Cleveland Clinic

Provider Handbook

For network providers of Cleveland Clinic's Employee Health Plan

Cleveland Clinic

Cleveland Clinic is a non-profit academic medical center based in Cleveland, Ohio. Cleveland Clinic provides clinical and hospital care and is a leader in research, education and health information.

Cleveland Clinic Employee Health Plan is a self-insured health plan offering comprehensive health and pharmacy benefits to over 130,000 members located in 34 states across the country. The Employee Health Plan employs an internal team of clinical physicians, nurses, and pharmacists who are dedicated to offering state-of-the-art medical management for our members. The plan utilizes internal clinical medical, pharmacy policies, in addition to InterQual Level of Care Criteria to determine medical necessity for benefit coverage.

We currently offer three benefit programs for our members — the EHP plan, EHP Plus plan, and the Martin Hospital Under 65 retirement plan. The Health Benefit Program (HBP) also includes a retiree plan for our retirees who are Medicare eligible; these members may elect either EHP, EHP Plus, or Retireee Under 65 group as their network.

EHP – The EHP Plan includes the Cleveland Clinic, Quality Alliance (QA) and certain Florida-aligned providers. These networks include Cleveland Clinic facilities and employed physicians as well as contracted facilities in Ohio and Florida. If you elect this plan, you must use providers from this provider network.

The EHP plan is supplemented with Aetna providers in the following specialties from the seven counties surrounding our Florida hospitals: Acupuncture, Allergy, Behavioral Health, Chiropractic, Dermatology, Endocrinology, Nutritionist, Ophthalmology, Otolaryngology (ENT), Oral Surgery, Pain Management, Pediatrics and Podiatry. The seven counties include Brevard, Indian River, St. Lucie, Martin, Palm Beach, Broward and Miami-Dade.

Effective 1/1/2026, the use of Aetna providers for the specialty of OB/GYN in our Florida region will be limited to Aetna OB/GYN providers in the counties of Broward, Palm Beach and Miami-Dade. The non-Cleveland Clinic Aetna OBGYN providers that have been included in-network for EHP from Brevard, St. Lucie, Indian River and Martin counties will be removed from the EHP network. Our Cleveland Clinic providers and facilities, Martin Tradition and Indian River hospitals, are able to treat members for these services.

EHP Plus –EHP Plus gives members access to the providers available in the EHP plan (above), PLUS Aetna's Open Access Select network, which includes providers nationwide.

For Behavioral Health, the EHP and EHP Plus networks include all Aetna contracted providers in the state of Ohio and Florida.

The **Martin Health Retiree Under 65 plan** has a two-tier network. The Tier 1 network consists of the EHP provider network described above. The Tier 2 network consists of providers in the Aetna Select Open Access network. The member's EHP Identification (ID) card reflects these relationships on the back of the card.

Member Benefits

- **EHP** Summary Plan Description
- **EHP Plus** Summary Plan Description
- **Martin Hospital** Under 65 retirement plan Summary Plan Description
- Additional information can be found on Cleveland Clinic's Employee Health Plan site at **employeehealthplan.clevelandclinic.org/**.

Our Partners

Cleveland Clinic Employee Health Plan's third-party administrator (TPA) is **Aetna**. Aetna's responsibilities include credentialing of licensed medical professionals, assessing and establishing qualified contracts with healthcare providers, verification and processing medical claims, and managing rules for payments.

CVS Caremark is our pharmacy benefit manager (PBM) and processes prescription drug claims under the direction of our EHP Pharmacy Department.

SilverScript is the plan's Medicare Part D Prescription Drug Plan for our Medicare-eligible retirees. SilverScript is affiliated with CVS Caremark, our pharmacy benefit manger.

Ohio Network

In Ohio, our network includes Cleveland Clinic employed physicians and facilities, and non-employed providers in the Cleveland Clinic Quality Alliance, a clinically integrated network.

The Quality Alliance is a select top-level provider network that integrates independent physician practices with employed Cleveland Clinic physicians. The network provides the metrics, data and support physicians need to improve the quality and efficiency of the care they provide, while reducing costs.

Independent physicians who join the Quality Alliance are able to deliver better care by adopting evidence-based clinical protocols. Efficiency is improved through use of a common data repository and reporting system. Joining the Quality Alliance offers independent physicians the opportunity to collaborate with Cleveland Clinic physicians while still maintaining their private practice.

The Quality Alliance spans more than 46 counties in Northeast Ohio, making it one of the largest clinically integrated networks in the nation. As such, the Quality Alliance is the premier healthcare network in Northeast Ohio supporting Cleveland Clinic's Employee Health Plan.

Florida Network

In Florida, the EHP plan provider network is supplemented with Aetna providers in the following specialties within the seven counties surrounding our Florida hospitals: Acupuncture, Allergy, Behavioral Health, Chiropractic, Dermatology, Endocrinology, Nutritionist, Ophthalmology, Otolaryngology (ENT), Oral Surgery, Pain Management, Pediatrics and Podiatry. The seven counties include: Brevard, Indian River, St. Lucie, Martin, Palm Beach, Broward and Miami-Dade.

