This volume of HealthMatters provides answers to many AlaskaCare frequently asked questions. Disclaimer: The information is provided for information purposes. In the event of a conflict between the above information and the AlaskaCare plan document, the plan document controls.

Medical Necessity

Health plans pay for covered services and supplies. The expenses covered through AlaskaCare are often called "eligible expenses." To be eligible, an expense must be medically necessary. These frequently asked questions (FAQ) provide information about how determinations of medical necessity are made under the AlaskaCare plans.

What is "medical necessity?"

Medical necessity is one factor the AlaskaCare health plans consider in determining whether to provide coverage for a service or supply. The AlaskaCare health plans do not pay for services or supplies that are not medically necessary, such as cosmetic procedures.

The AlaskaCare medical plans use Aetna's current Medical and Pharmacy Clinical Policy Bulletins to determine medical necessity. You may access the bulletins at: Aetna.com/cpb.

Determinations of medical necessity for dental procedures are made by Moda Health.

How does Aetna determine if a service or supply is medically necessary?

Aetna's clinical policy bulletins are based on:

- Reports in published, peer-reviewed medical literature
- Studies on a particular topic
- Evidence-based consensus statements
- Expert opinions of health care professionals
- Guidelines published by nationally recognized health care organizations that include supporting scientific data

Are there any limitations as to what kinds of services and supplies can be considered medically necessary?

Under the AlaskaCare plans, services or supplies are never considered medically necessary if they:

- Do not require the technical skills of health care professionals who are acting within the scope of their license;
- Are provided mainly for the personal comfort or convenience of you, your family, anyone who cares for you, a health care provider, or a health care facility;
- Are provided only because you are in the hospital on a day when you could safely and adequately be diagnosed or treated elsewhere; or
- Are provided only because of where you are receiving the service or supply, if it can be provided in a doctor's or dentist's office or other less costly place.

If a service or supply fits the definition of medical necessity, is it always covered by the plan?

No, not all medically necessary services or supplies are covered by a health plan. For example, a medically necessary service or supply is not covered by the AlaskaCare plans when:

- It is specifically excluded; or

- The duration of the medically necessary service reaches a plan limitation (for example, some benefits are limited to a certain number of days or visits).

Shouldn't medical necessity be defined by the plan document, and not the Third-Party Administrator?

The number of medically necessary procedures and unique circumstances of their application are virtually limitless. Thus, it is simply not feasible to produce a plan document that can account for every scenario.

Determinations of medical necessity are part of the claims processing function. Because AlaskaCare contracts with a Third-Party Administrator (TPA) to perform this function, it is the TPA who makes determinations of medical necessity as part of the claims processing function. This is not new. Prior TPAs also made medical necessity determinations as part of the claims processing function for the AlaskaCare plans. What is new is the publication of the data used by the TPA to make medical necessity determinations. This information is now available to AlaskaCare plan members through Aetna's contract with the State.

The clinical policy bulletins provided by Aetna set guidelines that are transparent to members and their physicians, and clearly show the medical evidence relied upon to make the determination. The evidence basis of the policy bulletins are reviewed regularly and the bulletins are updated as necessary.

If my doctor recommended the treatment isn't that enough to support medical necessity?

The National Institute of Health estimates that nearly 30% of all medical procedures or services performed in the United States are either unnecessary and provide no benefit to the patient, or even worse, are harmful. Aetna's clinical policy bulletins rely on medical evidence to make decisions about coverage that are weighed against clinically accepted standards of medical practice.

We encourage you to have your doctor review the clinical policy bulletins used to guide coverage decisions related to medical necessity. After your provider completes this review, and if they disagree, your provider may request a pre-determination of coverage and present additional medical evidence for consideration during the pre-determination review.

To review your doctor's recommended treatment plan, and verify whether the services or supplies fit the definition of medical necessity, contact Moda Health at (855) 718-1768 for services covered under the dental plan, or contact the Aetna Concierge at (855) 784-8646 for services covered under the medical plan.

If there continues to be a difference in opinion, you or your provider are encouraged to appeal the coverage decision.

What can I do if a claim is denied because the Third-Party Administrator determined my service is not medically necessary?

If a claim is denied based on a medical necessity, you may request an explanation of the scientific or clinical judgment for the determination, free of charge.

If you believe it's warranted, you may also initiate written appeal to the plan. The AlaskaCare Employee Health Plan booklet and the AlaskaCare Retiree Health Plan amendment describe the process and timeline required for submitting an appeal. These plan booklets and an informational brochure on the appeals process are available at **AlaskaCare.gov**.

Effective January 1, 2014, the appeals process used by AlaskaCare was enhanced to allow for the use of Independent Review Organizations (IRO) at level two for clinical appeals. Use of an IRO allows for an impartial review by a third-party medical expert when there is disagreement regarding medical necessity.

