Post-Acute Care Utilization Management Program for Aetna Members

New Jersey, New York, Pennsylvania & West Virginia

EviCore By EVERNORTH

aetna℠

Agenda

- Company Overview
- Post-Acute Care Program Overview
- Provider Portal & Registration
- Submitting Precertification Request
- Precertification Outcomes & Special Considerations
- Transitional Care Program Overview
- Provider Resources
- Q&A

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EviCore Company Overview

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Medical Benefits Management (MBM)

Addressing the complexity of the health care system

10 Comprehensive solutions

5k+ Employees, including **1k+** clinicians

Evidence-based clinical guidelines

Advanced, innovative & intelligent technology

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Post-Acute Care Program Overview

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Aetna Precertification Services

EviCore will begin accepting precertification request for post-acute care services for Aetna Medicare Advantage Members. Request can be initiated on December 29, 2025, for start of care dates of service January 1, 2026, and beyond. This process applies to Aetna Medicare Advantage plans in New Jersey, New York, Pennsylvania and West Virgina. This excludes NJ FIDE.

Precertification applies to the following services:

- Skilled nursing facilities (SNF)
- Inpatient rehabilitation facilities (IRF)

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Rationale for Hospital Submission of PAC Precertification Request

- **Appropriate Level of Care Determination:**
  - Hospitals present the most accurate clinical status for discharging patients
  - Engagement with discharge planners to determine appropriate level based on medical necessity
  - Patient-Centered alternative PAC setting recommendations
  - Hospitals are encouraged to submit an authorization request at the same time they are sending clinical to a PAC Servicing Provider to obtain a bed. **The authorization for PAC is tied to the level of care, not a specific facility.**

- **Coordinated Post Acute Care Placement:**
  - Proactively identify Servicing Provider for optimal outcomes and patient experience
  - Early initiation of plan of care with goals and risk assessment by EviCore staff members
  - Offer social work coordination to address discharge barriers

- **Medicare PAC Guidance:**
  - Medicare's position on PAC placement provides guidance for the least intensive setting to adequately meet the patient's need

Post-Acute Care Precertification Criteria includes, but not limited to:

- Medicare Benefit Policy Manuals (Medicare members only)
- Other Evidence-Based Tools

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EviCore Provider Portal

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Benefits of Web Authorizations

1. **Save time!**
   Web authorization requests take 3 minutes on average. Phone authorization requests take 12 minutes on average.
2. **24/7 access!**
   You can access the web authorization service at any time, on any day. Phone authorizations have to be requested during business hours.
3. **Save your progress!**
   Need to step away? Need to obtain additional information? Save your authorization request progress and come back to it.
4. **View and print authorization information!**
   Approval details and the approval number are easily available online, and can be printed at your convenience.
5. **Other online features**
   Features include the ability to access clinical criteria, check member eligibility, upload additional clinical information and schedule Clinical Consultations.

Go to www.EviCore.com and click “Register” to begin initiating authorizations online today!

