

**Centers of Excellence/ Institutes of Quality
Orthopedics (hip replacement and knee replacement) and
Spine (cervical and lumbar fusion, cervical and lumbar laminectomy/discectomy procedures)
Frequently Asked Questions (FAQs)
For Aetna Members Ages 18+**

Member Experience from Beginning to Post Surgery/Rehabilitation

1. Who are the specialists who generally provide the diagnosis which leads to each of these procedures?

Orthopedic surgeons and neurosurgeons.

2. What defines medical necessity for these procedures?

Please refer to Aetna's Coverage Policy Bulletins (CPBs) for the definition of medical necessity for each procedure.

- [Total Hip Replacement CPB 0287](#)
- [Total Knee Replacement CPB 0660](#)
- [Spine Fusion CPB 0743](#)

3. Who makes the determination of medical necessity and are those determinations routinely reviewed by Aetna?

Medical Directors and subject matter experts determine if the member's case meets the definition of medical necessary as written in the Coverage Policy Bulletins (CPBs). The CPBs are written and reviewed/updated by Aetna's Clinical Policy Counsel (CPC) committee.

a. What other treatment, tests, etc. are needed before medical necessity is determined?

- Refer to Aetna's CPBs which can be found in Question #2.

b. Describe the typical visits to/with a specialist(s) before determination for each procedure is made.

- A member's experience may vary. In some cases the member has been worked up and treated by their primary care provider and once they see the specialist he/she will request the surgery without further investigation and/or treatment. In other cases the specialist visit is the first presentation and it can take months of treatment and several office visits prior to the determination of the need for surgical intervention.

c. Does the specialist actually perform each procedure or is there another doctor/surgeon doing the actual procedure?

- In most cases the specialist will perform the procedure with or without the help of a secondary surgeon. If the case is deemed too difficult for that specialist, he/she may refer the member to another specialist who would then request the surgical procedure.

d. Who is responsible for follow-up with the member post-surgery – the member's PCP, the specialist or the doctor/surgeon that performed the actual procedure (if different from the specialist who provided the initial diagnosis)?

- The specialist/surgeon who performs the procedure is responsible for post-operative follow-up for any member that he/she operates on. It is possible that the specialist will have other providers involved in post-op care.

4. How are Aetna members made aware of COEs for the procedure?

Members are informed of the program through several means:

- Through the pre-certification (aka prior authorization or authorization) process. This occurs when a member contacts Aetna's national precertification team who would assist the member in selecting the appropriate facility for their procedure which follows their plan design set up.
- Member ID card which includes language to direct members to the Aetna member website for provider/facility look up.
- [Statewide Benefits Office's website](#)
- Aetna's Member Services team works to steer members to the IOQ facilities because the Institutes of Quality network is a national network of health care facilities that are designated based on measures of quality and cost criteria. Aetna's Customer Service Representatives are trained to promote the use of IOQs when it makes sense for the member.

5. If a member wants to use a COE and this requires duplication of services because they have been under the care of a specialist who does not have admitting privileges to a COE, how will that be addressed? Does Aetna provide any assistance to help members with transferring test results and/or medical records to a specialist who has admitting privileges to a COE, to avoid duplication of services where possible?

Most providers will ask for medical records and tests when they begin treating a member. Some physicians may be able to access certain records at a hospital without any cost to the member. Typically member records are transferred between offices when the member signs the appropriate releases. If there is a cost for these records, those costs are not covered under the medical plan.

6. If a member chooses to utilize a COE facility that is not in the local area, how is the travel reimbursement determined and how does a member obtain information about the travel reimbursement?

The travel reimbursement is \$50/night for lodging for each person, with a maximum of \$100/night. Travel and lodging reimbursement is limited to \$10,000 per episode of care. The \$10,000 is inclusive of expenses for the patient and one adult companion. Meals are not included in this reimbursement. The reimbursement period begins one day prior to surgery and ends six months after surgery and applies when the facility is more than 100 miles from the recipient's home. Members with questions should contact Aetna Customer Service at 1-877-542-3862 for assistance.

COE Designations

1. How are COE designated?

Aetna Institutes of Quality provide bariatric, cardiac and orthopedic procedures. We select hospitals that meet certain standards of quality and cost efficiency. We measure many factors, such as:

- How satisfied patients are
- Level of care
- How often people return to the hospital after surgery

More information on Aetna's program criteria for orthopedic care can be found on the [Aetna Member website](#).

2. How often are the COE facilities reviewed to determine continued eligibility as a COE? What data is considered when reviewing for continued eligibility?

Facilities are evaluated and have to apply or re-apply for the designation every three years via a Request for Information (RFI) that is sent out by Aetna. The criteria which is referenced on Aetna.com is refreshed as needed, and then used to develop the RFI to determine the facilities that fit the criteria of the program for both quality and cost efficiency.

3. What mechanisms does Aetna have in place to provide State of Delaware members with changes in COE designation (i.e. updated lists of facilities)? How/when are changes reflected in Aetna's provider search?

These updates are published in Aetna's provider search every three years when the re-designation cycle is completed and the listing in Directories and Resources is updated, as well as the designation tags.

4. If designation is lost, what is the notice timeframe to the facility, to the State of Delaware, to Aetna members, etc?

Aetna will notify all parties within 90 days. Terminations are prospective, so if a member is authorized for services at the de-designated facility prior to the facility's de-designation date, they will be approved for the procedure and claims will pay according to the benefit of the member's plan. In this case, the member's care is not interrupted.

5. How does the loss of status impact members who are approved/scheduled for services? What is the transition of care process in place for Aetna members using a COE in this instance?

If a pre-certification (aka prior authorization or authorization) has been provided to the facility for the member prior to the de-designation effective date of the facility, services are generally approved at the in-network benefit level and considered Transition of Care. If a pre-certification has not been provided, the member has the right to appeal.

6. For members who are in the process of preparing for treatment at a non-COE before the start of the July 1, 2018 plan year, is there a "grace period" so as not to penalize members who may be preparing for imminent treatment at a non-COE?

Aetna HMO members who have obtained a pre-certification (aka prior authorization or authorization) at a non-COE facility for orthopedic (hip replacement and knee replacement) or spine (cervical and lumbar fusion, cervical and lumbar laminectomy/discectomy procedures) from Aetna prior to July 1, 2018, and are enrolled in the Aetna HMO or Highmark Comprehensive PPO plan, will not be subject to the \$500 copay for obtaining treatment at the non-COE facility as long as the surgery is performed within the 6 month period in which the pre-certification applies. Members always have the right to appeal to the Statewide Benefits Office.

7. Where can members find a list of specialists performing these procedures at COE facilities?

Specialists with admitting privileges to COE facilities can be found on Aetna's provider search. Aetna has developed step-by-step instructions to assist members with this search. The Find a provider with admitting privileges to COE facility instructions can be found on [SBO's website](#).