We have also supplemented additional non-Cleveland Clinic hospitals in support of the admitting privileges of the above provider specialties. They are: Baptist Hospital, Broward Health Medical Center, HCA Florida Hospitals, HCA Florida Lawnwood Hospital, Holmes Regional Medical Center Aging Services, Holmes Regional Medical Center OP Pain Infusion and Wound, Holmes Regional Medical Center, Jupiter Medical Center, Memorial Hospital, Memorial Regional Hospital, Palm Bay Community Hospital, St. Mary's Medical Center, University of Miami Hospital and Clinics.

Provider Responsibility

Provider agrees to:

1. Provide quality services within the scope of Provider's medical license to any EHP member seeking Provider's service. Provider agrees to provide such services in a non-discriminatory fashion and will not differentiate or discriminate in the treatment of EHP members based on race, color, sex, age, religion, disability, sexual preference, national origin, health status, need for health services or source of payment in accordance with law.
2. Maintain all applicable state licensure requirements and maintain all federal and state permits, accreditations, certificates, and approvals required to provide health care services to EHP members.
3. Maintain in full force and effect, at least, minimum levels of professional liability insurance.
4. Allow EHP to use Provider's name, telephone number(s) and business location(s) in descriptive and other administrative materials.
5. Provide only medically necessary health care services:
    - appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
    - provided for the diagnosis, or the direct care and treatment of the Member's condition, illness, disease or injury;
    - in accordance with current standards of good medical practice;
    - not primarily for the convenience of the Member or Practitioner;
    - the most appropriate supply or level of service that can safely be provided to the Member; and/or
    - if inpatient services are required because of the Member's condition, Members must be directed to a Cleveland Clinic facility or nearest in network hospital.
6. Maintain accurate medical records and ensure confidentiality of such EHP member information in accordance with all federal and state laws regarding confidentiality, accuracy, and disclosure of medical records, including the applicable provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), which require reasonable administrative, technical, and physical safeguards to ensure the integrity and confidentiality of Covered Person (as defined in HIPAA) information.

Billing/Claims

Provider should submit claims for payment to the TPA directly for the services provided to:
Aetna, P.O. Box 981106, El Paso, TX 79998-1106, telephone number 888.632.3862.

There are no copayments for preventative services and vaccinations. The provider should only charge EHP members the applicable copayment amount as listed on the member's insurance card.

Billing should only occur after following all EHP precertification and procedural requirements, including but not limited to appeals and grievance procedures.

Availity

Providers who are contracted with Aetna and who see Cleveland Clinic Employee Health Plan members may use the Availity system. Availity is a provider portal that Aetna uses to streamline various administrative tasks for healthcare providers. Through the Availity portal, providers can:

- Submit claims and check claims status
- Check patient benefits and eligibility in real time
- Look up codes, payment, and coding policies
- Dispute a claim
- View EOBs
- View fee schedules
- View medical policy bulletins
- Submit medical records
- Submit provider appeals
- View and print member ID cards
- Update provider information

To register for Availity, follow these steps:

1. Visit the Availity website: Go to **www.availity.com**.
2. Start the registration process: On the homepage, click on the "Get Started" button to "Create Account."
3. Review the requirements: Make sure you meet all the necessary requirements before proceeding.
4. Complete the registration wizard: Follow the prompts in the registration wizard to fill out the online form. This will include providing your organization details, user information, and agreeing to the terms and conditions.
5. Submit your registration: Once all the information is filled out, submit your registration for approval.

If you need assistance during the registration process, you can contact Availity Client Services at 1.800.AVAILITY (282.4548) for support.

SilverScript Prior Authorizations/Coverage Decisions/Appeals Process

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists develop these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage members to utilize drugs that work for their specific medical conditions and are safe and effective. When a safe, lower-cost drug will work just as well medically as a higher-cost drug; the plan's rules are designed to encourage members and their providers to use that lower-cost option. For our Retirees on the plan, we also need to comply with Medicare's rules and regulations for drug coverage and cost.

If a drug is not covered, members or providers must get approval from the plan before we will agree to cover the drug. This is called "prior authorization". Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If a approval is not obtained for certain druges, the drug might not be covered by the plan. This form is available on our website at http://clevelandclinic.silverscript.com under the documents tab. Click the "Prior Authorization" link.

Members and providers may ask the plan to make an exception to cover the drug. Providers may assist members by requesting an exception to the rule if they believe there are medical reasons justifying the use of the drug in question.

If SilverScript Insurance Company denies the request for coverage of (or payment for) a prescription medication, members have the right to ask for a redetermination (appeal) of their decision. Members have 60 days from the date of their Notice of Denial of Medicare Prescription Drug Coverage to ask for a redetermination.