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EviCore Portal Registration

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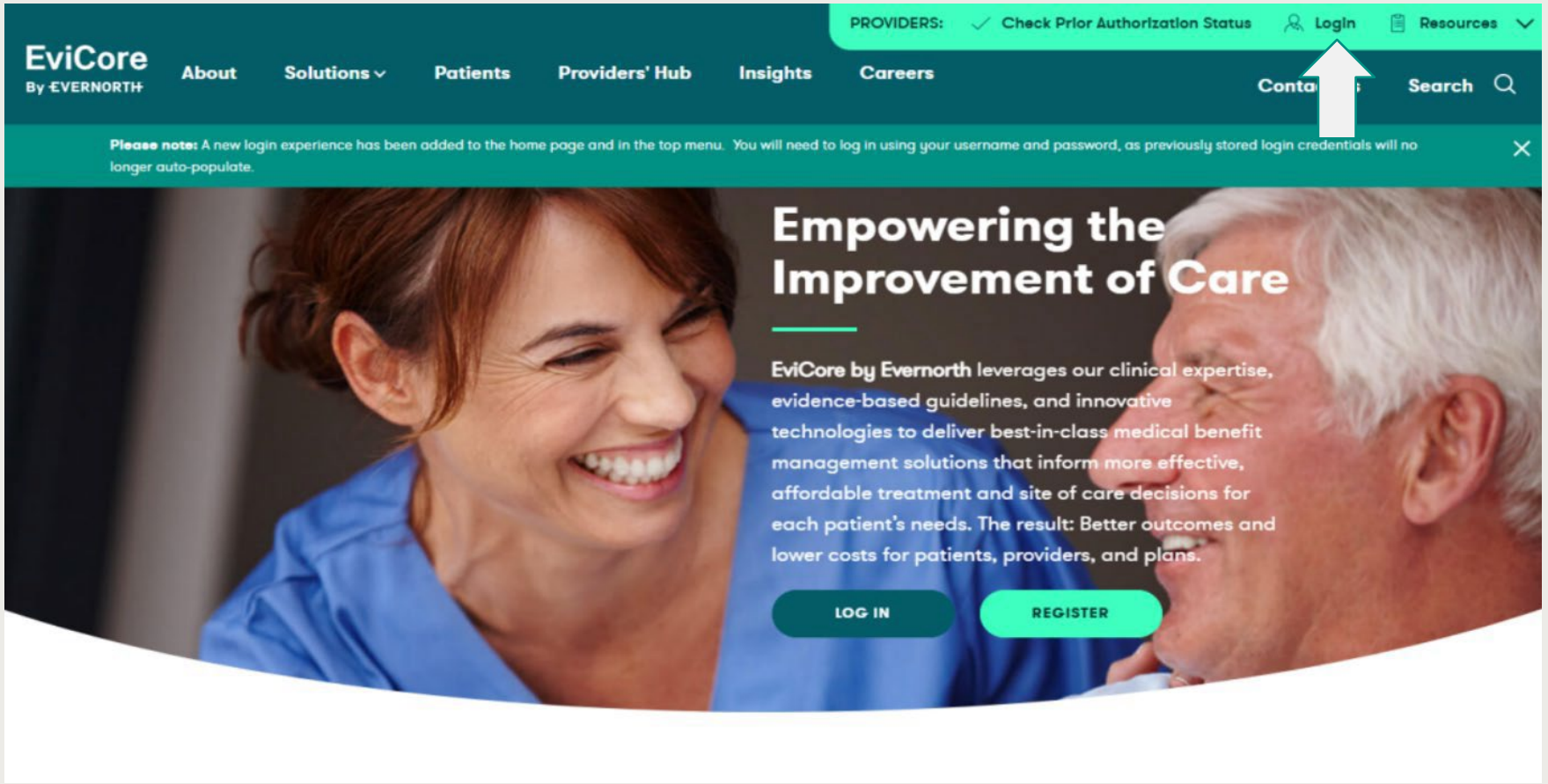
EviCore Provider Portal | Access and Compatibility

Most providers are already saving time submitting clinical review requests online vs. telephone.

+ To access resources on the EviCore Provider Portal, visit **EviCore.com**

+ Already a user?
  Log in with User ID & Password.

+ Don't have an account?
  Click **Register.**



EviCore's website is compatible with **all web browsers**. If you experience issues, you may need to **disable pop-up blockers** to access the site.

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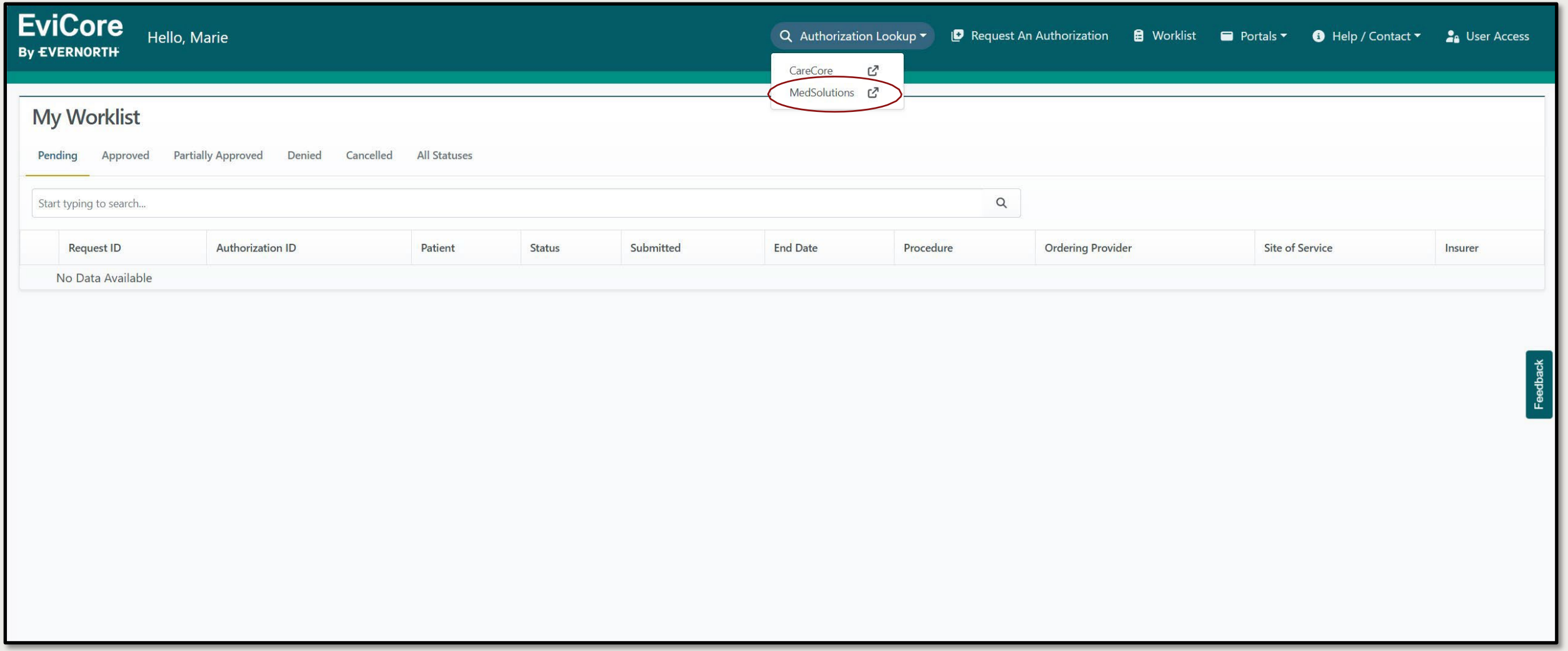
PAC Authorization – Landing Page