Premera Blue Cross Security Breach

On March 17, 2015, Premera Blue Cross / Blue Shield reported a security breach that may have resulted in the loss of sensitive personal information of their current and former clients. Among those affected are current and former Alaska state employees. To answer common questions related to this incident, the Division of Retirement and Benefits has provided some of its own information to help Alaska state employees understand how they may be affected. You can find this information at: **Alaska.gov/go/E7N4**

To contact Premera directly, please call (800) 768-5817, Monday through Friday, between 5:00 a.m. and 8:00 p.m. Pacific Time (closed on U.S.-observed holidays).

Medical, Vision and Audio Recognized Charge

This FAQ applies to the medical plan set forth in the AlaskaCare Employee Health Plan and to the medical, vision and audio plans set forth in the AlaskaCare Retiree Benefit Plan.

What is a recognized charge?

A *recognized charge* is the maximum amount that AlaskaCare's medical, vision and audio plans will pay for a covered service. The term recognized charge is sometimes referred to as the usual, customary and reasonable (UCR) charge, or the maximum allowed charge.

An out-of-network provider has the right to bill you for the difference between the recognized charge and the actual charge. This is sometimes referred to as balance billing.

When you use a network provider, you are not subject to balance billing for covered services. In other words, the provider has agreed to accept, as payment in full, the recognized charge for the service provided. You are only responsible for payment of other applicable charges such as deductibles, co-insurance, and/or non-covered charges.

The recognized charge is the ***lesser of:***

- The amount the provider bills; or
- The 90th percentile of the prevailing charge rate for the geographic area where the service is furnished. The 90th percentile of the prevailing charge rate means the charge that is at or below 90% for all of the charges reported for a service within a specific geographic area.

How is the recognized charge amount determined?

The recognized charge for out-of-network providers is the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished. The AlaskaCare plans establish the percentile (i.e., 90th percentile) to be applied to the prevailing charge rate; however, the prevailing charge rate is reported by FAIR Health, an independent not-for-profit corporation. FAIR Health collects charge data from claims received by insurance plans and health plan administrators across the country for charges billed by physicians, hospitals and other healthcare providers. Charges reported are the full fees that healthcare professionals report to insurers as part of the claims process—not the negotiated rates that apply when visiting a network provider. Charges reported are maintained by FAIR Health in its database, which is comprised of billions of claims for billed medical procedures from across the United States. New charge data is continually added to the FAIR Health database.

How does the plan know that FAIR Health's information is reliable?

FAIR Health has audit and validation programs in place to ensure the integrity of its data. Part of the validation process entails testing the data with statistical algorithms and examination by FAIR Health's in-house statistical and technology experts. A team of healthcare researchers from leading academic institutions advise FAIR Health on the best methods for analyzing its national claims data. FAIR Health is also advised by an independent Scientific Advisory Board of prominent researchers who review Fair Health's statistical methods and data. FAIR Health also seeks input from other stakeholders such as consumer and patient advocacy groups, healthcare providers, actuaries and federal officials.

How are the services identified in the FAIR Health database?

Each specific service, procedure or supply in the FAIR Health database has a unique *Current Procedural Terminology (CPT) code.* CPT codes are numbers assigned to medical services and procedures. CPT codes are part of a uniform system of coding maintained by the American Medical Association and are used by providers, facilities and insurers. Each CPT code is unique. There are currently over 10,000 medical services and procedures classified by CPT code. Most CPT codes are very specific. For example, the CPT code for a 15-minute office visit is different from the CPT code for a 30-minute office visit.

How are the geographical areas determined?

FAIR Health organizes its data by **geozip**—a geographical area usually defined by the first three digits of the U.S. zip codes. Geozips may include areas defined by one three-digit zip code or a group of three-digit zip codes. Geozips generally do not include zip codes in different states.

The State of Alaska is currently defined into three geozips:

- *995 and 997* – including Anchorage, Bethel, Fairbanks, Kotzebue, etc…
- *996 and 998* – including Homer, Kodiak, Juneau, Sitka, etc…
- *999* – including Ketchikan, Prince of Wales, Wrangell, etc…

What if there are not enough occurrences of a procedure in a particular geozip?

If there are fewer than nine occurrences of a procedure in a geographic area, the plan uses FAIR Health's "derived charge data" instead. This data is based on the charges for comparable services, multiplied by a factor that takes into account the relative complexity of the service. If this information cannot be obtained locally, then national data is used.

What factors can affect the recognized charge?