The Redetermination Form is available on Caremark's website at **https://caremark.com** or on the EHP website at **https://employeehealthplan.clevelandclinic.org**.

The completed form should be sent to:

Appeals Department
MC109
P.O. Box 52000
Phoenix, AZ 85072-2000
Fax number: 855.633.7373

Members can also ask for an appeal via the Caremark website at https://caremark.com. Expedited appeal requests can be made by phone at 866.884.9479 (TTY 866.236.1069). Call the toll-free numbers 24 hours a day, 7 days a week.

If we uphold all or part of the Level 1 Appeal, members can ask for a Level 2 Appeal. Under the retirement plan where Silverscript is involved, a Level 2 Appeal is conducted by an independent organization that is not connected to the Employee Health Plan. If the member is not satisfied with the decision at the Level 2 Appeal, they may be able to continue through additional levels of appeal. Please see the Evidence of Coverage from Silverscript for further details.

Precertification

Prior Authorization

The process of verifying member eligibility and benefit coverage under the Health Benefit Program (HBP). Prior Authorization also includes the process of determining whether a patient has met the medical necessity criteria outlined by the HBP for medical, prescription drug, and behavioral health/substance abuse services. Approval for a service prior to the service being rendered. Prior authorization, precertification, and prior approval are often used interchangeably.

Utilization management

The process of monitoring and evaluating, on a prospective, concurrent and retrospective basis, the medical necessity and appropriateness of health care that health care providers provide to members.

Utilization review

The review of a hospital stay or other service for appropriate admission, treatment and discharge. Any day(s) or treatment denied as inappropriate will not be paid.

To ensure that provided services are medically necessary, the Medical Management and Pharmacy Departments have established criteria for members to follow so that care is reimbursed correctly and efficiently. These rules and processes are addressed in the "Precertification and Concurrent Review for Medical Necessity" section that follows.

A service is NOT considered medically necessary if it is:

1. Not ordered by a licensed or accredited physician, hospital, or healthcare provider or other healthcare facility.
2. Not recognized throughout the medical profession as safe and effective, is not required for the diagnosis and treatment of a particular illness (physical or behavioral) or injury, and is not employed appropriately in a manner consistent with generally accepted United States medical standards.
3. Provided for vocational training.
4. An Educational Service, including those listed below, are not considered medically necessary unless required BECAUSE OF a new medical or behavioral condition or a change from baseline in a previous condition. Educational services that can be received within a school system are NOT considered medically necessary. Examples of services that are not covered include:
    - Training in the activities of daily living; and
    - Instruction in scholastic skills such as reading and writing; and
    - Preparation for an occupation, or treatment of learning disabilities for academic underachievement.
5. Determined to be Experimental or Investigational (E/I) which are drugs, devices, medical treatment, or medical procedures that are not considered to be a standard of practice in this healthcare market for a particular diagnosis. These may be under study and not yet recognized throughout the physician's profession in the United States as safe or effective for diagnosis and/or treatment of the illness or injury. This includes, but is not limited to: clinical trials, all treatment protocols based upon or similar to those used in clinical trials, and drugs approved by the Federal Food and Drug Administration that are being used for unrecognized indications. E/I services may be considered excluded or ineligible for predetermination or require precertification. Contact the Aetna concierge, Medical or Pharmacy Management team for more information.
6. Cosmetic in nature. Services that are obtained related to dermatology or plastic surgery visits may require prior approval and/ or may be considered cosmetic in nature and are not a covered benefit. Contact Medical Management for more information. Contact information is below.

Precertification and Concurrent Review for Medical Necessity

The EHP Medical Management and Pharmacy Departments have precertification and clinical review processes to help ensure quality and cost-effective medical care for HBP members. Please note, Emergency Services do not require precertification.

Precertification

Medical necessity approval is required before certain procedures will be covered. Prior authorization, precertification and prior approval are often used interchangeably. Many of our network providers have detailed information about the process to ensure medical necessity and will coordinate with the EHP Medical Management and/or Pharmacy Department to ensure that required precertification guidelines are met. Also, a complete list of medications that require prior authorization can be found in the Prescription Drug Formulary. For medications billed under the medical benefit without a drug-specific code (i.e. miscellaneous billing codes), these medications will require precertification review by the EHP Pharmacy Management team, if EHP has a precertification policy in place for the specific medication being billed/requested. If EHP does not have a precertification policy in place, then these medications will follow the Aetna predetermination/clinical claim review process.

Predetermination

If a service does not require precertification, an in-network provider has the option to submit a predetermination request through Aetna, to determine benefit coverage, prior to providing the service.

Concurrent Review

This is a medical necessity review for continued use of services that occurs either during a member's hospital stay or during the course of a prescribed treatment (e.g., inpatient stays, home care or skilled nursing facility care).