Under Authorization Lookup, select MedSolutions



Submitting Precertification Requests

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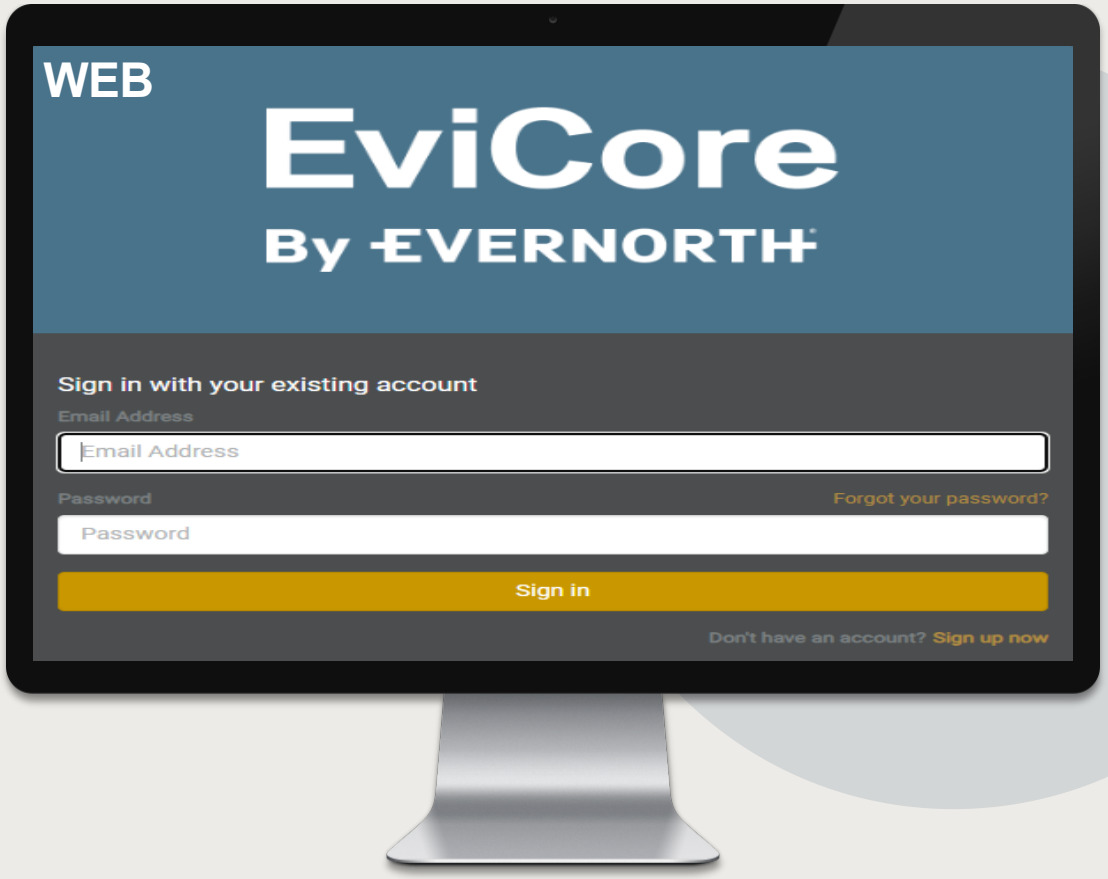
Methods to Submit Precertification Request

EviCore Provider Portal (preferred)

The EviCore online portal is the quickest, most efficient way to request precertification and check status.

