An “active course of treatment” is defined as a program of planned services that:*

- Starts on the date a physician or other health care professional first renders a service to correct or treat the diagnosed condition
- Covers a defined number of services or period of treatment
- Includes a qualifying situation (for example, a surgical follow-up)

The four steps for requesting transition of care

1. The member asks for a Transition Coverage Request Form from Member Services or their employer. The member completes the form with help, as needed, from the nonparticipating treating physician.
2. The member or nonparticipating treating physician faxes the completed form to the Aetna® fax number on the form.
3. We review the information. When necessary, an Aetna Medical Director evaluates the treatment program. The director may also contact the treating physician or health care professional.
4. We send a letter about the coverage decision to the member and the nonparticipating treating physician or health care professional. If coverage is approved, the letter also includes the length of time the transition benefits apply. We also send a letter to the member’s primary care physician, as applicable.

Complaints and appeals

We have a formal complaint and appeal policy for physicians, health care professionals and facilities.* The complaint and appeal process has **one level of appeal**.

Physician, health care professional and facility appeals involve payment decisions (claims). A provider may also appeal pre-service or concurrent medical-necessity decisions. However, those appeals will be handled through the **member appeal process**.

Note: State-specific laws do not apply to Medicare Advantage appeals. Commercial plans may vary based on state-specific requirements.

Physician and health care professional post-service appeals may either be on the provider’s behalf or on the member’s behalf. An appeal is not considered to be on behalf of the member unless it:

- Explicitly says “on behalf of the member”
- Includes written authorization from the member that was submitted by the physician or health professional

To learn more, see our **disputes and appeal process**.

In accordance with CMS requirements, we have a formal process for Aetna Medicare Advantage plan provider **dispute resolution for non-contracted providers**. Aetna Medicare Advantage plans must comply with CMS requirements and time frames when processing appeals and grievances received from Aetna Medicare Advantage plan members. Refer to the "Medicare" section for further information.

*FOR ACTIVE COURSE OF TREATMENT DEFINITION: State variations from our definition of "active course of treatment" exist. In those cases, use the state definition instead of our definition.

*FOR DISPUTE AND APPEAL POLICY: Aetna Medicare Advantage plans must comply with CMS requirements and time frames when processing appeals and grievances received from Aetna Medicare Advantage plan members. Refer to the **“Medicare”** section, which begins on **page 51** of this manual, for further information.