Precertification for medical necessity and concurrent reviews are performed on either a prospective or concurrent timeline to assure appropriateness of admissions; continued length-of-stay and appropriate levels-of-care within inpatient facilities; and episodes of treatment in the outpatient setting. The reviews are conducted as a mechanism for assuring consistent procedures and treatment across the network and for the identification of quality-of-care issues. The reviews are also done to identify discharge planning needs and to initiate discharge planning in a timely fashion.

Any unauthorized programs, services, or visits will not be covered by the HBP under any circumstances and the subsequent charges will be the financial responsibility of the member. This applies to any unauthorized out-of-network and out-of-area providers and facilities, with the only exception being for emergency services.

Business hours for the EHP Medical Management and Pharmacy Departments are from 8 a.m. until 4:30 p.m. Monday through Friday.

EHP Medical Management and Pharmacy Departments
25900 Science Park Drive, AC242
Beachwood, OH 44122
Phone: 216.986.1050
Toll-free: 888.246.6648

EHP Medical Management
Fax: 216.442.5791
EHP Pharmacy Fax: 216.442.5790

Medical and Behavioral Health Services That Require Precertification

For the most current list of services requiring precertification, please see the online version of the Summary Plan Description on Cleveland Clinic's Employee Health Plan site at **employeehealthplan.clevelandclinic.org/**.

The following list includes those medical services that must receive precertification for medical necessity, by the provider of service, prior to being rendered except for emergency/urgent situations.

Inpatient Hospitalizations

May be subject to concurrent review.

- Acute Rehabilitation Admission
- All Inpatient Admissions
- All Inpatient Behavioral Health
- Behavioral Health Residential Treatment
- Elective Hospital Admission
- Inpatient Maternity stays over 48 hours (normal vaginal delivery) or 96 hours (c-section)
- Long Term Acute Care (LTAC) Admissions
- Transplants (All human organ, bone marrow, stem cell and other tissue transplants)
- Out-of-Network and Out-of-Area Care (All)
- Skilled Nursing Facility (SNF)/Transitional Care Unit (TCU)/Sub-Acute Admission

Outpatient Services

- Behavioral Health – Applied Behavioral Analysis (ABA) – Partial Hospitalization Programs (PHP) – Transcranial Magnetic Stimulation (TMS)
- Medical – Bariatric Surgery – Botox – Breast reconstruction – Capsule Endoscopy – Capsule Motility device – Circumcision – Fixed Wing Conventional Air Transport – Gender affirming surgery – Home Healthcare – Implantable Neurostimulator – Injectable or Infused medications covered under the medical benefit – Lower extremity prosthetics – MRI/MRA/CT scans – Resigam/Synagis
- Durable Medical Equipment (DME)
- Bone anchored hearing aid
- Cochlear implants
- Power wheelchairs or motorized wheelchairs
- Scooters

Special Services

These services require precertification whether inpatient or outpatient:

- Bariatric restrictive procedures or malabsorptive procedures for weight reduction
- Bone Marrow Transplant

Infertility

Prior authorization for infertility services is completed by Aetna's National Infertility Unit (NIU) at 800.575.5999. Members seeking infertility treatment must first enroll with Aetna's Fertility Advocate at 833.415.1709.

Pharmaceuticals

See the Prescription Drug Benefit Formulary for a list of medications that require precertification. This comprehensive list includes medications covered under the medical and/or prescription drug benefit.

Transition of Care (TOC) Coverage Request

If an in-network provider changes status and becomes an out of network provider, their patients who are members of our plan may request a transition of care for a temporary period and for specific conditions within 90 days of the network status change. The member will work with the current provider to complete the required form which can be located on the EHP website. The current provider would continue to be paid at the Network Provider rate during this time if the request is approved. The Transition of Care Coverage Request Form can be found in the Forms section of our web site: **https://employeehealthplan.clevelandclinic.org/**

Care Outside of EHP Cleveland Clinic Network of Providers

Under the Health Benefit Plan (HBP), there are no benefits for out-of-network services, except in cases of urgent or emergency care. The EHP Network of Providers encompasses providers within a 130-mile radius of the Cleveland Clinic facility that the member is associated with and supports. If there are providers within this distance who can offer the required service, out-of-network referrals will not be considered.

In certain situations, a physician may determine that a member requires care outside of the member's EHP network of providers. Coverage for such services under the Health Benefit Plan (HBP) is permitted only when the necessary medical or behavioral healthcare cannot be provided within their network.

All out-of-network requests must be initiated by the member by calling the Aetna Concierge at 833.414.2331. Members should contact the Aetna concierge before scheduling any service with an out-of-network provider for further information.

Please note that Akron Children's, University Hospital System, University Case Medical Center, Summa Health System, and Aultman Hospital System and their affiliates are not considered part of the EHP network.

