Provider manual

State Supplement

Aetna.com

4274231-01-01 (2/25)

Table of Contents

ALABAMA

Medicare Dual Eligible Special Needs Plans (D-SNPs)

ALASKA

Obtaining fee schedule information

For fee schedule/allowable rate information, please register with Availity® and then go to Fee Schedules on the Availity Reference Center website. Note: Only medical doctors (MDs) or doctors of osteopathy (DOs) who have direct contracts with us can get their fee schedules through Availity. No other type of provider can access their fee schedule via Availity. If you need allowable fees for 10 codes or less, the Provider Contact Center (PCC) can provide that information over the phone at **1-888-632-3862 (TTY: 711)**. If you need allowable fees for 11 codes or more, please put the codes on an Excel® spreadsheet and email it to **FeeSchedule@aetna.com**.

On the spreadsheet, include the following information:

- Contact phone number
- Current Procedure Terminology (CPT) code
- Modifiers
- Tax identification number (TIN)

You will receive the results within 30 business days.

Performance programs

We use practitioner and provider performance data to help improve the quality of service and clinical care our members receive if certain thresholds are met. To learn more, see the Performance Programs section in our **Provider Manual**.

Medicare Dual Eligible Special Needs Plans (D-SNPs)

ARIZONA

Enhanced clinical review program

For radiation therapy, prior authorization is required on all Arizona Aetna® fully insured, and Individual & Family plan® and Banner|Aetna members enrolled in our commercial plans (except Traditional Choice® indemnity plans). CVS Health manages this prior authorization for radiation therapy. Please contact CVS Health for details.

Affordable Care Act (ACA) Individual and Family Plans (IFP)

ARKANSAS

Specified Low-Income Medicare Beneficiary Plus (SLMB+)

Specified Low-Income Medicare Beneficiary Plus (SLMB+) members in Arkansas may be subject to a Medicaid copay for inpatient care. Copay amount will be based on the hospital's bill for the first day of service.

Credentialing

The State of Arkansas requires a current (within 120 days) CCVS (Centralized Credentials Verification Service) Attestation and Renewal form on file before releasing the provider file. Providers are encouraged to contact **ARMedicalBoard.org** to ensure that their CCVS Attestation and Renewal Form is up to date.

Medicare Dual Eligible Special Needs Plans (D- SNPs)

CALIFORNIA

Access standards*

These regulations require that each health plan's contracted provider network has adequate capacity and availability of licensed health care providers. Each network must offer enrollees appointments that meet the following time frames:

- **Urgent care appointments for services that do not require prior authorization:** within 48 hours of the request for appointment, except as provided in (G)
- **Urgent care appointments for services that require prior authorization:** within 96 hours of the request for appointment, except as provided in (G)
- **Nonurgent appointments for primary care:** within 10 business days of the request for appointment, except as provided in (G) and (H)
- **Nonurgent appointments with specialist physicians:** within 15 business days of the request for appointment, except as provided in (G) and (H)
- **Nonurgent appointments with nonphysician mental health care and substance use disorder providers:** within 10 business days of the request for appointment, except as provided in (G) and (H)
- **Nonurgent appointments for ancillary services for the diagnosis or treatment of injury, illness or other health conditions:** within 15 business days of the request for appointment, except as provided in (G) and (H)

*FOR ACCESS STANDARDS SOURCE: See California Code of Regulations, Title 28 — Managed Care, Chapter 2 — Health Service Plans, Article 7 — Standards, § 1300.67.2.2 **Timely Access to Non-Emergency Health Care Services**.

- **Nonurgent follow-up appointments with nonphysician mental health or substance use disorder providers:** within 10 business days for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition.

Note: *We do not delegate monitoring and assessment of these standards to any of the contracted provider groups. We will assess our contracted provider network against these standards by conducting an annual survey to assess availability of appointments and a provider satisfaction survey to solicit concerns and perspectives.*

Enhanced clinical review program

California physicians affiliated with a medical group or Independent Practice Association (IPA) should follow the precertification process established by their medical group or IPA.

California Language Assistance Program (LAP)

Need help giving care to non-English-speaking Aetna members? Just use our LAP. There is no charge for this interpretation service. You can call **1-800-525-3148 (TTY: 711)** to reach a qualified interpreter directly.

Members can also request interpretation services from our LAP by calling the number on their ID card. Members can also contact our LAP to get answers to general questions, file a grievance or get a grievance form.

Questions? Get help from your state.

- CA Department of Insurance at **1-800-927-4357** for traditional plans
- CA Department of Managed Health Care Help Center at **1-888-466-2219** (TDD: **1-877-688-9891**) for HMO and DMO plans

You can reach the CA Department of Managed Health Care Help Center 24/7. The Department's internet web site is **dmhc.ca.gov**. It provides written translation of independent medical review and complaint forms in Spanish and Chinese as well as other languages. You can get paper copies of the forms by submitting a written request to:

California Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Make member grievance forms available at your office

California regulations request providers to make member **grievance forms** for health plans available at all office or facility locations. Aetna® members may file a grievance with Aetna, the CA Department of Managed Care or the CA Department of Insurance for any reason, including delays in timely access to care or timely referrals.

You can download the California HMO and California DMO grievance forms which include information about member rights and responsibilities, in English and Spanish.

Maternal Mental Health Screening

Aetna recognizes the importance of maternal mental health and requires all licensed health care practitioners who provide prenatal or postpartum care for a patient to screen or offer to screen mothers for maternal mental health conditions. Mental health concerns which include not only depression but conditions like anxiety disorders, and postpartum psychosis, are often missed or mistaken as "normal" within pregnancy and postpartum periods. Careful screening can identify those with mental health conditions, and improve the outcome for at least two patients, if not the whole family.

Screening tools

The final determination for a referral to treatment resources belongs to the screening or treating professional. Practitioners serving Aetna® members can, however, use screening tools as aides in the decision-making process.

Prenatal screening tools

The **Pfizer PHQ Screeners page** provides the **Patient Health Questionnaire-9 (PHQ-9)**

Scoring using the PHQ-9

Score	Action
1 to 4	**Take no immediate action**
5 to 14	**Refer the member to a behavioral health counselor via the Member Services number on their member ID card.** **Instruct the member to ask for Behavioral Health (BH) Customer Service**
15 or higher	**Immediately call BH Condition Management Services at:** **1-800-424-4660 (TTY: 711).**

Postnatal screening tools

The American Academy of Pediatrics website provides the **Edinburgh Postpartum Depression Scale**.

Screening services are reimbursable

The screening services described in this section are reimbursable. Submit your claim with the following billing combination: CPT codes 96127 or G0444 (brief emotional/behavioral assessment) in conjunction with diagnosis code Z13.31 (screening for depression).

Specific medical record criteria

California requires that all medical record documentation include the following information:

- Documentation indicating the patient's preferred language
- Documentation of an offer of a qualified interpreter and, if interpretation services are declined, the enrollee's refusal practitioners and providers to submit claims electronically, when possible.

If you have any questions about our claim submission process, you can contact our Provider Service Center by calling **1-888-632-3862 (TTY: 711)**.

Outpatient behavioral health services

Beginning on March 1, 2024, behavioral health services performed on an outpatient basis to any fully insured commercial HMO, PPO, EPO, IFP or student health plan will no longer require prior authorization. All inpatient behavioral health services will require prior authorization.

CA Provider Reminder: Paper Claims Address

As a reminder, for paper claims submissions please use the industry standard claim form and mail it to the addresses below:

Aetna Medical Claims
Aetna
P.O. Box 14079
Lexington, KY 40512-4079

Aetna Dental Claims
Aetna Dental
P.O. Box 14094
Lexington, KY 40512-4094

To assist us in processing and paying claims efficiently, accurately, and timely, the health plan highly encourages practitioners and providers to submit claims electronically, when possible. If you have any questions about our claim submission process, you can contact our Provider Service Center by calling **1-888-632-3862 (TTY: 711)**.