The following factors can affect the recognized charge:

- *Billing errors:* when a provider makes a mistake on either the procedure code or zip code.
- *Multiple procedures:* when a provider performs multiple surgical procedures during a single session. The standard practice in such cases is to bill 100% for the primary (largest) procedure, 50% for the secondary procedure and 25% for all others. However, incidental items that require little or no additional time should not have an additional fee.
- *Unbundling:* when a provider shows separate codes on the bill for related or incidental services. For example, instead of being billed separately, related blood tests performed at the same time should be billed under a single General Health Panel code.

How can I make sure an out-of-network provider's rate will be within the recognized charge?

You can verify whether an out-of-network provider's charges are within the recognized charge by calling the Aetna Concierge and providing the following information:

1. The procedure code,
2. The zip code where the service is to be performed, and
3. The projected cost.

Aetna will use this information to estimate whether the proposed amount is within the recognized charge. Remember, if you use an Aetna network provider, those providers have already contracted with Aetna to offer discounted fees and those discounted fees are deemed to be within the recognized charge.

When I use an out-of-network provider, how much of the bill am I responsible for?

If you use an out-of-network provider, you are responsible for the difference between the recognized charge and the amount charged by the provider in addition to other applicable charges such as deductibles, co-payments, co-insurance and non-covered charges.

What should I do if my out-of-network provider charges more than the recognized charge?

If the out-of-network provider's claim exceeds the recognized charge and you have already paid your out-of-network cost-sharing amount, wait for the provider to send you a bill, since the out-of-network provider may adjust their charges after reviewing the claim payment. If not, ask the out-of-network provider to:

1. Consider reducing or waiving their fee to meet the recognized charge amount;
2. Review the bill to ensure the correct procedure code and amount was used (and if not, submit a corrected bill to the plan); and
3. Confirm that the out-of-network provider charged their normal fee for the service, or if the out-of-network provider increased the charge due to unusual circumstances. If so, ask the out-of-network provider to either submit a corrected bill to the plan or provide a written explanation so you may file an appeal with the plan.

Is the recognized charge provision a change in my plan?

No, the plan has always determined claims payment based upon the recognized charge. Prior to January 1, 2014, AlaskaCare plan documents referred to the recognized charge as the "usual, customary and reasonable (UCR) charge or the "maximum allowed charge."

As our claims administrator, what are Aetna's policies for claims reimbursement?

Aetna's claim reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- The duration and complexity of a service;
- Whether multiple procedures are billed at the same time, but no additional overhead is required;
- Whether an assistant surgeon is involved and necessary for the service;
- Whether follow-up care is included in the price of the service;
- Whether there are any other characteristics that may modify or make a particular service unique; or
- When a charge includes more than one claim line, whether any service described by a claim line is part of, or incidental to, the primary service provided.

These claim reimbursement policies are based on:

- Policies developed for Medicare;
- Peer-reviewed, published medical journals;
- Available studies on a particular topic;
- Evidence-based consensus statements;

- Expert opinions of health care professionals; and
- Guidelines from nationally recognized health care organizations.

How can I appeal a recognized charge determination for an out-of-network provider?

You may appeal a recognized charge determination by providing additional information to indicate why the recognized charge was not correct, such as incorrect procedure codes, an incorrect zip code, etc. Information on appealing claim decisions is available in the AlaskaCare plan documents or in the appeals brochure on the Division's Web site at **AlaskaCare.gov**.

Where can I get more information about recognized charges?

Specific plan language regarding recognized charges is available in the January 1, 2014 AlaskaCare Retiree Health Plan Amendment on pages 16 through 18 and in the AlaskaCare Employee Health Plan on pages 187 through 189. Both are available on the Division's Web site at **AlaskaCare.gov**.

How do I avoid recognized charge issues?

See a network provider if one is available. When you see a network provider, the plan will pay based on the lesser of the billed amount or the provider's discounted fee amount.

Dental Plan Recognized Charge

This FAQ applies to the AlaskaCare Dental Plans only.

The AlaskaCare Dental Plans limit payment of covered services to the recognized charge.

An out-of-network provider has the right to bill you for the difference between the recognized charge and the actual charge. This is sometimes referred to as balance billing.

When you use a Delta Dental network provider, you are not subject to balance billing for covered services. In other words, the provider has agreed to accept, as payment in full, the recognized charge for the service provided. You are only responsible for payment of applicable deductibles, co-insurance and/or non-covered charges.

What is the recognized charge?

The *recognized charge* is the maximum amount the AlaskaCare Dental Plans will pay for a covered service.

The recognized charge for each service or supply provided by a *network* provider in Alaska is the lesser of:

- 100% of the covered expense;
- 100% of the provider's accepted filed fee with Delta Dental; or
- 100% of the provider's billed charge.

The recognized charge for *out-of-network* providers in Alaska is the lesser of:

- The provider's billed charge; or
- 75% of the 80th percentile of the prevailing charge rate as determined by Delta Dental.