+Homepage | EviCore by Evernorth



Fax:

855.633.8631- Fax can also be used to submit additional clinical information

877.502.0810 for concurrent review.
*Indicate case # when submitting additional clinical information

Phone:

888.622.7329
Hours of operation:

- Monday through Friday 8 a.m. to 8 p.m. EST
- Saturday 9 a.m. to 5:00 p.m. EST
- Sunday 9 a.m. to 2 p.m. EST
- Holidays 9 a.m. to 4 p.m. EST

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Required Information for Initial Post-Acute Care Precertification Request

Admission Details

- Service type being requested
- Accepting Servicing Provider demographics (if known)
- Patient demographics
- Anticipated date of hospital, LTAC, or IRF discharge (if applicable)

Clinical Information

- Hospital admitting diagnosis
- History and physical
- Progress notes, i.e., attending physician, consults & surgical (if applicable)
- Medication list
- Wound or incision/location and stage (if applicable)
- Discharge Summary

Mobility & Functional Status

- Prior and current level of function
- Prior living situation
- Current therapy evaluations: PT/OT/ST (Within 24-48 hours of request)
- Therapy progress notes, including level of participation

Please note: EviCore by Evernorth precertification form is encouraged and supporting clinical documentation is required for all post-acute care requests.

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Initial Case Creation

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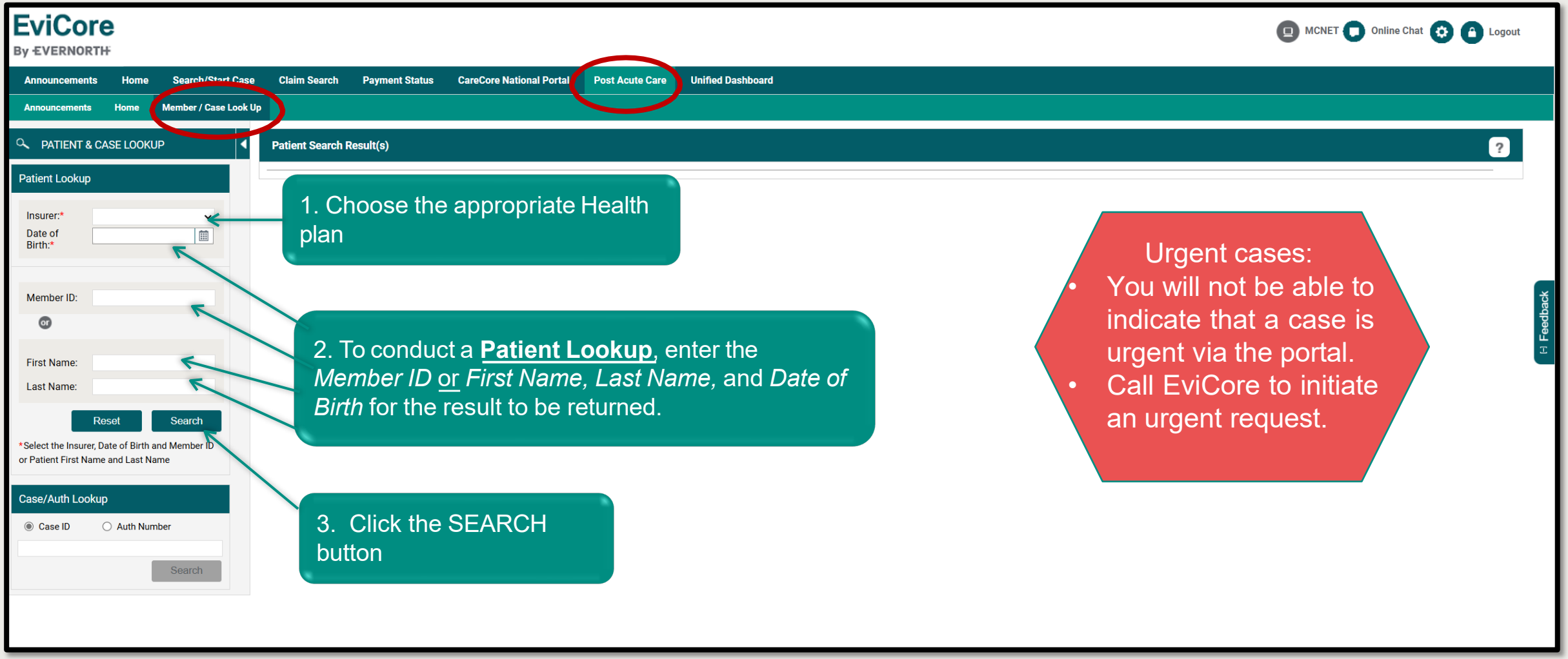
Initiate Case Process