Affordable Care Act (ACA) Individual and Family Plans (IFP)

Medicare Dual Eligible Special Needs Plans (D-SNPs)

COLORADO

Specified Low-income Medicare Beneficiary Plus (SLMB+)

For SLMB+ and FBDE members, Colorado Medicaid covers Medicare cost-share for services that are also covered by Medicaid.

Access standards

Regulations, combined with our provider access standards, require that our contracted providers meet the following time frames:

- **Emergent/urgent care (medical, behavioral, mental health, substance use):** immediately or refer to the emergency room
- **Primary care (routine, nonurgent symptoms):** within 7 calendar days
- **Behavioral health, mental health and substance use disorder care (initial and follow-up appointments, routine, nonurgent, nonemergency):** within 7 calendar days
- **Prenatal care:** within 7 calendar days
- **Primary care access to after-hours care:** office number answered 24/7 by an answering service or by an answering machine that provides instructions on how to reach a physician
- **Preventive visit/well visits:** within 30 calendar days
- **Specialty care (nonurgent):** within 30 calendar days

Medicare Dual Eligible Special Needs Plans (D-SNPs)

CONNECTICUT

Access and availability

A member's ability to obtain a health care appointment with a participating practitioner within a reasonable time period is an important driver of member satisfaction with the health plan. Appropriate wait time varies according to the type of care situation (such as urgent, emergent or routine care) and provider type. Access to care is contingent on access to participating practitioners both during and outside of normal business hours.

In the state of Connecticut, providers are required to meet the following time frames for scheduling in-network care:

- **Urgent care:** within 48 hours
- **Nonurgent appointments for primary care:** within 10 business days
- **Nonurgent appointments for specialist care:** within 15 business days
- **Nonurgent for ancillary services:** within 15 business days
- **Nonurgent for nonphysical behavioral health:** within 10 business days

Aetna® periodically assesses its networks for adequacy in order to meet the health care needs of current membership.

Many factors impact the adequacy of the network: network composition, geographic distribution of providers, practitioners and members, types and numbers of practitioners, and available providers and specialties. A member's perception of the network is another key driver of member satisfaction with the health plan and the member's assessment of health plan quality. An adequate network facilitates appropriate and efficacious treatment.

Network composition and adequacy are determined by state-specific or federal regulatory standards. Connecticut has established specific time and distance standards for primary care, specialist types and hospital services. Reports evaluating Connecticut's network availability are generated annually, and results of the reports are used in developing and implementing market contracting plans.

Provider termination patient list

Connecticut law requires participating providers, after either giving or receiving notice of termination from a health carrier's network, to submit to that health carrier a list of the providers' patients who are covered persons under that health carrier's network plan. To meet this requirement, providers who either give or receive a notice of termination should mail their list of Aetna patients within 30 days of the date of the notice of termination to:

Aetna
PO Box 981106
El Paso, TX 79998-1106

Please title your list "CT Provider Termination Patient List." For a termination due to cause, we ask that the list be sent upon receipt of the termination notice.

Surprise bills

Connecticut law protects members covered under fully insured plans that are written in Connecticut from surprise out-of-network bills (claims). As a contracted provider, you play an important role in preventing our members from incurring surprise bills. So be sure to select participating providers or entities (for example, an anesthesiologist, a radiologist, a laboratory or an

assistant surgeon) when coordinating care for our members. This will help avoid generating surprise bills and any administrative hassles that members and nonparticipating providers may face when addressing those bills. A surprise bill is a bill for covered nonemergency health services rendered by:

a) An out-of-network provider at an in-network facility, during a service or procedure performed by an in- network provider or during a service or procedure previously approved or authorized by the health carrier when the insured did not knowingly elect to obtain such services from such out-of-network provider, or

b) A clinical laboratory that is an out-of-network provider, upon the referral of an in-network provider.

A surprise bill is not a bill for services received when an in-network provider was available to render such services and a member knowingly chooses to use an out-of-network provider.

Direct-access specialties

Medicare Dual Eligible Special Needs Plans (D-SNPs)

DELAWARE

Specified Low-Income Medicare Beneficiary Plus (SLMB+)

Delaware Specified Low-Income Medicare Beneficiary Plus (SLMB+) members may be responsible for Medicaid copays.

Capitated programs

Direct-access specialties

Affordable Care Act (ACA) Individual and Family Plans (IFP)

Medicare Dual Eligible Special Needs Plans (D-SNPs)

DISTRICT OF COLUMBIA

Claims submission

In accordance with District of Columbia law, providers may submit claims to us once they have completed credentialing. In order to ensure that claims are paid at the contracted rate during initial claim processing, we ask that providers hold claims until their contract with us has been fully executed and our systems have been updated. Once the system is updated, we will pay claims at your contracted rate, retroactive back to the date that we received your credentialing application from CAQH®. To verify participation status, providers should go to our **provider referral directory** or contact our Provider Service Center.

HMO-based and Medicare Advantage plans: **1-800-624-0756 (TTY: 711)**

All other plans: **1-888-632-3862 (TTY: 711)**

Access standards

District of Columbia regulations require that our contracted providers meet the following time frames for appointment access:

Service type	Time frame
First appointment with a new or replacement primary care physician	Within 7 business days
First appointment with a new or replacement provider for behavioral health treatment, including substance use treatment	Within 7 business days

FLORIDA

Florida D-SNP Provider FAQ

Affordable Care Act (ACA) Individual and Family Plans (IFP)

Medicare Dual Eligible Special Needs Plans (D-SNPs)

GEORGIA

Claims submission

In order to ensure that claims are paid at the contracted rate during initial claim processing, we ask that providers hold claims until their contract with us has been fully executed and our systems have been updated. To verify participation status, providers should go to our provider referral directory or contact our Provider Service Center.

- HMO-based and Medicare Advantage plans: **1-800-624-0756 (TTY: 711)**
- All other plans: **1-888-632-3862 (TTY: 711)**

American Specialty Health Group, Inc. (ASH) administers certain components of the network chiropractic benefits for all Aetna® commercial and Aetna Medicare Advantage products. You should refer Aetna members enrolled in these plans to participating ASH chiropractors. For a list of participating ASH chiropractors, use our online provider portal.

ASH handles benefits administration for chiropractic services provided to these members, including:

- Claims administration
- Network management and contract administration
- Utilization management

Referral process for primary care physicians (PCPs)

If the member's plan requires a referral, you should submit an electronic referral to ASH prior to the member's visit to the chiropractor. You can use ASH's existing electronic data interchange vendor or our provider portal. Include the appropriate ASH provider ID on your referral:

Georgia: **9210671**

If you have questions about referral status, you should contact ASH:

Phone: **1-800-972-4226**

Website: **AshCompanies.com**

Affordable Care Act (ACA) Individual and Family Plans (IFP)

Medicare Dual Eligible Special Needs Plans (D-SNPs)

IDAHO

Demographic data changes

Demographic changes that are submitted via our secure provider website on Availity® and that do not require intervention will be processed within seven business days of receipt, in accordance with Idaho regulations.

Obtaining fee schedule information

For fee schedule/allowable rate information, please register with Availity and then go to Fee Schedules on the Availity Reference Center website.

If you need allowable fees for 10 codes or less, the Provider Contact Center (PCC) can provide that information over the phone at **1-888-632-3862 (TTY: 711)**. If you need allowable fees for 11 codes or more, please put the codes on an Excel® spreadsheet and email it to **FeeSchedule@aetna.com**. On the spreadsheet, include the following information:

- Contact phone number
- Current Procedure Terminology (CPT) code
- Modifiers
- Tax identification number (TIN)

You will receive the results within 30 business days.