Care Outside of the EHP Plus Cleveland Clinic Network

Under the Health Benefit Plan (HBP), there are no benefits for out-of-network services, except in cases of urgent or emergency care. The EHP Plus Network of Providers encompasses a nationwide network of providers. If there are providers within 130 miles of the member's home address who can offer the required service, out-of-network referrals will not be considered

In certain situations, a physician may determine that a member requires care outside of the member's EHP network of providers. Coverage for such services under the Health Benefit Plan (HBP) is permitted only when the necessary medical or behavioral healthcare cannot be provided within their network.

All out-of-network requests must be initiated by the member by calling the Aetna Concierge at 833.414.2331. Members should contact the Aetna concierge before scheduling any service with an out-of-network provider for further information.

Please note that the University Hospital System, University Case Medical Center, Summa Health System, and Aultman Hospital System and their affiliates are not considered part of the EHP network.

Pharmacy Benefits

The Prescription Drug Benefit is administered through CVS Caremark under the guidance of the EHP Pharmacy Management Department. CVS Caremark has a dedicated toll-free Customer Service phone number available 24 hours a day, seven days a week: 866.804.5876. CVS Caremark is also available through email at customerservice@caremark.com and the CVS Caremark website at https://www.caremark.com. You can also contact the EHP Pharmacy Management Department Monday through Friday from 8 a.m. to 4:30 p.m. at 216.986.1050, option 4 or toll-free at 888.246.6648, option 4. The EHP Pharmacy Management Department is also available through email at **EHPRxMgmt@ccf.org**.

Medicare eligible retirees are enrolled in a Part D Benefit administered by SilverScript.

EHP Pharmacy Formulary

All requests must meet the clinical criteria approved by the Pharmacy and Therapeutics (P&T) Committee before approval is granted. In some cases, approvals will be given a limited authorization date. If a limited authorization is given both the member and the physician will receive documentation on when this authorization will expire. Most requests will be processed within 1-2 business days from the time of receipt. A response will be faxed to the requesting physician, and the member will be informed of the request and the decision via mail.

Please consult the EHP Formulary for all medication definitions that apply to the particular strength/formulation of the medication, quantity limits, exception process, and formulary failure review process.

> The EHP Prescription Drug Formulary does not guarantee coverage. The drug formulary is available on our website at **https://employeehealthplan.clevelandclinic.org** and is updated on a quarterly basis.
>
> Silverscript Part D enrollees have a separate formulary and is available on the EHP website at **https://employeehealthplan.clevelandclinic.org**. Click on the “Retirees” tab.

Pharmacy Prior Authorizations

Prior authorization is required for coverage of certain medications. These medications are listed in the Pharmacy Management Program section of the EHP Prescription Drug Formulary. This list may change during the year due to new drugs being approved by the FDA or as new indications are established for previously approved drugs. A Prior Authorization, Formulary Exception and Appeal form must be completed, or sufficient documentation must be submitted by the member’s provider before a case will be reviewed. Please refer to the Formulary Failure Review Process below for information about obtaining a form. Completed forms can be faxed to 216.442.5790.

All prior authorization requests must meet the clinical criteria approved by the Pharmacy and Therapeutics (P & T) Committee before approval is granted. Obtaining medications through a previous insurance plan or from prior use and participation in a manufacturer bridge or assistance program does not supersede EHP medication-specific prior authorization criteria and does not guarantee coverage under the EHP. Members will still be required to meet all of the EHP P&T approved prior authorization criteria for coverage of the requested medication. In some cases, approvals will be given a limited authorization date. If a limited authorization is given, both the member and the physician will receive documentation on when this authorization will expire. Prior authorization approvals are subject to future plan benefit changes or utilization management programs that may impact coverage of the authorized medication. A response will be faxed to the requesting physician, and the member will be informed of the request and the decision via mail.

Formulary Failure Review Process

The EHP Prescription Drug Formulary is designed to meet the needs of the majority of HBP members. However, if it is determined that your patient requires treatment with a medication not included in the EHP Prescription Drug Formulary, you may request a review for preferred coverage of a Non-Formulary medication.

To start the review process, call the EHP Pharmacy Management Department at 216.986.1050, option 4 or toll-free at 888.246.6648, option 4 and request a Prior Authorization, Formulary Exception and Appeal Form. The form is also available online at **https://employeehealthplan.clevelandclinic.org**.

Formulary Failure Review Process *continued*

Providers should complete the form using specific laboratory data, physical exam findings, and other supporting documentation whenever possible in order to document the medical necessity of using a Non-Formulary medication. Approvals will be granted only if the provider can document ineffectiveness of Formulary alternatives or the reasonable expectation of harm from the use of Formulary medications. A separate form should be submitted for each member for each Non-Formulary drug.

All requests must be signed by the prescribing provider.