The recognized charge for *out-of-network* providers outside Alaska is the lesser of:

- The provider's billed charge; or
- the prevailing charge rate as determined by Delta Dental.

How is recognized charge determined in Alaska?

Delta Dental of Alaska maintains a database of billed charges from its adjudicated claims in Alaska. The 80th percentile is calculated for every American Dental Association (ADA) procedure code using a statistically valid methodology, which removes outlier charges. This calculation is based on the most recent 12 months of processed claims and serves as the starting point for determining updates to the prevailing charges.

How is the prevailing charge determined in Alaska?

Delta Dental of Alaska incorporates a number of additional processes in order to validate the results of the 80th percentile calculation before making changes to the prevailing charges:

a) The 80th percentile is determined statewide in order to maximize the statistical significance of the calculation.
b) Additional data sources are compared to the results of the 80th percentile calculation for consistency purposes. Other data sources reviewed by Delta Dental are:
    - The Delta Dental Submitted Charges Database (DSC): This dataset is maintained by Delta Dental nationally and includes submitted charges from all Delta Plans for services rendered in Alaska.
    - The rates reported by Fair Health, an independent non-profit corporation.
    - Market research on prevailing charges used by other insurance carriers.
c) For each procedure code, the current prevailing charge is compared to the 80th percentile calculation. Any changes to the current prevailing charge indicated by the 80th percentile calculation must be consistent with the other data sources referenced above. For new procedure codes, or those where there are too few procedures for a statistically valid 80th percentile calculation, additional considerations taken into account are:
    - The complexity of the service or supply.
    - The degree of skill needed, and
    - The cost of any materials required for the service.
d) When a change in the prevailing charge is indicated, the change is limited to maximum percentage change unless otherwise indicated.

Is this same 80th percentile calculation used for specialists?

If the service provided by the specialist is exactly the same as that provided by the general dentist, the prevailing charge is the same for both (e.g. full mouth X-rays). However, if the services provided are specific to a specialist's training, the specialist will be reimbursed at a higher prevailing charge.

How does the prevailing charge rate determination differ outside of Alaska?

The prevailing charge is determined by Delta Dental methodology for each individual state. If you are receiving services at an out-of-network provider outside of Alaska, please contact Moda Health/Delta Dental at 1-888-718-1768 for more details.

Retiree Vision Benefits

Why is my vision claim being denied?

Many retirees have reported that Aetna denied their vision claims in error. Over the past few months, Aetna completed a thorough review of AlaskaCare vision claims and identified a few issues, which, at this point should be resolved. Here's what happened:

- Aetna asked some members to provide a Medicare Explanation of Benefits (EOB) document to support a routine vision claim. AlaskaCare is the primary payer for routine vision benefits—a Medicare EOB should not be needed.

Be sure to note that Medicare does cover certain vision exams (for example, glaucoma screenings for people with diabetes). When you receive these services, Aetna may contact you to request a Medicare EOB.

- Vision Claims Denied as Not Covered. Aetna erroneously denied some members' vision services. Aetna updated its claims system mid-May and has reprocessed impacted claims retroactive to January 1, 2014.

What should I do if my provider tells me I don't have vision coverage but I know I do?

Providers may receive incorrect information when verifying your vision benefits through Aetna's self-service tool. While Aetna continues to update its systems, you can call Aetna Concierge at (855) 784-8646 to verify your vision benefits.

How do I find a network vision provider?

The retiree vision plan does not have a network. This means you may choose to see any provider and receive benefits for covered services. However, payments are subject to recognized charge limitations discussed on page 3.

Will my vision provider submit my claims for me?

No, you are responsible for returning your vision claims. Your provider may be willing to file the claim for you, but it is the member's responsibility. The vision claim form can be located at ***Alaska.gov/drb/pdf/ghlb/retiree/visionBenefitsRequest.pdf.***

What should I do if I am only enrolled in the AlaskaCare dental-vision-audio plan (and not medical) and do not have an ID card to show my provider?

For vision and audio with Aetna, you can log on to Aetna's online Navigator tool and click on "Get an ID Card" to print an ID card that includes your name and Aetna ID number. You can access Aetna Navigator through the AlaskaCare Web site at ***AlaskaCare.gov***. If you are not registered for Aetna Navigator, you can call Aetna Concierge at (855) 784-8646 to obtain your Aetna ID number to give your provider.

For dental, Moda Health/Delta Dental will send you an ID card for your dental services. If you need assistance with your dental cards, please contact their Customer Service Center at (855) 718-1768.

What is VSP?

