet to review our members' medical records before certain 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 claims coding to the services provided.

Affected specialties:

• Dermatology • Ear, nose and throat (otolaryngology) • Hand surgery • Neurology
• Neurosurgery • Orthopedic surgery • Pain management • Physiatry • Plastic surgery
• Podiatry • Sports medicine • Urology

Where to send Aetna records
If your office is asked to send records to Aetna, you can:
Fax to: 859-455-8650
Mail to: Aetna, PO Box 14079, Lexington, KY 40512-4079

When faxing or mailing records, be sure to include a cover sheet 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 identification number and/or the Aetna provider ID number