Instructions for a Provider on How to Complete the Prior Authorization, Formulary Exception and Appeal Form

1. Complete all information requested.
2. Submit a separate form for each member and for each drug you wish to have reviewed.
3. Keep a copy for your records.
4. Fax the form to: Cleveland Clinic Employee Health Plan EHP Pharmacy Management Department – 216.442.5790

OR Mail the form to: Cleveland Clinic Employee Health Plan EHP Pharmacy Management Department 6000 West Creek Road, Suite 20, Independence, OH 44131

OR Cleveland Clinic and Quality Alliance providers may create an electronic referral in EPIC by selecting EHP Pharmacy for new referral type.

Exception Processes

Routine requests will be processed within 10 days. Expedited requests may be made by calling EHP Pharmacy Management at 216.986.1050, option 4 or toll-free at 888.246.6648, option 4.

In most cases, these expedited requests will be reviewed and processed the same business day, but may take up to 72 hours. Calls/requests received after 4 p.m. or during the weekend will be handled the next business day. One of the following criteria must be met to file an expedited request:

- The drug is necessary to complete a specific course of therapy after discharge from an acute care facility (e.g. hospital, skilled nursing facility).
- The timeframe required for a standard review would compromise the member's life, health or functional status.
- The drug requires administration in a timeframe that will not be met using the standard process.

Appeals Process for Medical & Pharmacy Services

Definition:

Appeal process — The formal process that a member, or a provider on behalf of a member with the member's consent, can use to request review of a plan decision. Typically, the issues involve benefits, utilization management, quality of care and service.

Time Period for Making Decision on Provider Appeals

The provider has one level of post claim appeal. After reviewing a claim that has been appealed, the TPA or Health Benefits Program will notify the provider of its decision within a reasonable period but not later than 60 calendar days after the Benefit Program receives the request for review.

Provider Acting on Behalf of the Member:

- If a provider has authorized a representative (individual agent, revenue recovery organization, etc.) to act on behalf of the provider in an appeal, the provider is responsible to ensure that the appropriate business associate agreement is in place to ensure protection of personal health information.
- A provider may request an appeal on behalf of the health benefit plan covered member.
- If a covered member has authorized the provider to appeal a clinical or benefit coverage decision on their behalf, a copy of the covered member's written authorization is required and must be submitted with the appeal.
- A provider may request an expedited appeal on behalf of a covered member for covered services involving urgent care. Written authorization of the covered member is not required when filing an expedited appeal on behalf of a covered member.
- Expedited appeals for urgent care are those where waiting for a standard appeal decision could:
  - Seriously jeopardize the life or health of the covered member or the ability of the covered member to regain maximum function, or
  - In the opinion of the provider, subject the covered member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
- An appeal made by a provider on behalf of a covered member for denied urgent, pre-service or post-service requests or claims will expend one of the appeals available to the covered member under their coverage policy with the Company. Such an appeal will follow the process governing member appeals as outlined in the covered member's summary plan description.
- Covered members may also have external review rights through an independent review organization, as described in the covered member's summary plan description. If an independent review organization has made a binding determination on a denied request or claim in conjunction with an appeal, no further appeals may be filed.

Urgent Review Process:

A request for an expedited or urgent review must be certified by the Provider that the member's condition could, without immediate medical attention, result in any of the following:

1. Seriously jeopardize the member's life or health or the member's ability to regain maximum function; or
2. In the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The appeal does not need to be initiated in writing. The member or physician can call the Aetna Concierge telephone number on the member's identification card as soon as possible. After a call is placed to the Aetna Concierge telephone number, clinical documentation supporting the urgent review should be faxed to EHP at 216.442.5791.

Urgent Review Process *continued*

Urgent reviews will be resolved within 72 hours after the receipt of the request.

The expedited review process does not apply to prescheduled treatments, therapies, surgeries or other procedures that do not require immediate action.