Vision Services Plan (VSP) is not part of the AlaskaCare Retiree optional vision benefit currently. However, it has been requested we consider this plan (currently used with the AlaskaCare Employee Health Plan) for our retiree population. The plan has a similar benefit structure to our existing retiree vision plan, and offers discounts and exclusive savings that can save our members money. The VSP vision network has over 63,000 access points across the country, including retail outlets, such as Costco and Walmart. Under VSP, you have the freedom to choose any eye care provider, but your benefits may differ from the coverage you receive with a VSP doctor. Additional information on this plan can be found at: ***Vsp.com/eye-insurance.html.***

Dental Plan Updates

Why is nitrous oxide no longer covered by my dental plan?

After talking to our members, we have added coverage for nitrous oxide to the dental plan. This change is retroactive to January 1, 2014. Denied claims were automatically reprocessed. If you have had a claim for nitrous oxide denied and have not received a revised Explanation of Benefits, please contact Moda/Delta Dental at (855) 718-1768.

Why are cleanings limited to once every six months?

Some of our members have advised us of scheduling challenges when making appointments, especially for those members that have to travel to see a dentist. To address this issue, we have changed the frequency for exams and cleanings from once every six months, to twice per benefit year.

What if my health condition makes more frequent cleanings necessary?

Recognizing that some members may need more frequent cleanings, we have increased the frequency limits in some cases. Your dental professional can contact Moda/Delta Dental to determine if cleanings in excess of the following limits can be approved.

- Two cleanings per year, under normal circumstances.
- Up to three cleanings per year for pregnancy.
- Up to four cleanings per year for diabetes or periodontal disease.

Additional cleanings are available when dentally or medically necessary with Moda/Delta Dental of Alaska prior approval.

Save Yourself Money by Using Network Providers

Using "network" providers can provide substantial benefits to members through the elimination of what's known as "balance billing." It can also generate substantial savings to members through negotiated provider discounts. To find out whether your doctor is a member of the Aetna network, call Aetna's Health Concierge at (855) 784-8646 or select the "Find a Doctor" button on our Web site at ***AlaskaCare.gov***. To find out whether your dentist is a member of the Moda/Delta Dental network call Moda/Delta Dental at (855) 718-1768 or select the "Find a Dentist" button on our Web site.

What is "balance billing?"

The AlaskaCare plans limit payment of covered services to the recognized charge. The recognized charge is the maximum amount the AlaskaCare plans will pay for a covered service. Aetna and Moda/Delta Dental, and their respective network providers (sometimes referred to as participating providers), agree to a set of discounted negotiated rates for services provided. The recognized charge for network providers is the negotiated rate. For an explanation of how the recognized charge is calculated for out-of- network providers, please see the recognized charge questions under the Medical, Vision and Audio and Dental sections.

An out-of-network provider has the right to bill you for the difference between the recognized charge and the actual charge. This is often referred to as balance billing. Network providers have agreed to accept, as payment in full, the negotiated charge. Therefore, you are not subject to balance billing when you use a network provider.

If I have a procedure or service at a network facility, can I be balance billed?

You may find that not all providers at a "network" facility are part of the Aetna network. For example, if you have a surgical procedure performed at a network hospital, you may find that the hospital and surgeon are in the network, but the anesthesiologist is out-of-network. When you get your bill, you'll see that it reflects the negotiated network rates for your hospital and surgeon. The anesthesiologist, however, may charge what s/he chooses since s/he has no negotiated contract with Aetna. If the anesthesiologist claim exceeds the recognized charge, you may receive a bill for the balance.

How do I avoid receiving a balance bill?

You may prevent balance billing by verifying all medical providers are in the Aetna network and making sure your AlaskaCare Plan covers the services you need. For example, if you're having x-rays, MRIs, CT scans, or PET scans, make sure both the imaging facility and the radiologist who will read your scan are in the network. If you're planning surgery, ask whether the anesthesiologists are in the network. If available, the facility should accommodate your request to use a network provider for your services.

Similarly, for AlaskaCare covered dental services, you may prevent balance billing by verifying the provider is in the Moda/Delta Dental network.

What if there is no network provider available?

If your provider is not a network provider, you may ask for an estimate of charges, the codes that will be used for billing, and the provider's zip code. When you receive this information, contact the Aetna Concierge at (855) 784-8646 or Moda/Delta Dental at (855) 718-1768. A member of the Aetna Concierge or Moda Customer Service team can review the estimated charges and will advise you if the charges fall within the recognized charge for your area. If the estimated charges exceed the recognized charge, you may request that your provider accept that amount and not balance bill you, or you may request payment arrangements with their office.

If your current provider is not listed as a network provider, you can ask your provider to contact Aetna at (800) 720-4009 or Moda at (855) 718-1768 for a participation application. Members are also encouraged to nominate their out-of-network providers to join the network. Contact the Aetna Concierge or Moda Customer Service to find out how.