Note: *Only medical doctors (MDs) or doctors of osteopathy (DOs) who have direct contracts with us can get their fee schedules through Availity. No other type of provider can access their fee schedule via Availity.*

Performance programs

We use practitioner and provider performance data to help improve the quality of service and clinical care our members receive if certain thresholds are met. To learn more, see the Performance Programs section in our **Provider Manual**.

ILLINOIS

Access standards

Regulations, combined with our provider access standards, require that our contracted providers meet the following time frames:

- **Primary care access to after-hours care:** office number answered 24/7 by an answering service or by an answering machine that provides instructions on how to reach a physician
- **Women's principal health care providers:** office number answered 24/7 by an answering service or by an answering machine that provides instructions on how to reach a physician

Facility or provider of mental, emotional, nervous or substance use disorders or conditions for outpatient treatment

Behavioral health providers: Members shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment (and no longer than 20 business days for repeat or follow-up appointments).

Affordable Care Act (ACA) Individual and Family Plans (IFP)

INDIANA

Access standards

In the state of Indiana, each health maintenance organization shall establish guidelines for reasonable periods of time within which an enrollee must be given an appointment with a participating provider. The following time frames were established for the type of health care services most often requested:

- **Prenatal care appointments:** within 30 business days
- **Well-child visits and immunizations:** within 30 business days
- **Routine physicals:** within 30 business days
- **Adult preventive services:** within 30 business days
- **Urgent visits:** immediately or referred to the emergency room, as appropriate

Affordable Care Act (ACA) Individual and Family Plans (IFP)

IOWA

Specified Low-Income Medicare Beneficiary Plus (SLMB+)

In Iowa, for SLMB+ and FBDE members Medicaid covers Medicare cost-share for services that are also covered by Medicaid.

SLMB+ and FBDE members who qualify for Medicaid under the Medically Needy program, are cost-share protected after their spend-down is met.

Medicare Dual Eligible Special Needs Plans (D-SNPs)

KANSAS

Specified Low-Income Medicare Beneficiary Plus (SLMB+)

In Kansas, for SLMB+ and FBDE members Medicaid covers Medicare cost-share for services that are also covered by Medicaid.

SLMB+ and FBDE members who qualify for Medicaid under the Medically needy program, are cost-share protected after their spend-down is met.

Affordable Care Act (ACA) Individual and Family Plans (IFP)

KENTUCKY

Medicare Dual Eligible Special Needs Plans (D-SNPs)

LOUISIANA

Medicare Dual Eligible Special Needs Plans (D-SNPs)

MAINE

Provider notification

A carrier may file a notice of a proposed amendment to a provider agreement only four times per calendar year on January 1, April 1, July 1 and October 1, except that, at any time, a carrier may file a notice of a proposed amendment in response to a requirement of the state or federal government or due to a change in current procedural terminology codes used by the American Medical Association.

Claims processing

In accordance with Maine law, providers may submit claims to Aetna® once they have completed credentialing. In order to ensure that claims are paid at the contracted rate during initial claims processing, we ask that providers hold claims until their contract with Aetna has been fully executed and our systems have been updated. Once the system is updated, Aetna will pay claims at your contracted rate, retroactive to the date that we received your credentialing application from CAQH®. To verify participation status, providers should go to our provider referral directory or contact our Provider Service Center:

- HMO-based and Medicare Advantage plans: **1-800-624-0756 (TTY: 711)**
- Aetna non-HMO-based plans: **1-888-632-3862 (TTY: 711)**

Subluxation chiropractic care

With regard to access to chiropractic care, our chiropractic care benefit complies with the Maine state mandate, as follows:

A member may self-refer to a participating chiropractic provider if the member needs acute chiropractic treatment. "Acute chiropractic treatment" is defined as treatment by a chiropractic provider for accidental bodily injury or sudden, severe pain that impairs the person's ability to engage in the normal activities, duties or responsibilities of daily living. Self-referred acute chiropractic treatment is covered if all of the conditions listed below are met:

- The injury or pain requiring acute chiropractic treatment occurs while the member's coverage under the Aetna® plan is in effect.
- Acute chiropractic treatment is provided by a participating chiropractor.
- The participating chiropractic provider prepares a written report of the member's condition and treatment plan, including any relevant medical history, the initial diagnosis and other relevant information.

Coverage for self-referred acute chiropractic treatment is limited to an initial maximum treatment period lasting until the last day of the third week from the member's first treatment visit or the 12th treatment visit, whichever occurs first. At the end of this initial treatment period, the chiropractic provider will determine whether the services provided during this initial treatment period have improved the member's condition. We will not cover self-referred acute chiropractic treatment provided after the point at which the chiropractic provider determines that the member's condition is not improving from the services. At this point, the chiropractic provider must discontinue treatment and refer the member to the member's primary care physician.

If the chiropractic provider recommends further acute chiropractic treatment, we will cover this further treatment up to the limits specified below, but only if he or she sends a written progress report of the member's condition and a treatment plan to the member's primary care physician before any further treatment is provided.

If the chiropractic provider fails to follow this requirement, we will not cover any further acute chiropractic treatment in connection with the same illness or injury causing the member's condition. The coverage for this further acute chiropractic treatment is limited to a maximum treatment period lasting until the last day of the 5th week from the member's first further treatment visit or the 12th further treatment visit, whichever occurs first. Coverage for all self-referred acute chiropractic treatment is limited to a maximum of 36 treatment visits during any consecutive 12-month period. The member's primary care physician must authorize further treatment for the same condition.

Note: *The chiropractic provider must send the report and treatment plan to the primary care physician within three business days of the member's first treatment visit. If the chiropractic provider does not follow this requirement, we are not required to cover acute chiropractic treatment provided by the chiropractic provider, nor will the member be required to pay for services.*

Women's Health and Cancer Rights Act of 1998

Members who have had, or are going to have, a mastectomy may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided after a consultation between the attending physician and the patient.

They'll discuss:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to create a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, like lymphedema

Benefits will be provided to a person who has already undergone a mastectomy as a result of breast cancer while covered under a different health plan. Coverage is provided according to the member's plan design. It's subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in the member plan documents. For more information, just contact the Provider Contact Center. Or see this **fact sheet** from the Centers for Medicare & Medicaid Services.

Out-of-network (OON) referrals in relation to Title 24-A M.R.S. § 4303(22)

In accordance with Maine law, we are required to allow a referral from a direct primary care (DPC) provider to a network provider. DPC providers do not submit referrals or claims to Aetna. In the event that a DPC refers a member to a participating provider, the claim may initially be denied because the referral must be made by an in-network provider. Therefore, if a DPC refers a member to an in-network provider and the claim is denied, contact us at the toll-free phone number on the Aetna® member ID card and we will reevaluate the claim. System limitations prevent Aetna from processing referrals from nonparticipating DPCs upon initial receipt. Accordingly, we address these limitations by reviewing, on a monthly basis, claims denied for no referral in order to identify whether a DPC is listed as the referring physician. If a DPC is listed as the referring physician, we will reprocess the claim at the appropriate benefit level.

Medicare Dual Eligible Special Needs Plans (D-SNPs)

MARYLAND

Maryland provider terminations

To comply with Maryland Insurance Code 15-112 — Provider Panels, go to our **provider referral directory** to check for current participating providers.

This quarterly report lists specialists in HMO-based plans that have terminated their participation in our network during the specified time frame.

Maryland Uniform Consultation Referral Form To comply with Maryland Insurance Code 31.10.12.06, we're providing you with the **Maryland Uniform Consultation Referral Form** for use by PCPs.