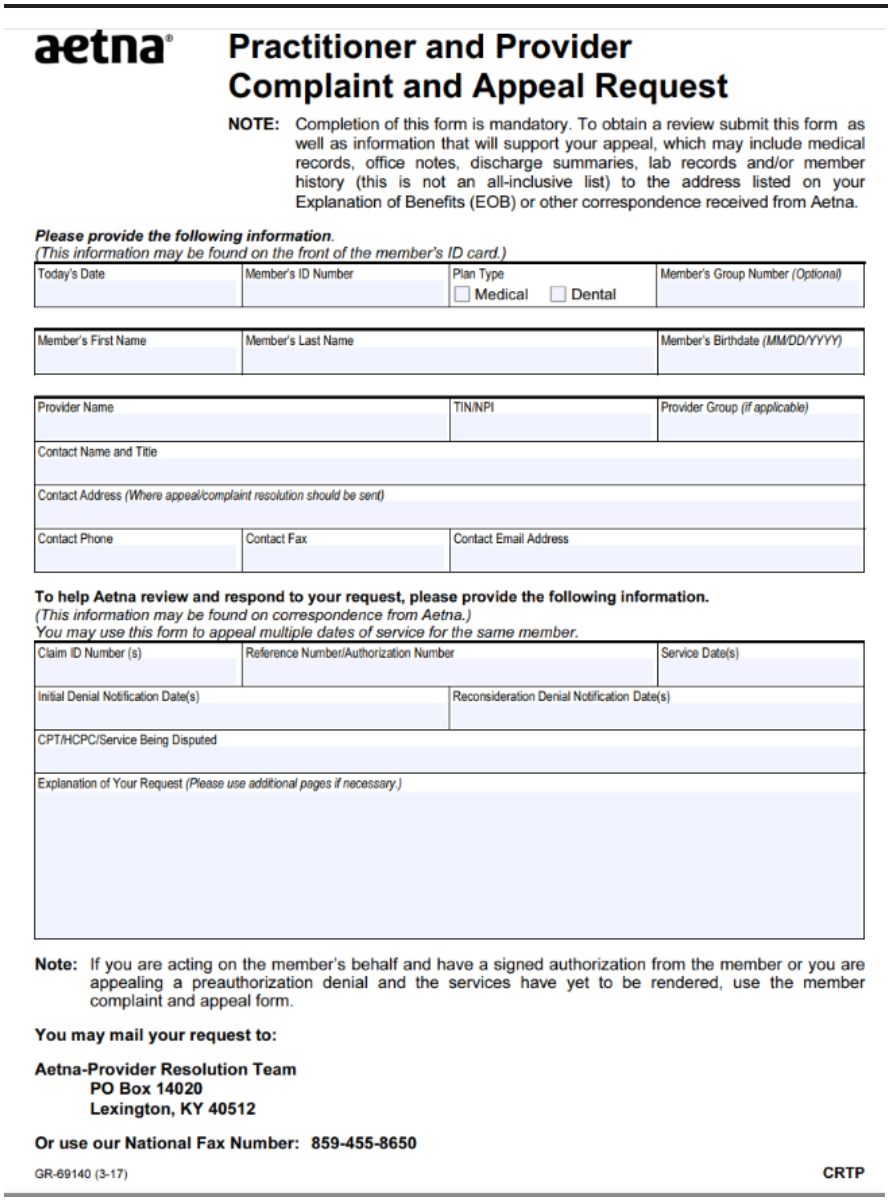
NOTE: When members request an internal review for an urgent care claim or for a concurrent care claim that is urgent, the member may also be eligible to file a request at the same time for an expedited external review.

Filing a Medical Benefits Appeal with Aetna:

If the provider is not satisfied with any of the following:

- A benefit determination decision; or
- A Medical Necessity determination decision.

To submit an appeal, the provider must use the Provider Complaint and Appeal form found on the Aetna website at **www.aetna.com**. For convenience, the form may also be found in the forms section of our web site: **https://employeehealthplan.clevelandclinic.org/**



aetna®

Practitioner and Provider Complaint and Appeal Request

NOTE: Completion of this form is mandatory. To obtain a review submit this form as well as information that will support your appeal, which may include medical records, office notes, discharge summaries, lab records and/or member history (this is not an all-inclusive list) to the address listed on your Explanation of Benefits (EOB) or other correspondence received from Aetna.

Please provide the following information.
(This information may be found on the front of the member's ID card.)

Today's Date	Member's ID Number	Plan Type ☐ Medical ☐ Dental	Member's Group Number *(Optional)*

Member's First Name	Member's Last Name	Member's Birthdate *(MM/DD/YYYY)*

Provider Name	TIN/NPI	Provider Group *(if applicable)*

Contact Name and Title

Contact Address *(Where appeal/complaint resolution should be sent)*

Contact Phone	Contact Fax	Contact Email Address

To help Aetna review and respond to your request, please provide the following information.
(This information may be found on correspondence from Aetna.)
You may use this form to appeal multiple dates of service for the same member.

Claim ID Number (s)	Reference Number/Authorization Number	Service Date(s)

Initial Denial Notification Date(s)	Reconsideration Denial Notification Date(s)

CPT/HCPC/Service Being Disputed

Explanation of Your Request *(Please use additional pages if necessary.)*

Note: If you are acting on the member's behalf and have a signed authorization from the member or you are appealing a preauthorization denial and the services have yet to be rendered, use the member complaint and appeal form.

You may mail your request to:

Aetna-Provider Resolution Team
PO Box 14020
Lexington, KY 40512

Or use our National Fax Number: 859-455-8650

GR-69140 (3-17) **CRTP**

Filing a Medical Benefits Appeal with Aetna *continued*

Send Medical Appeals to:

Aetna Provider Resolution Team
P.O. Box 14020
Lexington, KY 40512
Fax: 859.455.8650

Send Pharmacy Appeals to:

Health Benefit Program Pharmacy Appeals
6000 Westcreek, Suite 20
Independence, OH 44131
Phone: 216.986.1050 (option 4) or toll-free at 888.246.6648 (option 4)

The request for review must come directly from the patient unless they are a minor or have chosen an authorized representative. The member may choose another person to represent them during the appeal process, if Aetna or the Health Benefit Plan has a signed and dated statement from the member authorizing the person to act on the member's behalf.