In some cases, unfortunately, there will not be a network provider for the service you need in your area. The Division, Aetna and Moda/Delta Dental are working diligently to improve network access, but please understand that we cannot force providers into the network.

Is there a "network" for durable medical equipment (DME)?

Aetna does have a DME national provider listing on their DocFind Web site. To get the current listing, contact the concierge at (855) 748-8646 or go to AlaskaCare.gov and select the *Find a Doctor* tool. In DocFind under the *Search by Location* tab, use the *Search for:* drop down menu to select *Other (X-ray, Surg Ctrs; Med Equip, etc.)* and the *Type:* drop down menu to select *Durable Medical Equipment-National.*

For local DME providers, change the *Type:* to *Durable Medical Equipment-Local* and enter the appropriate zip code and plan.

Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan

This article does not apply the AlaskaCare Employee Health Plan. For details about coverage in the Employee Plan, see the plan document at AlaskaCare.gov.

Outpatient rehabilitative services such as chiropractic care, physical therapy, massage therapy, and occupational therapy are commonly obtained following joint replacement surgery or after suffering an injury to your back, knee, shoulder, or other joints. If you are planning an upcoming surgery or are currently under care for this type of condition, it is important to understand your rehabilitative care benefits under the AlaskaCare plan.

What coverage for rehabilitative services does the AlaskaCare Retiree Health plan offer?

The Medical Plan covers **outpatient** rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. Care (excluding speech therapy) aimed at slowing deterioration of body functions caused by neurological disease is also covered.

How does the plan determine if the services are medically necessary?

The AlaskaCare claims administrator (currently Aetna) is required to verify that services are medically necessary per the guidelines listed in the AlaskaCare plan document. In order to do so, they will request copies of your treatment records from your provider. Generally medical review is not needed for these services if the course of treatment does not exceed 25 visits. Under Aetna, clinical records are requested from your provider when the claim for the 20th visit for a condition is received.

What information does my provider need to supply?

Your provider will need to supply clinical records that contain information on the initial evaluation, the most recent therapy re-evaluation with an updated plan of care, the last five daily therapy and progress notes, and documentation supporting the need for ongoing supervised rehabilitative care including dates of surgery, invasive procedures or a change of diagnosis. The goal of therapies and treatment should be to rehabilitate the patient to a point where he/she can function adequately in his/her normal daily activities. There must be reasonable expectations that the therapy/ treatment will produce significant improvement in the patient's condition within a reasonable period of time. The AlaskaCare plan does not cover "maintenance" care, that is, services to keep the patient in his/her "rehabilitated" state. Maintenance is not considered a "medically necessary service".

What happens if my provider does not submit my records after the 20th visit?

The AlaskaCare claims administrator will continue to process claims until the claim for the 25th visit is received. At that point all claims in excess of the 25th visit will be pended awaiting clinical records that support medical necessity. If no records are received within 45 days, the claims will be denied. (If you live in North Carolina or Texas the timeline may vary, please contact Aetna Concierge at 1-855-784-8646 for additional information.)

What if the AlaskaCare claims administrator determines the clinical records do not support the treatment as medically necessary?

It is essential that AlaskaCare members understand that "medical necessity" in this instance requires continued significant clinically documented improvement. You may want to direct your provider to Aetna's Clinical Policy Bulletin found online at Aetna.com/cpb in advance of your 25th visit. (The bulletins are numbered as follows: 0243 for speech therapy, 0325 for physical therapy and 0107 for chiropractic services.) This will allow your provider to see additional detail on what services and procedures are considered medically necessary. If it is determined by the AlaskaCare claims administrator that the treatment is not medically necessary, all claims after the 25th visit for that condition will be denied.

Is the need to verify medical necessity a change with this administrator?

No, the requirement for treatment to be medically necessary is a provision of the AlaskaCare retiree health plan. Previous claims administrators were also required to make medical necessity determinations per the guidelines listed in the AlaskaCare plan document.

What can I do if my rehabilitative care is denied?

You have the right to appeal a denial. You should work with your provider to ensure all clinical records supporting that the services were medically necessary are supplied to AlaskaCare Claims Administrator with your level I appeal. The Member Complaint and Appeal form is available at AlaskaCare.gov.

If your appeal is denied, you may apply for an external review. At this level an independent review organization (IRO) will consider the AlaskaCare plan provisions, your clinical information, your provider's recommendation, Aetna's recommendation, and other applicable information, such as appropriate practice guidelines, etc. Should the IRO find that the denied claims were medically necessary, Aetna will process the denied claims upon receipt of the IRO's determination. If the IRO upholds Aetna's denial, you can advance your appeal to the Alaska Office of Administrative Hearings.

What should I do if I am approaching the 25th visit?