To initiate a new case for PAC certification. On the Post Acute Care tab, you will start with **Member/Case Look Up.**



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Searching a Submitted Request

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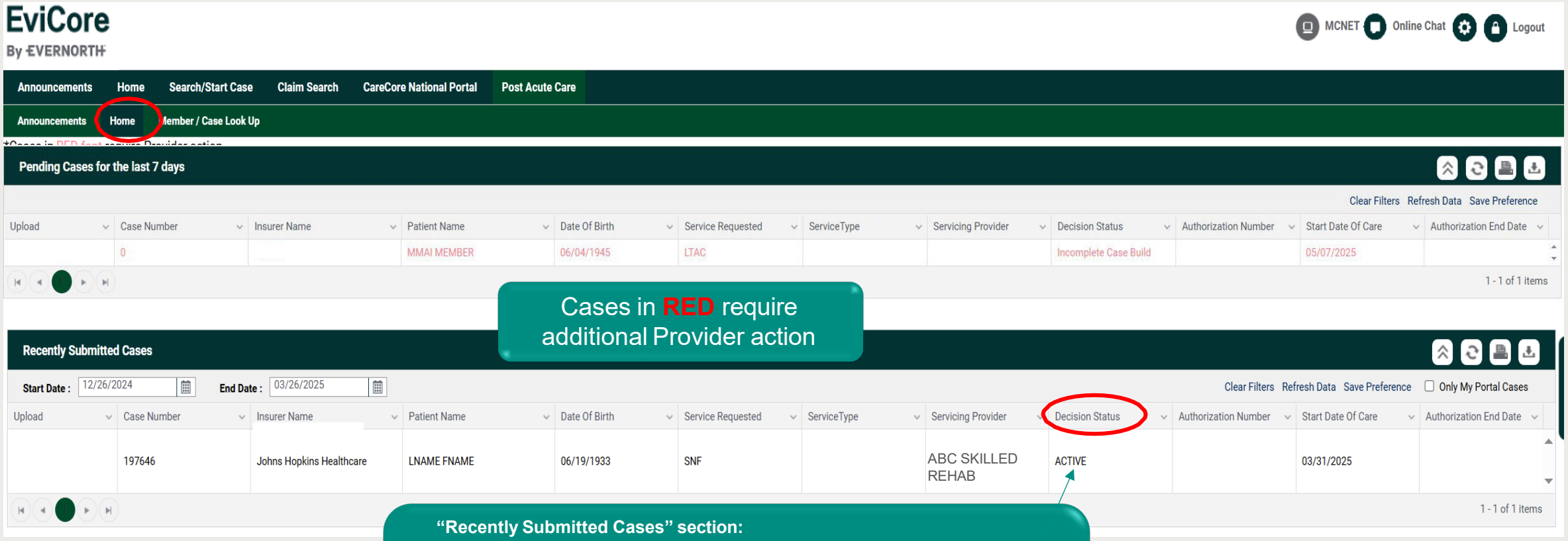
Search Case Status – Decision Status Descriptions

Once a request has been submitted, the member will show up on the user's HOME tab. If you have recently submitted a case, it is important to choose **"Refresh Data" for both pending and recently submitted cases.**



"Recently Submitted Cases" section:

- Active – Actively working the case and no decision has been made
- Authorized – Authorization is complete and approved. If the case is marked in RED, additional clinical is needed for concurrent review
- Denied – Request has been denied
- Pending – EviCore requires additional review

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Concurrent Review Process

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Required Information for Date Extensions (PAC Concurrent Review Requests)

Extension Details

- Servicing Provider name and NPI
- Patient demographics
- Servicing Provider contact person name, phone and fax number

Clinical Information

- Current admission ICD-10 code
- Clinical progress notes
- Medication list
- Wound or Incision/location and stage (if applicable)

Mobility & Functional Status

- Prior and current level of function
- Focused therapy goals: PT/OT/ST
- Therapy progress notes, including level of participation
- Discharge plans (include discharge barriers, if applicable)

Important: SNFs should submit clinical for extension (PAC concurrent review) precertification requests 72 hours prior to the last covered day to allow time for Notice of Medicare Non-Coverage (NOMNC) to be issued. Only updated information since the last review needs to be submitted. The Servicing Provider is responsible for issuing the NOMNC to the customer to review, sign and return to EviCore by Evernorth.