Claims submission

In accordance with Maryland law, providers may submit claims to us once they have completed credentialing if the provider:

- Is employed by or a member of the group practice
- Has applied for acceptance on the carrier's provider panel and the carrier has notified the provider of the carrier's intent to continue to process the provider's application to obtain necessary credentialing information
- Has a valid license issued by a health occupations board to practice in the state
- Is currently credentialed by an accredited hospital in the state or has professional liability insurance

In order to ensure that claims are paid at the contracted rate during initial claim processing, we ask that providers hold claims until their contract with us has been fully executed and our systems have been updated. Once the system is updated, we will pay claims at your contracted rate, retroactive back to the date that we received your credentialing application from CAQH®. To verify participation status, providers should go to our **provider referral directory** or contact our Provider Service Center:

- HMO-based and Medicare Advantage plans: **1-800-624-0756 (TTY: 711)**
- Aetna non-HMO-based plans: **1-888-632-3862 (TTY: 711)**

Access standards

Maryland state regulations require that our contracted providers meet the following time frames for appointment access:

Service type	Time frame
Urgent care for medical services	72 hours
Inpatient urgent care for mental health services	72 hours
Inpatient urgent care for substance use disorder services	72 hours
Outpatient urgent care for mental health services	72 hours
Outpatient urgent care for substance use disorder services	72 hours
Routine primary care	15 calendar days
Preventive care/well visit	30 calendar days
Non-urgent specialty care	30 calendar days
Non-urgent mental health care	10 calendar days
Non-urgent substance use disorder care	10 calendar days

Affordable Care Act (ACA) Individual and Family Plans (IFP)

Medicare Dual Eligible Special Needs Plans (D-SNPs)

MASSACHUSETTS

Demographic data quarterly attestation

To address guidance from both the Centers for Medicare & Medicaid Services (CMS) and the commonwealth of Massachusetts regarding provider directory accuracy, Aetna® uses a vendor — currently Availity® — to request validation of their demographic information listed in our directory.

As a participating provider, you are obligated to comply with this validation. Failure to respond and validate your information may result in us removing your information from our directory. If that happens, patients and other providers will not see a listing for you in the Aetna directory. This could result in your practice losing patients or revenue. If you move your office or change your phone number or other demographic information, you should go to the CAQH website and update your profile. Be sure to do so within seven days of the change. Do not wait for the quarterly attestation process and do not call or fax the information to Aetna. We will get the update from the vendor and process it accordingly.

Massachusetts-only requirements

Massachusetts General Laws (MGL) Chapter 175, Sec. 47FF, 47GG; MGL Chapter 176G, Sec. 4Z; and the 4A A Bulletin 2015-15

The following requirements of the above-referenced Massachusetts laws apply to members who are covered under fully insured plans written in Massachusetts and are seeking certain behavioral health and substance use disorder treatment.

- Precertification: Sometimes, we will pay for care only if we have given an approval before a member receives care. We call that "precertification" or "preauthorization." The Aetna PCP or network provider is responsible to get this approval for covered in-network services.
- To get started, call the precertification number on the member's Aetna ID card. You can find our **precertification requirements**, our **concurrent review policies and procedures** and this **Massachusetts law bulletin** on our website.

- We do not require precertification or authorization for routine behavioral health therapy or routine behavioral health outpatient medical visits (psychopharmacology visits, for example).
- You can find the **Aetna® behavioral health precertification list** on our website. Or you can call Member Services to find the behavioral health outpatient services that require authorizations.
- Providers (facilities or individual providers) certified or licensed by the Massachusetts Department of Public Health (DPH) are not required to request prior authorization or precertification for substance use disorder treatment. But the DPH does expect providers to notify carriers of the initial treatment plan within 48 hours of an admission or the start of services.
- Providers should notify us in the same way they do for services that require precertification.
- We'll cover medically necessary (as determined by the treating clinician) inpatient acute treatment services* and clinical stabilization services* for substance abuse for up to a total of 14 days. Any days beyond that are subject to utilization review.

Massachusetts General Laws (MGL) Chapter 1760, Section 25(c)
Massachusetts law [M.G.L. c. 176O, Section 25(c)] requires providers to use and us to accept certain standard prior authorization forms. We can't accept prior authorization requests that aren't submitted on the applicable form. See the **Standard Prior Authorization Forms** page on Mass.gov to find forms.

Executive Order No. 609: Protecting Access to Medication Abortion Services in the Commonwealth
The following requirements of the above-referenced Massachusetts Executive Order applies to members who are covered under fully insured plans written in Massachusetts and are seeking medication abortion services in the Commonwealth. Covered persons under fully insured plans written in Massachusetts include coverage for the prescribing, dispensing, and administration of mifepristone with misoprostol, or misoprostol alone, without the application of any cost-sharing, except as specified by the 2022 Shield Law and referenced in Bulletin 2023-01. See **Executive Order No. 609** on Mass.gov for reference.

Pain management access plan

In accordance with Mass. Gen. Laws Ch. 175 §§ 47KK, Aetna® covers medication and nonmedication pain management opiate alternatives ("Opiate Alternatives") that are medically necessary. Generally, Aetna considers an Opiate Alternative to be medically necessary if it is supported by adequate evidence of safety and effectiveness in the peer-reviewed published medical literature. Coverage for an Opiate Alternative that Aetna considers medically necessary is subject to applicable benefits plan limitations and exclusions.

To check whether Aetna considers a nonmedication Opiate Alternative to be medically necessary, please refer to the **Aetna Clinical Policy Bulletins (CPBs)**. Relevant CPBs may include the ones addressing acupuncture (#0135), biofeedback (#0132), physical therapy (#0325) and chiropractic services (#0107). Coverage for a nonmedication Opiate Alternative, even if medically necessary, is subject to applicable benefits plan limitations and exclusions.

Refer to the **Find a Medication page** to check whether a medication Opiate Alternative is covered by an Aetna formulary. Relevant medications may include acetaminophen, NSAIDs, muscle relaxants, anticonvulsants, antidepressants, topical analgesics, and corticosteroids. Coverage for a medication Opiate Alternative is subject to applicable benefits plan limitations and exclusions.

Capitated programs

Direct-access specialties

MICHIGAN

Medicare Dual Eligible Special Needs Plans (D-SNPs)

*FOR ACUTE TREATMENT SERVICES NOTE: 24-hour medically supervised addiction treatment for adults or adolescents. This care is provided in a medically managed or medically monitored inpatient facility, as defined by the DPH. These services provide evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

*FOR CLINICAL STABILIZATION NOTE: 24-hour clinically managed post detoxification treatment for adults or adolescents, as defined by the DPH. These services usually follow acute treatment services for substance use disorder. This may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

MINNESOTA

Minnesota Union Companion Guides (MUCG)

Minnesota Statutes section 62J.536 and related rules require the development and use of Minnesota Uniform Companion Guides (MUCGs) as companions to HIPAA Implementation Guides. The law, including compliance with the MUCGs, applies to health care providers that provide services for a fee in Minnesota, or who are otherwise eligible for reimbursement under the state's Medical Assistance program, as well as group purchasers (payers) and health care clearinghouses that are licensed or doing business in Minnesota.

Specialist as a PCP

Minnesota law (Minn. Stat. 62Q.58) allows members with an approved standing referral to a specialist may request primary care services from that specialist. The specialist, in agreement with the enrollee and primary care provider or primary care group, may elect to provide primary care services to the enrollee, authorize tests and services, and make secondary referrals according to procedures established by the health plan company. The health plan company may limit the primary care services, tests, and services, and secondary referrals authorized to those that are related to the specific condition or conditions for which the standing referral was made.

Standing referrals

A health plan company shall establish a procedure by which an enrollee may apply for and if appropriate, receive a standing referral to a health care provider who is a specialist if a referral to a specialist is required for coverage. This procedure for a standing referral must specify the necessary managed care review and approval an enrollee must obtain before such a standing referral is permitted. (Minn. Stat. 62Q.58).