Claims for services after the 25th visit may be denied. In advance of the 25th visit, you should consult with your provider to ensure that the "medical necessity" requirements of the AlaskaCare plan have been met. Direct your provider to Aetna's Clinical Policy Bulletin for additional information.

If treatment after the 25th visit is determined to be medically necessary, will I be asked to provide clinical records again for the same condition?

If treatment after the 25th visit is considered medically necessary, based on a person's individual clinical situation, Aetna may at some later date(s) request treatment records to verify that services continue to be medically necessary.

What if I have a new injury or condition after I have reached maximum benefit from another series of rehabilitative services?

Your provider should submit the proper diagnosis codes for the course of treatment designed to restore and improve bodily function lost due to the new injury or illness.

Coordination of Benefits

What is Coordination of Benefits?

Coordination of Benefits (COB) is a method of ensuring that people covered by more than one medical plan will receive the benefits they are entitled to but not more than 100% of their covered expenses. The AlaskaCare health plans coordinate benefits with other group health care plans to which you or your covered dependents belong. Coordination of benefits can be very confusing, even for people who work at a physician's office.

With COB, if you are covered by more than one health care plan, the plans work together to provide benefits. One plan is considered "primary" and pays your covered expenses first. The other plan is "secondary" and pays any remaining covered expenses up to 100%. In some cases, there may be a third or fourth plan, as well.

It is important to remember that not all expenses are covered expenses.

Who sets COB rules?

Most COB rules are set by the National Association of Insurance Commissioners (NAIC). Rules for coordinating with Medicare and Medicaid are set by federal and state law. Most plans follow the NAIC rules, but there is no requirement that they do so. The AlaskaCare health plans follow standard NAIC rules to ensure ease of coordination with other plans.

What are the rules?

Here are examples of common COB situations and rules:

If You Are Covered Under…	Here's How the Plans Pay
Active employee plan and retiree plan	**Primary:** Active employee plan **Secondary:** Retiree plan
Retiree plan and as dependent under another person's plan through active employment	**Primary:** Retiree plan **Secondary:** Other person's plan
Retiree plan and Medicare-eligible	**Primary:** Medicare **Secondary:** Retiree plan
Two retiree plans	**Primary:** Plan in force the longest **Secondary:** Other plan
Retiree plan, as dependent under another person's plan through active employment, and Medicare-eligible	**Primary:** Other person's plan **Secondary:** Medicare Pays third: Retiree plan
Active employee plan, retiree plan, as dependent under another person's plan through active employment, and Medicare-eligible	**Primary:** Active employee plan **Secondary:** Other person's plan **Pays third:** Medicare **Pays fourth:** Retiree plan

If your dependent children are covered under more than one plan, in most cases, the plan of the parent whose birthday falls earlier in the year (not the oldest) is primary. If both parents have the same birthday, the plan that has covered the children longer is primary. If the parents are separated or divorced, here's how the plans pay:

- **Primary:** plan of the parent whom the court has established as financially responsible for the child's health care (the claims administrator must be informed of the court decree)
- **Secondary:** plan of the parent with custody of the child
- **Pays third:** plan of the spouse of the parent with custody of the child
- **Pays fourth:** plan of the parent who does not have custody of the child

What if none of the rules describe my situation?

If none of the above rules applies, the plan that has covered the patient the longest is primary.

How do the plans coordinate if my AlaskaCare plan is secondary?

When an AlaskaCare plan is secondary, the amount the plan pays after the deductible is met is figured by subtracting the benefits payable by the other plan from 100% of expenses covered by the AlaskaCare plan on that claim.

Example:

- You obtain a filling from a network dentist who charges $200.
- Both your dental plans pay 80% for class II (restorative) services.
- You have met your deductibles for the year.
    - Primary plan pays: $160 (80% of $200)
    - Secondary plan pays: $40 (20% of $200)
    - Total paid: $200

Will the coverage from two AlaskaCare plans always pay 100% of what the provider charges?

No, you may receive a balance bill if you use an out-of-network provider. In this case, the plan will pay up to the recognized charge for this service in your area. For more information on how recognized charges are calculated, see the Recognized Charges FAQ on the AlaskaCare Web site.

Example:

- You obtain a filling from an out-of-network dentist who charges $250 for a filling.
- The recognized charge for this service in Alaska is $150.
- Both your plans pay 80% for class II (restorative) services.
- You have met your deductibles for the year.
    - Primary plan pays: $120 (80% of $150)
    - Secondary plan pays: $30 (20% of $150)
    - Total paid: $150
    - Potential balance bill amount: $100 ($250 - $150)

You may also receive a balance bill if one of your plans has a lower coinsurance rate (the percentage of the cost you pay for covered expenses once you meet any deductible) or excludes coverage for the service.