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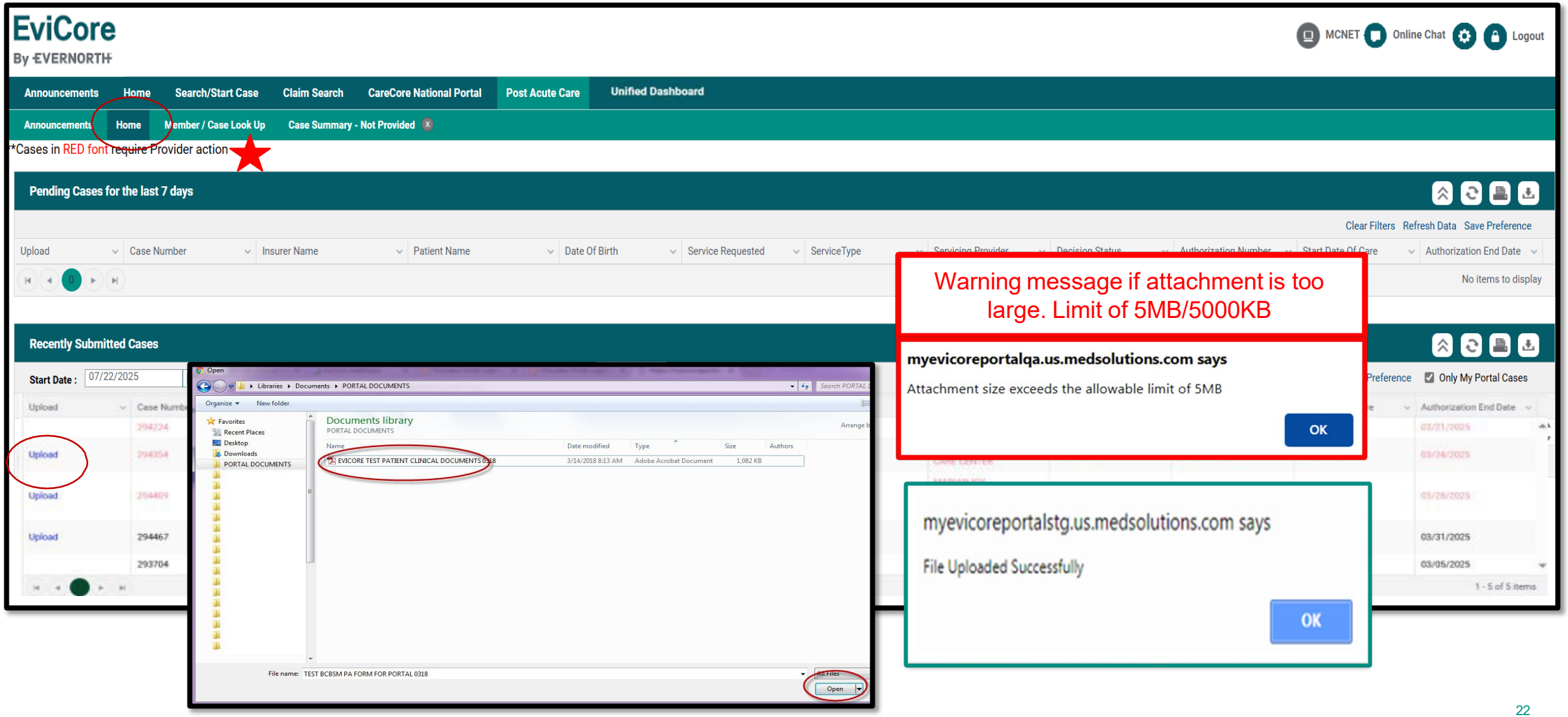
Concurrent Review Process

Return to the Home screen. Under “Recently Submitted Cases”, locate the patient whom you would like to upload clinicals. Select the “Upload” link, attach the clinical record, select “Open”, and the file will be uploaded to the patient’s EviCore chart in real time.