MISSISSIPPI

Medicare Dual Eligible Special Needs Plans (D-SNPs)

MISSOURI

Hospitalist programs in Kansas City and St. Louis

Hospitalists can act as referring physicians for the coordination of medical and surgical inpatient services. Hospitalists may provide notification and written documentation of your patient's status on admission, both during the stay and upon discharge. They may also contact members upon discharge to check on their post-discharge progress.

Peer-to-peer review time frames in Missouri
Providers may request a peer-to-peer review as a result of an adverse determination. This information doesn't apply to appeals.

- **Time frame to request peer-to-peer review:** within 14 calendar days of the denial letter date
- **Time frame to expect a response to the request:** within one 24-hour working day of the request

Note: *These time frames apply to commercial fully insured business only.*

Missouri narrow networks

Aetna offers several narrow networks in Missouri. These networks are not inclusive of all providers in our broad Aetna networks. To verify if you are participating in one of our narrow networks, just visit our Provider Referral Directory. Kansas has the following sections:

- **Aetna Carelink® plan**

  Carelink — geography: St. Louis/metropolitan area

- **Aetna CVS Health® plans**

  Individual plans offered on the exchange

  Carelink — geography: Kansas City, Springfield, and the St. Louis/metropolitan area

- **Kansas & Missouri preferred networks**

  KC Care Network Plus/I-35 Network — geography: Kansas City/metropolitan area

  St. Louis Select Network — geography: St. Louis/ Metropolitan area

Note: *Participating providers shall not provide less than Medically Necessary services to our members and shall not induce any other provider to provide less than Medically Necessary services. For all PPO plans, our members must be allowed to receive services from a nonparticipating provider and utilize their out-of-network benefit without interference by a participating provider, if they so choose. In no instance does Aetna encourage or induce participating providers to provide less than Medically Necessary services to our members. Failure to direct medically appropriate care upon request by a Missouri member and failure to provide services to a Missouri member, due to the absence of a referral, violate the provisions of your contract and could result in financial penalties and/or termination of the contract. Provider acknowledges that solely Aetna shall determine the amount of any financial penalty imposed.*

Specialists as PCPs

Missouri (MO) law (MoRS 354.615.3) allows members to have participating specialists function as their PCP without a referral and to coordinate their care including referrals, procedures, and tests when they have a life-threatening, degenerative, or disabling disease or condition and that is subject to the terms of a treatment plan. When this happens, the specialist functioning as the PCP receives the PCP cost share and can refer to other specialists as a PCP would.

Standing referrals

PCPs can make standing referrals to specialists for members that require ongoing treatment from a specialist.

Medicare Dual Eligible Special Needs Plans (D-SNPs)

NEVADA

Access standards

Regulations, combined with our provider access standards, require that our contracted providers meet the following time frames:

- **Routine care, without symptoms:** within thirty (30) days from the time the enrollee contacts the provider
- **Routine care, with symptoms:** within five (5) business days from the time the enrollee contacts the provider
- **Urgent care for illnesses/injuries which require care immediately, but which do not constitute emergencies as defined by §354.400 Revised Statutes of Missouri (RSMo):** within twenty-four (24) hours from the time the enrollee contacts the provider.
- **Emergency care:** a provider or emergency care facility shall be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency care as defined by §354.400 RSMo.
- **Obstetrical care:** within one (1) week for enrollees in the first or second trimester of pregnancy; within three (3) days for enrollees in the third trimester. Emergency obstetrical care is subject to the same standards as emergency care, except that an obstetrician must be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency obstetrical care.
- **Mental health care:** telephone access to a licensed therapist shall be available twenty-four (24) hours per day, seven (7) days per week.

Affordable Care Act (ACA) Individual and Family Plans (IFP)

Medicare Dual Eligible Special Needs Plans (D-SNPs)

NEBRASKA

Specified Low-Income Medicare Beneficiary Plus (SLMB+)

In Nebraska, for SLMB+ and FBDE members Medicaid covers Medicare cost-share for services that are also covered by Medicaid.

SLMB+ and FBDE members who qualify for Medicaid under the Medically Needy program, are cost-share protected after their spend-down is met.

Obtaining fee schedule information

For fee schedule/allowable rate information, please register with Availity and then go to Fee Schedules on the Availity Reference Center website.

If you need allowable fees for 10 codes or less, the Provider Contact Center (PCC) can provide that information over the phone at **1-888-632-3862 (TTY: 711)**. If you need allowable fees for 11 codes or more, please put the codes on an Excel® spreadsheet and email it to **FeeSchedule@aetna.com**. On the spreadsheet, include the following information:

- Contact phone number
- Current Procedure Terminology (CPT) code
- Modifiers
- Tax identification number (TIN)

You will receive the results within 30 business days.

Note: *Only medical doctors (MDs) or doctors of osteopathy (DOs) who have direct contracts with us can get their fee schedules through Availity. No other type of provider can access their fee schedule via Availity.*

Aetna Whole Health℠ network

Aetna Whole Health includes a subset of our larger Nevada network and this network is available in Clark County. The Aetna Whole Health℠ name appears at the top-center of the member's ID card. Go to the **provider referral directory** to check your status in Aetna Whole Health℠ - Las Vegas.

Affordable Care Act (ACA) Individual and Family Plans (IFP)

Medicare Dual Eligible Special Needs Plans (D-SNPs)

NEW HAMPSHIRE

Access standards

New Hampshire state regulations require that our contracted providers meet the following time frames for appointment access:

- **Behavioral health (non-life-threatening emergency):** within 6 hours
- **Urgent care:** within 48 hours
- **Initial or evaluation visit:** within 10 business days
- **Primary care:** urgent care within 48 hours; routine care (including an initial or evaluation visit) within 30 days)

Direct-access specialties

NEW JERSEY

Provider appeals

Fill out the required New Jersey Department of Banking and Insurance **Health Care Provider Application to Appeal a Claims Determination** form.

See the **Provider Appeal Procedures for New Jersey document** for information about the appeal process, which applies to all providers, both participating and nonparticipating.

Visit the **Disputes and Appeals Overview** page for further information on our general process for disputes and appeals.

Capitated programs

Direct-access specialties

Affordable Care Act (ACA) Individual and Family Plans (IFP)

NEW YORK

Provider responsibilities

The provider shall perform all of the duties listed below:

1. Provide complete, current information concerning a diagnosis, treatment and prognosis to an enrollee in terms the enrollee can be reasonably expected to understand.
2. Advise enrollees, prior to initiating an uncovered service, that the service is uncovered and that there is a cost related to the service.
3. Recognize the definition of emergency condition* as follows: “Emergency condition” means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person; or a condition described in § 1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.
4. Along with us, grant access to patient-specific medical information and encounter data to the New York State Department of Health, which records shall be maintained for a period of six years after the date of services to enrollees or cessation of Aetna® operations. For minors, the period shall be six years from the date of majority.
5. If serving as a primary care provider (PCP), deliver primary care services and coordinate and manage care.

The provider shall not bill enrollees, under any circumstances, for the costs of covered services, except for the collection of applicable copayments, coinsurance, or deductibles.

Discharge plans following inpatient substance use disorder treatment

Since January 1, 2020, New York law has required that the facility provide us with the written discharge plan when a member is being discharged from a facility following inpatient treatment for a substance use disorder.* During the utilization review process, we’ll ask for a written discharge plan and let you know where to send it.

Provider contracting information

If the provider’s license, certification or registration is revoked or suspended by the state of New York, the provider will be terminated from the Aetna® network.

