
How the Aetna Settlement Agreement helps the physician practice

The Aetna Settlement Agreement (“Settlement”) benefits physicians in a number of ways including reducing administrative burdens and simplifying claims submission and processing. Physicians and their staff can register referrals, pre-certify procedures, submit claims for covered services, check plan member eligibility for covered services, and check the status of claims for covered services at Aetna’s Web site www.aetna.com.

Contracts provided by Aetna to physicians in its provider network must conform to the Settlement. **Physicians should review all future Aetna contracts to make sure that they include a clear written representation that the proposed contract does not waive or conflict with any of the business practice initiatives Aetna has agreed to implement under the Settlement.** An example of such language would be:

Aetna represents that nothing in this contract waives or conflicts with any of the business practice initiatives it has agreed to undertake pursuant to the Settlement Agreement dated as of May 21, 2003, in the In Re: Managed Care Litigation, Master File No.: 00-1334-MD-MORENO.

Under the Settlement, certain business practices are prohibited, such as those reflected in “gag” clauses, “all products” clauses, and restrictions on stop-loss coverage from other insurers. However, it must be underscored that physicians can waive the protections that are contained in the Settlement. **If the physician receives a contract with terms that are inconsistent with the Settlement and signs the contract then the Settlement protections may be waived.** Physicians should consult with their attorney before agreeing to waive any protections provided in the Settlement. Physicians should consider asking Aetna to separately identify and explain in writing each provision in the physician’s contract that is inconsistent with the Settlement and that could result in a waiver by the physician of the protections provided to the physician in the Settlement.

Physicians should review **all** contracts from every payer before signing any contract to understand the implications of the contract on their practices. The American Medical Association (AMA) provides several useful tools to educate physicians on managed care contracts. The *AMA Model Managed Care Contract* contains sample contract language designed to assist physicians in avoiding common contracting pitfalls. The “15 Questions to Ask Before Signing a Managed Care Contract” flyer is designed to complement the *AMA Model Managed Care Contract* and provides a roadmap to help physicians evaluate whether to sign a managed care contract. This material is available on the AMA Web site at www.ama-assn.org/go/psa.

Physicians should note that the Settlement provides that if state law offers more protection than the Settlement, then state law applies. Physicians need to be aware of relevant state laws and regulations, particularly in the area of prompt payment of claims to ensure that they are receiving available protections.

A summary of the “key” business practices mandated in the Settlement can be found on the reverse side of this flyer. This flyer does **not** summarize or identify all of the protections provided in the Settlement. Physicians are encouraged to download the Settlement from www.hmosettlements.com or obtain additional information, including compliance dispute processes, from the AMA Web site at www.ama-assn.org/go/settlements. Physicians may consider filing a compliance dispute if prohibited clauses are contained in a contract submitted by Aetna.

For additional information, go to the AMA Private Sector Advocacy Web site at www.ama-assn.org/go/psa. You may also visit the American Urological Association’s Web site at www.auanet.org.

This informational flyer was developed through a cooperative effort between the American Medical Association and the American Urological Association.



Summary of “Key” Aetna Settlement Provisions

Coding Rules

- Aetna shall comply with most American Medical Association (AMA) Current Procedural Terminology (CPT®)* codes, guidelines and conventions.
- No automatic downcoding of any evaluation and management (E/M) CPT code for covered services.
- If a bill contains a CPT code for the performance of an E/M CPT code appended with a modifier 25 and a CPT code for the performance of a non-E/M service procedure code, both codes will be recognized and eligible for payment.
- A CPT code appended with a CPT modifier 59 will be recognized and separately eligible for payment to the extent that they designate a distinct or independent procedure performed on the same day by the same physician.
- No CPT modifier 51 exempt CPT codes are subject to the multiple procedure reduction logic or rule.
- Supervision and interpretation CPT codes are separately identifiable and payable.
- “Add-on” codes, as designated by CPT, will be recognized and eligible for payment as separate codes and shall not be subject to the multiple procedure logic or rule.
- A CPT code will not be automatically changed to a CPT code reflecting a reduced intensity of the service when such CPT code is one among a series that differentiates among simple, intermediate and complex.
- Recommended vaccines and injectibles, as well as the administration of these vaccines and injectibles, will be reimbursed as appropriate.
- No global period for surgical procedures will be longer than any period designated on a national basis by the Centers for Medicare and Medicaid Services (CMS) for such surgical procedures.

Disclosure of Fee Schedule Information, Claim Coding and Payment Policies

- Physician fee schedules shall be made available to all contracted physicians through the Internet and can be changed only once a year.
- Physicians will be provided with 90 days advance notice of all planned Material Adverse Changes to Aetna’s policies and procedures affecting performance under contracts with participating physicians.
- Payment policies will be consistent across all of Aetna’s products and claim systems.
- A pre-adjudication tool on Aetna’s Web site provides informational edits on CPT code combinations so that physicians can obtain Aetna’s allowable amount in advance of the actual payment.
- Certain medical payment policies, code editing policy and claims adjudication logic will be disclosed to physicians through Aetna’s Web site.

*CPT is a registered trademark of the American Medical Association.

- Copies of contracts will be provided to physicians upon written request.
- Capitation fees will be paid retroactive to the date of enrollment, when a patient chooses a primary care physician (PCP) or is assigned to the PCP.

Prompt Payment Requirements

- Generally, Aetna is required to issue a check or electronic funds transfer within 15 calendar days of the receipt of clean electronic claims and within 30 calendar days of the receipt of clean paper claims.
- Interest will be paid at the lesser of prime rate or 8% on delayed claims.
- Paper claims will be date stamped upon receipt in the mailroom and an electronic acknowledgment will be generated when an electronic claim is received.

Overpayment Recovery

- Overpayment recovery efforts will not be initiated more than 24 months after the original payment. A 30-day written notice will be provided to the physician prior to initiating an overpayment recovery effort (other than for recovery of duplicate payments).

Medically Necessary or Medical Necessity Definition

- Aetna accepts the following definition of medical necessity.

“Medically Necessary” or “Medical Necessity” shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: a) in accordance with generally accepted standards of medical practice; b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Arbitration

- Arbitration fees for solo and small group physicians are capped at \$1,000.

New Physician Credentialing

- New physician group members will be credentialed within 90 days of the receipt of the application. Physicians also can submit an application prior to their employment.