Precertification Outcomes and Special Considerations

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Precertification Approval

Approved Requests

- Standard requests are processed within 48 hours **after** receipt of all necessary clinical information
- Authorization letters are faxed to the Requesting Provider for initial requests and Servicing Provider for extension requests
- Patients receive an authorization letter by mail
- Initial precertification's are **valid for 7 calendar days** to help acute providers (hospitals) with discharge planning and to enable them to request authorization prior to the expected acute discharge date

Number of precertified days are provided by PAC service type as follows:

Precertification	Skilled Nursing Facility	Inpatient Rehab Facility
Initial	Five (5) calendar days	Five (5) calendar days

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Determination Outcomes: Unable to Approve/Alternate Recommendation

Unable to approve (pending additional review)

- When a request does not meet criteria during nurse review, it goes to second level review by an MD.
- If the MD is unable to approve the request based on the information provided, notification is made to the Requesting Provider.
- The Requesting Provider is given the option to either send additional information to support medical necessity or schedule a clinical consultation (peer-to-peer).
- ***Important:** If this option is not utilized by the Requesting Provider within one business day, an adverse determination is made, and the request is denied.

Alternate Recommendation

- The MD may also offer an alternate recommendation. The Requesting Provider can accept or reject the alternate recommendation or schedule a clinical consultation.
- The Requesting Provider has up to 48 hours to accept the alternate recommendation.
- If accepted, the initial requested service will be denied, and the alternate recommendation will be approved.

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Clinical Consultation Requests (Peer-to-Peer)

Unable to approve (pending additional review)

- If EviCore is unable to approve a request with the provided information, a clinical consultation is offered with the Ordering Physician and an EviCore Medical Director

- Clinical consultations, after an Unable to Approve decision has been made, may result in either a reversal of decision to deny or an uphold of the original decision

- A clinical consultation may be requested by calling EviCore. **Medical Directors are available for Clinical Consultations 365 days a year.**

Adverse determination

- For adverse determinations, or final denials, providers can request a clinical consultation with an EviCore physician to better understand the reason for denial.

- Once a final denial decision has been made, however, the decision cannot be overturned via a clinical consultation.

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Precertification Outcomes - Adverse Determination

- When a request does not meet medical necessity based on evidence-based guidelines, an adverse determination is made, and the request is denied
- In those instances, a denial letter with the rationale for the decision and appeal rights will be issued by EviCore to the Ordering Physician, Requesting Provider and patient
- Adverse determinations letters can be printed on demand from the EviCore by Evernorth portal

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Special Circumstances

Urgent precertification requests

- EviCore uses the NCQA/URAC definition of **urgent**: when a delay in decision-making may seriously jeopardize the life or health of the customer.
- Urgent requests can be initiated by phone (recommended) or fax and will be reviewed within 72 hours.

Retrospective requests

- Retrospective reviews are not allowed, except for special circumstances. Please contact Aetna directly for consideration.

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Post-Decision Options: Appeals Process

Appeals Process

- Aetna will process first-level appeals. Delegation of second level appeals will vary by plan and/or state regulations
- The timeframe to submit an appeal request will be outlined on the determination letter *
- Appeal requests can be submitted to Aetna in writing via US Mail or by fax. The Aetna appeal address and fax number will be provided on the determination letter
- Providers with appeal questions may call the number indicated on the customer's ID card
- The appeal determination will be communicated by Aetna to the ordering provider and customer
- Appeal turnaround times:*
  - Expedited - 72 hours
  - Standard provider - 30 days

** May vary by plan and/or state regulations*

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Transitional Care Program Overview

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Transitional Care Program

Transition of Care Program (TOC) Overview

TOC will manage Aetna plan member through the Post-acute care continuum to ensure oversight aimed at successful recovery at home, and to reduce the risk of readmissions. Upon discharge from a PAC facility or HH services, or whether a community referral, post-ED visit, or Observation stay, The TOC program will follow patients for a period of 90 days. The frequency of patient contact is based on a scheduled call cadence and is further personalized based on a member's individual needs and nursing clinical judgment.

Service provided

Compressive health risk assessments to understand a members care coordination needs, risk factors, and any gaps in care following discharge.

- Medication reconciliation, adherence, and education.
- Data capture for Transition of Care HEDIS /STAR measure requirements: falls/pain/functional status/medication reconciliation
- Review of discharge summary to support continuation of care across settings
- Disease education, including self-management
- Assistance with MD appointment scheduling and follow-up
- SDoH assessment to support members with socioeconomic needs including caregiver issues, financial, housing, and food poverty. We also provide community resource information
- Care coordination for additional services that may be needed to support recovery, ex: DME, continued case management
- Access to a clinician to answer questions or concerns that may arise during the program duration
- Care summaries provided to PCPs and health plans to support transition, including referrals for ongoing services

Differentiators

- End-to-end management from post-acute care through the recovery period as patients adapt to their “new normal” and sustain recovery
- Unique position at the intersection of utilization management, network management, and home
- Ability to support at scale, can manage an entire population and/or serve high vs. low-risk members as directed by health plans
- Partnership with health plan as requested: case conferences, referral for continued case management.
- Reduce readmissions and ED visits, fulfillment of HEDIS and CMS Star Measures requirements

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Provider Resources

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Contact EviCore's Dedicated Teams

Provider Services and Portal Support

- Live chat
- Clientservices@evicore.com
- Phone: **800.646.0418**

Provider Engagement

You can contact your Provider Engagement Representative by visiting the Provider's Hub and viewing the Provider Engagement Territory Map in the Training Resources.