1. We are legally obligated to report to the appropriate professional disciplinary agency within 30 days of the occurrence of the following:

*FOR EMERGENCY CONDITION DEFINITION SOURCE: See NY Fin Serv L § 603. Available at: **nysenate.gov/legislation/laws/FIS/603**. Accessed December 30, 2024.

*FOR SUBSTANCE USE DISCHARGE PLAN REQUIREMENT SOURCE: See NY Ins Law § 4303(k). Available at: **nysenate.gov/legislation/laws/ISC/4303**. Accessed December 30, 2024.

a. Termination of a health care provider for reasons relating to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare.

b. Voluntary or involuntary termination of a contract or employment or other affiliation with such organization to avoid the imposition of disciplinary measures.

c. Termination of a health care provider contract in the case of a determination of fraud or in a case of imminent harm to patient health; we are legally obligated to report to the appropriate professional disciplinary agency within 60 days of obtaining knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct as defined in the New York Education Law.

2. The provider may request application procedures and minimum qualification requirements used by us.

3. The provider may request to be provided with any information and profiling data used to evaluate the provider's performance. Such information shall be provided to the provider on a periodic basis. Providers may also request policies and procedures to review provider performance, including the criteria against which the performance of health professionals will be evaluated, and the process used to perform the evaluation. Providers will be given the opportunity to discuss the unique nature of the provider's professional patient population, which may have a bearing on the provider's profile, and to work cooperatively with us to improve performance.

4. In compliance with New York law, the provider's contract shall not be terminated unless we provide to the provider a written explanation of the reasons for the proposed contract termination and an opportunity for a review of hearing pursuant to PHL 4406-d 2.(b).* The provider termination notice shall include: (a) the reasons for the proposed action, (b) notice that the provider has the right to request a hearing or review, at the provider's discretion, before a panel appointed by us, (c) a time limit of not less than 30 days in which a health care professional may request a hearing, and (d) a time limit for a hearing date which must be held within 30 days after the date of receipt of a request for a hearing. (If a provider's contract is non-renewed, this is not considered as a termination under PHL 4406-d and thus the requirements described above do not apply.)

5. The provider shall not be prohibited from the following actions, nor shall a provider be terminated or refused a contract renewal solely for the following reasons: (a) advocating on behalf of an enrollee, (b) filing a complaint against a managed care organization, (c) appealing a decision of the managed care organization, (d) providing information or filing a report pursuant to PHL 4406 c regarding prohibitions of plans, or (e) requesting a hearing or review.

6. The provider may request a hearing or review before a panel appointed by us upon being terminated by us. Such a hearing panel will be comprised of three persons appointed by us. At least one person on the panel must be in the same discipline or same specialty as the person under review. The panel can consist of more than three members, provided the number of clinical peers constitutes one-third or more of the total membership. The hearing panel shall render a decision in a timely manner. Decisions will include one of the following and will be provided in writing to the health care professional: reinstatement, provisions of reinstatement with conditions set forth by us, or termination.

   Decision of the termination shall be effective not less than 30 days after the receipt by the health care professional of the hearing panel's decision. In no event shall the determination be effective earlier than 60 days from receipt of the notice of termination. A provider terminated due to the following is not eligible for a hearing or a review: a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice. A terminating provider, with our approval, may agree to continue an ongoing course of treatment with an enrollee for a transition period of up to 90 days. If the health care professional is providing obstetric care and the member has entered her second trimester of pregnancy, the transitional period includes postpartum care directly related to the delivery. The provider must agree to: (a) continue to accept reimbursement at rates applicable to transitional care, (b) adhere to the organization's quality assurance program and provide medical information related to the enrollee's care, (c) adhere to Aetna's policies and procedures, including referrals and obtaining preauthorization and a treatment plan approved by us.

*FOR PROVIDER TERMINATION REQUIREMENT SOURCE: See NY Ins Law § 4803(b) et seq. Available at: **nysenate.gov/legislation/laws/ISC/4803**. Accessed December 30, 2024.

7. The provider shall agree, or if the Agreement is between the Managed Care Organization (MCO) and an Independent Practice Association (IPA) or between an IPA and an IPA, the IPA shall agree and shall require the IPA's providers to agree, to comply with the human immunodeficiency virus (HIV) confidentiality requirements of Article 27-F of the Public Health Law.

Hospital nonbinding mediation

New York Insurance Law § 3217-b requires that insurance carriers and hospitals enter nonbinding mediation 60 days prior to a contract termination in order to resolve any outstanding contractual issues. Therefore, Aetna® and our participating hospitals are obligated to enter into nonbinding mediation 60 days prior to any termination when the terms of the current agreement are unresolved.

Confidentiality of HIV-related information

Each health care provider must develop policies and procedures to ensure confidentiality of HIV-related information. Policies and procedures must include:*

- An initial and annual in-service education of staff (including contractors)
- Identification of staff who are allowed access and a description of the limits of that access
- A procedure to limit access to trained staff (including contractors)
- A protocol for secure storage (including electronic storage)
- Procedures for handling requests for HIV-related information
- Protection protocols

Providers of OB/GYN care must require HIV pretest counseling with clinical recommendation of testing for all pregnant women. Those women and their newborns must have access to services for positive management of HIV disease, psychosocial support, and case management for medical, social and addictive services.

Policies

The policies and procedures promulgated by Company which relate to this Agreement include, but are not limited to:

- Quality improvement/management
- Utilization management, including, but not limited to prior authorization of elective admissions and procedures, concurrent review of services and referral processes or protocols
- Preadmission testing guidelines
- Claims payment review
- Member grievances
- Physician credentialing
- Electronic submission of claims and other data required by Company
- Any applicable participation criteria as set forth in the participation criteria schedules

Policies and procedures also include those set forth in the Company's manuals, including the office manual, or their successors (as modified from time to time); Clinical Policy Bulletins made available via Company's public website; and other policies and procedures, whether made available via a secure website for physicians (when available), by letter, newsletter, electronic mail or other media.

Quality strategy statement

The quality strategy provides value by facilitating effective member-plan-provider relationships to promote desired health outcomes. The strategy is consistent with the core set of principles of the U.S. Department of Health and Human Services (HHS) National Quality Strategy. Our strategy includes:

- Promoting better health and health care delivery, focusing on engagement
- Attending to the health needs of all members
- Eliminating disparities in care
- Aligning public and private sectors
- Supporting innovation, evaluation and rapid-cycle
- Learning and dissemination of evidence
- Using consistent national standards and measures
- Focusing on primary care and coordinating and integrating care across the health care system and community
- Providing clear information so members and providers can make informed decisions

The distinguishing factor in our strategy is our view toward quality itself. Quality Management is not an isolated departmental function. Quality activities and metrics are integrated and coordinated across different functional areas to ensure consistent adherence with nationally recognized metrics.

*FOR HIV CONFIDENTIALITY REQUIREMENT SOURCES: NY Public Health Law § 2782 and NY Ins Law § 2611. Available at: **nysenate.gov/legislation/laws/PBH/2782** and **https://www.dfs.ny.gov/industry_guidance/circular_letters/cl1989_03**. Accessed December 30, 2024.

We are committed to Health Plan (HPA), Health Equity (HE) and Managed Behavioral Healthcare Organization (MBHO) accreditation as well as the Long-Term Services and Supports (LTSS) Distinction and Physician Quality Certification by the National Committee for Quality Assurance (NCQA) as one means of demonstrating a commitment to continuous quality improvement (CQI) and meeting customer expectations. Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) reports are produced annually and submitted to NCQA for public reporting and accountability. HEDIS is audited in accordance with NCQA specifications by NCQA-certified HEDIS auditors. CAHPS and the Quality Health Plans (QHP) Enrollee Experience Surveys (EES) are executed by approved survey vendors according to published technical specifications.