Example:

- You obtain a filling from a dental network provider who charges $200.
- Your dental plan pays 80% for class II (restorative) services, but your spouse's plan only pays 10%.
- You have met your deductibles for the year.
    - Primary plan pays: $160 (80% of $200)
    - Secondary plan pays: $20 (10% of $200)
    - Total paid: $180
    - Potential balance bill amount: $20 ($200 - $180)

Are there other benefits to being covered by more than one plan?

If you are covered under two AlaskaCare plans, the annual maximum that the plan pays will double. For example, under the Alaska care retiree dental plan, the annual $2,000 individual maximum would double to $4,000.

Do frequency limits double?

No, the maximum frequency of services per year is not increased due to having other coverage. For example, if you have two plans that each cover a single vision exam each year, the plans coordinate to pay up to 100% of the single vision exam. They do not pay for two vision exams in a year.

How do the AlaskaCare plans coordinate with Medicare?

If you are covered under AlaskaCare and eligible for Medicare, Medicare is your primary coverage. This means that the AlaskaCare plan reduces your benefits by the amount you are eligible to receive from Medicare Parts A and B, regardless of whether you actually enroll in Medicare.

It's your responsibility to enroll in Medicare Parts A and B as soon as you become eligible and to pay applicable Medicare Part B premiums.

I am covered under the AlaskaCare Employee Health Plan. Is there anything my spouse or qualified same-sex partner should consider when making elections to a State employee union health trust?

The AlaskaCare Employee Health Plan will only pay 30% of the covered charges for your dependents if your spouse, qualified same-sex partner or child(ren) are covered by a state employee health trust and that coverage:

- Has been waived,
- Pays less than 70% of covered expenses, or
- Has an individual out-of-pocket maximum (including deductible) of more than $3,500.

This applies to any dependent covered by the AlaskaCare Employee Health Plan whether the plan pays as primary or secondary.

Example:

- You incur covered expenses of $1,000. Your spouse elected limited coverage under a union health trust that pays 20% coinsurance, so your AlaskaCare Employee Health Plan will pay 30% after the deductible.
    - Spouse's plan pays: $200 (20% of $1,000)
    - AlaskaCare plan pays: $300 (30% of $1,000)
    - Total paid: $500
    - Potential balance bill amount: $500 ($1,000 - $500)

I am retired and eligible for Medicare, but covered under my spouse's active employee plan…

Am I required to enroll in Medicare Parts A and B?

You are not required to enroll in Medicare Parts A and B, but the AlaskaCare Retiree Health Plan will estimate the portion that Medicare would have covered and pay third (after spouse's plan and Medicare).

Do I have to pay a premium for Medicare?

For many people, Medicare Part A is premium-free. However, if you are not eligible for premium-free Part A, you may submit a copy of the denial letter from Social Security to the Third-Party Administrator. The claim administrator will document your file to reflect that the estimation of Medicare coverage will not occur for an expense that would have been covered under Medicare Part A. All coordination rules, including estimating Medicare benefits, would continue to apply to Part B expenses, even if you do not enroll.

You do need to pay a monthly premium for Medicare Part B. For additional information, visit ***Medicare.gov***.

What if I am only enrolled in Medicare Part B, and/or enrolled in Medicare Part A on a premium-paying basis?

In this limited situation, standard Medicare coordination of benefits provisions do not apply. The plans will pay as follows:

- Primary: Medicare
- Secondary: Your spouse's active employee plan
- Pays third: Your retiree plan

Pre-paid Cash Card Scam Targeting Survivor Benefits

The Division of Retirement and Benefits recently received information of a scam aimed at survivors eligible to receive death benefits from the Public Employees' (PERS) or Teachers' (TRS) Retirement Systems. As a precaution for our members, the Division is providing information about the scam, as well as resources to help our members protect themselves in the remote possibility they are contacted by the scammers.

The objective of the scam is to obtain identity information about the survivor's deceased spouse and thousands of dollars in the form of pre-paid cash cards.

The scam works like this: The scammer contacts the survivor and asserts that the survivor or deceased spouse owes money on an insurance policy and the State of Alaska will either withhold part or all of the death benefits until the amount is paid. The survivor is then instructed to provide the deceased's Social Security number and to mail pre-paid cash cards, along with the receipt for the cards and his/her signature on the back to a specified address. In one reported case, an individual claiming to be representing the State of Alaska verified that the pension benefits would be withheld if their instructions were not complied with.

Please be assured that State of Alaska retirement system death benefits will never be withheld for debt payment. The Division will never contact you by phone and demand cash cards for any attachments.

For more information how to protect yourself from this scam, visit the Division's web page at ***Alaska.gov/drb*** or call toll-free at (800) 821-2251. For more tips, visit the Identity Theft Resource Center at ***idtheftcenter.org*** and type "deceased" in the search box or call toll-free at (888) 400-5530.