Call Center/Intake Center

Call **888.622.7329.** Representatives are available from 7 a.m. to 7 p.m. local time.

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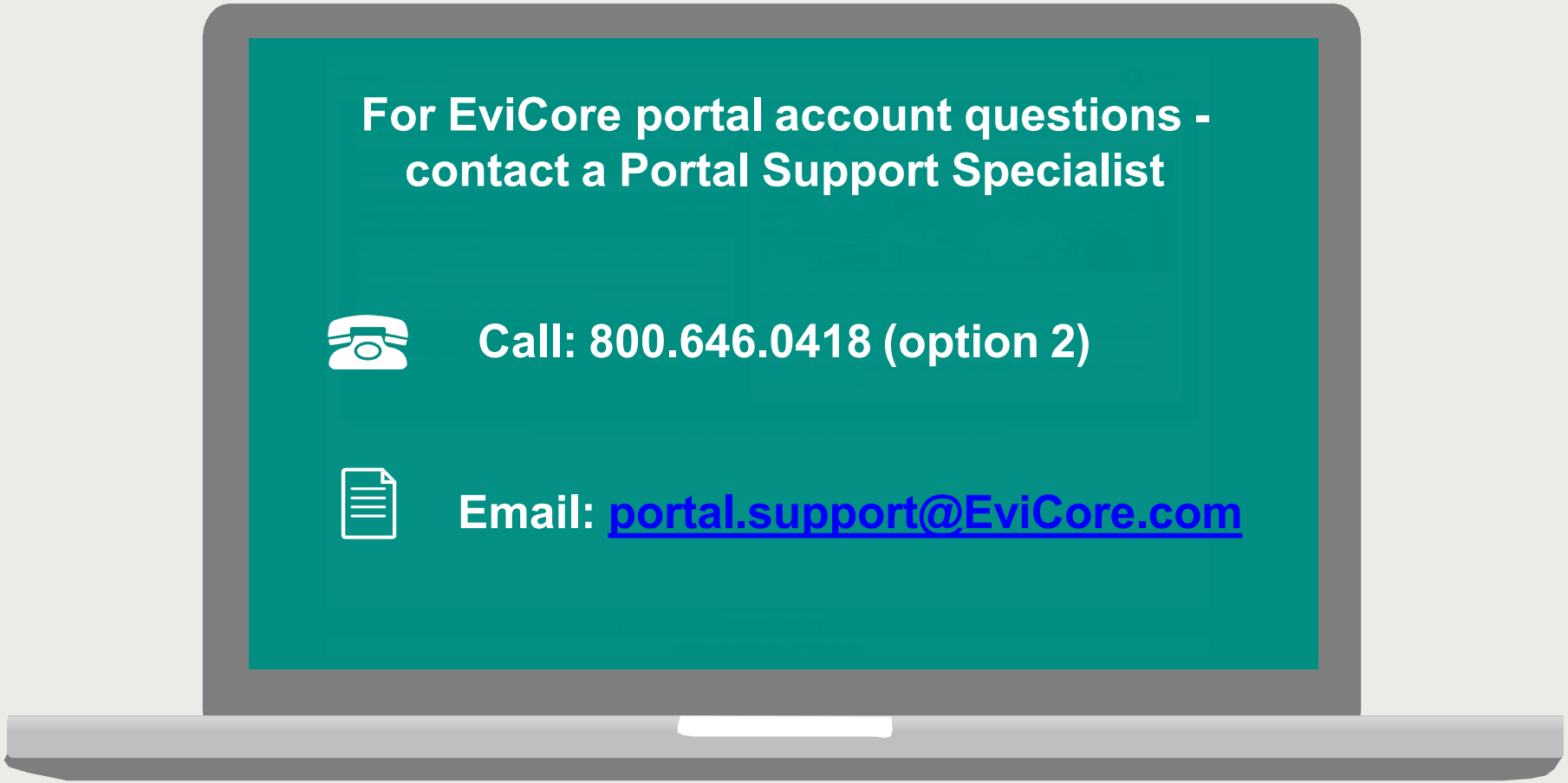
EviCore Provider Portal Support



Portal Support Services: Available Monday through Friday, 8:00 a.m. – 7:00 p.m. EST

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Thank You

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