Our clinical programs and initiatives are designed to enhance the quality of care delivered to members and to better inform members through reliance on clinical data and industry-accepted, evidence-based guidelines. We're committed to supporting transparency by providing participating practitioners and members with credible clinical information and tools to make informed decisions.

Quality Management (QM) program

The focus of the Quality Management (QM) Program is the ongoing assessment and enhancement of consumers' care, health, cost per member and equitable outcomes, while simultaneously improving the level of care teams' engagement in serving members. There are many benefits from the implementation and iteration of a QM program that include the following:

- Driving efficiency of the QM program through continuous quality improvement (CQI) principles
- Engaging members and providers using desired channels at the right time to influence behavior and optimize member health
- Technology, automation and sourcing: driving efficiency of QM programs through CQI, robotics, analytics and vendor management
- Data optimization and insights: comprehensive ingestion and innovative use of data to inform clinical strategies and drive performance
- Anticipating likely compliance and performance risk for early intervention
- Providing a framework by which to monitor and strengthen all functional processes of the organization through the measurement of performance in service and quality of care
- Providing a multi-departmental approach to quality improvement (QI)

Quality management (QM) process

We use CQI techniques and tools to improve the quality and safety of clinical care and service delivered to members. This includes systematic and periodic follow-up on the effect of interventions, which allows for correction of problems identified through internal surveillance, analysis of complaints/grievances or other mechanisms. Quality improvement is implemented through a cross- functional team approach, as evidenced by multidisciplinary committees. Quality reports are used to monitor, communicate, and compare key indicators.

Our strategy is to drive a culture of continuous improvement and everyday problem solving, where all associates are focused on improving employee engagement and driving value to our customers and shareholders.

Quality Management (QM) program goals

QM program goals include the following:
To operate the QM program in compliance with and responsive to applicable requirements of plan sponsors, federal and state regulators and appropriate accrediting bodies

- To promote the principles and spirit of CQI
- To address disparities in health care associated with race, ethnicity, sexual orientation, gender identity, and social determinants of health that could negatively impact quality health care
- To institute company-wide initiatives to improve the safety of members and our communities and to foster communications about the programs
- To implement a standardized and comprehensive QM program that addresses and is responsive to the health needs of our population, including but not limited to, serving members with complex health needs across the continuum of care as well as serving those with rising-risk levels and those that are relatively healthy
- To increase the knowledge/skill base of staff and to facilitate communication, collaboration and integration among key functional areas relative to implementing a sound and effective QM program
- To measure and monitor previously identified issues, evaluate the QM program, and improve performance in key aspects of quality and safety of clinical care, including behavioral health (BH) and quality of service for members, customers and participating practitioners/providers

- To maintain effective, efficient and comprehensive practitioner/provider selection and retention processes through credentialing and recredentialing activities
- To ensure collaboration with behavioral health care networks to improve continuity and coordination of care between BH specialists and primary care practitioners
- To encourage the development and use of services and activities that support public health goals

QM program scope

The scope and content of the QM program are designed to continuously monitor, evaluate and improve the quality and safety of clinical care and services provided to members. The QM program includes, but is not limited to:

- Review and evaluation of preventive and BH services; ambulatory, inpatient, primary and specialty care; high-volume and high-risk services; and continuity and coordination of care
- Involvement of a designated physician and a designated psychiatrist as evidenced by direction and oversight provided by the Chief Medical Officer (CMO), Chief Psychiatric Officer (CPO) and Deputy Chief Psychiatric Officer in the medical and behavioral aspects of the program
- Objectives for servicing a culturally and linguistically diverse membership
- Development of written policies and procedures reflecting current standards of clinical practice
- Development, implementation and monitoring of patient safety initiatives, and preventive and clinical practice guidelines
- Monitoring of medical and BH population health management programs
- Achievement and maintenance of regulatory and accreditation compliance
- Evaluation of network adequacy, including accessibility and availability of network providers
- Establishing standards for, and auditing of, medical and BH record documentation: BH record documentation is completed based on state mandated requirements
- Monitoring for overutilization and underutilization of services (Medicaid and Medicare)
- Performing credentialing and recredentialing activities
- Performing oversight of delegated functions
- Evaluation of member experience and practitioner satisfaction
- Supporting initiatives to address health care disparities associated with race, ethnicity, sexual orientation, gender identity, and social determinants of health
- Collaborating in the development of provider performance programs: standardization and sound methodology; transparency; collaboration; and acting on quality and cost, or quality only, but never cost data alone except in unique situations where there are no standardized measures of quality and/or where there is insufficient data
- Oversight of QI functions by the QI Committee

Contracted BH and non-BH practitioners provide input into the QM program through review and feedback on quality improvement studies and surveys, clinical indicators, member and practitioner/provider initiatives, practitioner/ provider communications, the QM Program Description and the QM Work Plan. A variety of mechanisms are used to encourage providers to participate in CMS and Health and Human Services (HHS) QI initiatives, including but not limited to: provider contract provisions, the provider manual and provider newsletters.

Accountability and committee structure

A. Board of Directors

The applicable Boards of Directors have delegated ultimate accountability for the management of the quality of clinical care and service provided to members to the Chief Medical Officer (CMO) or designee. The CMO or designee is responsible for providing national strategic direction and oversight of the QM program. As state regulations require, licensed physicians are involved in the QM program.

B. National Quality Oversight Committee (NQOC)

The Medical Directors referenced above delegate authority for oversight of the national QM program to the NQOC. It facilitates the sharing of QM best practices for accreditation, survey management, regulatory and other areas as appropriate. Delegated responsibilities include, but are not limited to, development, implementation, and evaluation of the QM program.

The role of the NQOC includes, but is not limited to:

- Review and approval of the following documents:
  - QM Program Description with State Amendments, QHP Amendments and Medicare Dual Eligible Special Needs Plans (D-SNPs) Addendum and Medicare Institutional Special Needs Plans (I-SNPs) Addendum
  - QM Work Plan

  - HMO/PPO QM Program Evaluations (includes Exchanges)
  - Care Management Program Description
  - Clinical Claim Review Program Description
  - BH QM/Care Management Program Evaluations
  - Patient Safety Strategy
  - Population Health Management Strategy
- Adopting clinical criteria and protocols for both medical and BH care with consideration of recommendations from the National Quality Advisory Committee (NQAC)
- Establishing goals, monitoring, evaluating and prioritizing QM and Care Management program activities
- Reviewing and adopting QM, National Clinical Services (NCS) and selected policies and procedures and approving state amendments
- Reviewing and approving (as applicable) regular reports from national workgroups and committees for discussion and feedback as necessary
- Evaluating identified Potential Quality of Care (PQoC) concerns related to facilities/vendors
- Final approval and adoption of medical and BH clinical practice guidelines (CPGs) and preventive services guidelines (PSGs) with consideration of recommendations from the National Quality Advisory Committee (NQAC)
- Overseeing, coordinating and establishing company-wide initiatives to improve the safety of our members and our communities; additionally, the committee fosters communications about our safety programs to members, employees, physicians, hospitals and other health care professionals and plan sponsors
- Reviewing and approving Quality Improvement Initiatives based on subcommittee identification of needed actions
- Reviewing and evaluating Quality Improvement Initiatives to determine their effectiveness

The NQOC meets at least ten times a year. The NQOC is a multidisciplinary committee composed of department representatives and includes, but is not limited to, the following areas:

- Medical Director, Chairperson
- Medical Director BH, Co-Chairperson
- Office of Chief Medical Officer
- Medical Directors, Medical and BH
- Quality Management
- Medicare Service Operations
- Aetna Pharmacy Health Plan
- Clinical Services
- Behavioral Health/Mental Wellbeing Clinical Operations
- Network Strategy and Provider Experience
- Customer Service
- Claims
- Complaints/Grievances and Appeals
- National Accounts
- Medicare Compliance
- Service Operations
- Plan Enrollee(s) as state regulations require
- Participating Practitioners as state regulations require