The member will receive continued coverage pending the outcome of the appeals process. This means that the Benefit Program may not reduce or eliminate coverage of ongoing treatment until the appeal is exhausted.

Peer-to-peer Review

Providers who would like more information to understand the denial rationale may request an informational peer-to-peer review by contacting either the EHP Medical Management or Pharmacy department. Peer-to-peer is available for informational purposes only – denials will not be overturned.

Business hours for the EHP Medical Management are from 8 a.m. until 4:30 p.m. Monday through Friday.

EHP Medical Management
Phone: 216.986.1050
Toll-free: 888.246.6648
Fax: 216.442.5791

EHP Pharmacy Management
Phone: 216.986.1050 - option 4
Toll-free: 888.246.6648 - option 4
Fax: 216.442.5790

Joining the Aetna Network

Contracting with Aetna

Apply here: **https://extaz-oci.aetna.com/pocui/join-the-aetna-network**

Aetna Provider Service Center: 888.632.3862

Credentialing: 800.353.1232

Joining the Quality Alliance (Ohio Clinically Integrated Network)

Membership into the Quality Alliance requires approval through Cleveland Clinic's credentialing process and adherence to an approved Participation Agreement.

Criteria for Joining:

- Members are required to be on an OHIP (Ohio Health Information Partnership) preferred EMR
- Quality Alliance Membership Criteria SOP
  Link: Quality Alliance Membership Criteria SOP v.6 (**policytech.com**)

Requirements:

- Participation Agreement
- Business Associate Agreement
- Provider Election to Participate in CC EHP
  - Physician Providers (MD, DO, DPM, or PhD)
  - Allied Health Professionals
- Provider Election to Participate in Humana Medicare Agreement
- Provider Election to Participate in Humana Medicaid Agreement
- Provider Election to Participate in the Oscar Agreement
- Membership Questionnaire
- Arcadia EMR Discovery Questionnaire
- ACH Payment Form

Expectations of Membership:

- Maintain an OHIP preferred EMR through which the QA can access patient data
- Use physician-developed protocols, quality standards and efficiency criteria in practices
- Collaborate to improve performance
- Refer within the QA when feasible and appropriate, in accordance with patient preference
- Adhere to compliance programs and protocols

Contact Information

Website: **ccqualityalliance.org**

Email: **TheQualityAlliance@ccf.org**

Telephone: 216.986.1277

Contacts

Aetna – Third Party Administrator

Aetna
P.O. Box 981106
El Paso, TX 79998-1106
833.414.2331

Aetna Provider Service Center: 888.632.3862
Aetna Credentialing: 800.353.1232

Cleveland Clinic – Employee Health Plan – Administration

Patricia A. Zirm, RN, BSN, MPA,
Senior Director
25900 Science Park - Mail Code AC242
Beachwood, OH 44122
Telephone: 216.448.1701
Toll-free: 888.246.6648 – option 2
Fax: 216.448.2053
Email: **zirmp@ccf.org**

Jeanne Kubiak, MBA, Administrator
6000 West Creek Road – Mail Code RC20
Independence, OH 44131
Telephone: 216.372.4343
Email: **kubiakj6@ccf.org**

Web Site:
https://employeehealthplan.clevelandclinic.org/

Cleveland Clinic – Employee Health Plan – Medical Management Director

Evelyn Regotti MBA, BSN, RN, CCM
Director, Medical Management
6000 West Creek Road
Mail Code RC20
Independence, Ohio 44131

Telephone: 216.215.8845
Email: **regotte@ccf.org**

Cleveland Clinic – Employee Health Plan – Pharmacy Director

John Perone, Rph, MBA,
Senior Director Pharmacy
6000 West Creek Road –
Mail Code RC20
Independence, OH 44131

Telephone: 216.554.7564
Email: **peronej@ccf.org**

Quality Alliance – Ohio Clinically Integrated Network

Quality Alliance
Jeanne Kubiak, MBA, Administrator
6000 West Creek Road
Independence, OH 44131

Telephone: 216.372.4343
Email: **TheQualityAlliance@ccf.org**

Website: **ccqualityalliance.org**

9500 Euclid Avenue, Cleveland, OH 44195

Cleveland Clinic is a globally integrated multispecialty healthcare system combining hospital and outpatient care with research and education for better patient outcomes and experience. Cleveland Clinic has 81,000 caregivers worldwide, including 5,700 physicians and scientists. The health system consists of 23 hospitals and 276 outpatient locations, including a main campus in Cleveland; 15 regional hospitals in Northeast Ohio; five hospitals in Southeast Florida; a center for brain health in Las Vegas, Nevada; executive health and sports health services at two locations in Toronto, Canada; a hospital and outpatient center in London, United Kingdom; and a hospital and cancer center in Abu Dhabi, United Arab Emirates.
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