The NQOC delegates authority to the:

- National Quality Advisory Committee (NQAC) to provide direction on clinical quality and to review and make recommendations on the CPGs and PSGs
- National Vendor Delegation Oversight Committee (NVDOC) for oversight and approval of delegated activities
- Credentialing and Performance Committee (CPC) for the decision-making for credentialing, recredentialing and the review of professional conduct
- Practitioner Appeal Committee (PAC) to conduct and render decisions on professional review hearings
- National Quality Management Policy Committee (NQMPC) and the National Clinical Services Policy Committee (NCSPC) for policy development and approval
- Dual Eligible Special Needs Plans Model of Care Oversight Committee (D-SNP MOC) to provide a central point for review and decision making on key operational performance metrics, health plan performance guarantees and other performance outcomes as appropriate
- Institutional Special Needs Plans Model of Care Oversight Committee (I-SNP MOC) to provide a central point for review and decision making on key operational performance metrics, health plan performance guarantees and other performance outcomes as appropriate

The NQAC, NVDOC, D-SNP MOC and I-SNP MOC provide reports to the NQOC at least semiannually.

The NQMPC, NCSPC and NQAC present policies, procedures, CPGs and PSGs to the NQOC for adoption as they are developed or revised.

The Aetna Pharmacy Health Plan Quality Oversight Committee (APHPQOC) is the designated committee to provide guidance and direction on pharmacy

administrative, clinical services and quality issues. It provides annual program documents as informational to the NQOC.

The respective Boards receive comprehensive reports on QM and Care Management program activities at least annually. State laws and regulations may exceed the requirements of the QM Program Description; if/when state regulations apply, they are documented in state amendments.

C. National Quality Advisory Committee (NQAC)

The NQAC activities include, but are not limited to, the following:

- Provide input into the QM program through review and feedback on quality improvement studies and surveys, clinical indicators, member and practitioner or provider initiatives, practitioner or provider communications, QM Program Description and QM Work Plan (includes Exchanges)
- Review and provide feedback on clinical criteria such as UM clinical criteria, BH clinical criteria, Medical Clinical Policy Bulletins (CPBs) and protocols for adoption by the NQOC
- Review and provide recommendations to the NQOC regarding medical and behavioral health clinical practice and preventive services guidelines
- Provide recommendations via meeting minutes to the NQOC at least quarterly

The NQAC meets at least four times a year. Members include:

- Medical Director, Chairperson
- Medical Director BH, Co-Chairperson
- BH participating practitioners of different backgrounds including psychiatrists, psychologists and master's prepared clinicians
- Representatives from a range of contracted participating practitioners in specialties that include primary-care and high-volume specialists (other specialty practitioners may be included as necessary for clinical input)
- Plan Enrollee(s) as state regulations require

D. National Vendor Delegate Oversight Committee (NVDOC)

The NVDOC has oversight of the following:

- Delegation oversight and vendor policies, procedures, and processes
- Review and approval of delegated credentialing, claims, customer service, and clinical functions, which includes approval of delegate's program descriptions
- Review of delegates related to general controls, finance, and network management as appropriate
- Review of oversight activities required by CMS, including but not limited to, fraud, waste, and abuse (FWA), business conduct and integrity (BCI)/code of conduct (COC) and other regulations
- Overall monitoring and reporting of risk and delegate performance
- Review and approval of oversight audit reports for delegated claims agreements, claims pass- through agreements, Aetna Signature/TPA agreements, Customer Service agreements, and TeleSales Call Center agreements
- Approval and oversight activities delegated to external (non-Aetna) entities under national delegation
- Provision of semiannual reports to NQOC

The NVDOC meets monthly and membership includes the following Voting Members (non-voting members may also attend):

- Senior Medical Director over Delegation or their designee (Chairperson)
- Medical Directors
- Quality Management Managers over Credentialing and Clinical Delegation Oversight or their designee
- Senior Manager Finance/Senior Finance Auditor
- Claims Audit Manager
- Network Market Head/Senior Network Managers
- Compliance (Legal/Regulatory, Medicare)
- Counsel, Law Department
- Medicaid Plan Representatives

E. Medicare Utilization Management Committee (MUMC)

- Chief Medical Officer — Chairperson
- Executive Director, Operations, MMP

The Aetna Medicare Utilization Management Committee (MUMC) serves as the review and approval body for all utilization management (UM) clinical policies used to determine medical necessity for Aetna's Medicare Advantage plans. The Committee considers coverage decisions and guidelines as required by Original Medicare, including CMS National Coverage Determinations, Local Coverage Determinations and other applicable guidance (such as CMS Benefit Policy Manuals); applicable laws and regulations; and relevant current clinical guidelines. The Committee will only approve UM clinical policies that use or impose coverage criteria that comply with these requirements and standards.

The MUMC is responsible for:

- Review and approval of UM policies to ensure compliance with CMS requirements based on the following hierarchy:
  - CMS National Coverage Determinations
  - CMS Local Coverage Determinations
  - Applicable CMS guidance (such as Benefit Policy Manuals)
  - Aetna Clinical Policy Bulletins (CPBs)
  - Aetna supplemental policies, including MCG™ Guidelines
  - Other applicable guidelines
- Documentation of the process for determining coverage criteria to comply with CMS standards
- The MUMC retires clinical policies, as applicable, when regulations and standards change

F. Credentialing and Performance Committee (CPC)

The CPC makes determinations for those applicants being considered for exceptions to established Aetna requirements for professional competence and conduct. The committee conducts professional review activities involving the professional competence or conduct of practitioners whose conduct adversely affects, or could adversely affect, the health or welfare of members for the purpose of evaluating continued participation in the Aetna network.

The CPC meets at least every 45 days, and membership includes the following:

- Medical Director, Facilitator
- Representatives from a range of participating practitioners in specialties that include primary-care and high-volume specialists (other specialty practitioners may be included as necessary for peer review, e.g., dentists, chiropractors)
- Behavioral health practitioners, including a psychiatrist, a psychologist and a masters-level behavioral health clinician

G. Provisionally credentialed providers (New York)

When a completed application of a newly licensed health care professional or a health care professional who has recently relocated to this state from another state and has not previously practiced in this state; who joins a group practice of health care professionals each of whom participates in an Aetna® network; and who is not approved or declined within 60 days of submission of a completed application shall be deemed "provisionally credentialed"* and may participate in the network, provided, however, that a provisionally credentialed physician may not be designated as an enrollee's primary care physician until such time as the physician has been fully credentialed. The network participation for a provisionally credentialed health care professional shall begin on the day following the 60th day of receipt of the completed application and shall last until the final credentialing determination is made by Aetna. A health care professional shall only be eligible for provisional credentialing if the participating group practice of health care professionals notifies Aetna in writing with the appropriate documentation.

H. Practitioner Appeals Committee (PAC)

The PAC is responsible for practitioner appeals/hearings of adverse determinations related to quality-of-care concerns and credentialing decisions from CPC determinations.

The PAC meets on an ad hoc basis and is facilitated by a Medical Director.

The committee is composed of three to seven participating network practitioners:

- A majority of members are peers of the affected practitioner.
- At least one peer must be licensed in the same state as each practitioner reviewed by the committee.
- At least one voting member of the PAC shall practice in a specialty substantially like the specialty of the practitioner, if specialty knowledge is required by the nature of the appeal.

No voting member of the PAC may have had substantial prior involvement in the matter under appeal. However, this does not preclude PAC members who have participated in prior appeals by the same practitioner from voting.

Specialist as a PCP

Members can elect to have a participating Specialist function as their PCP, without a referral, to coordinate their care including referrals, procedures, and tests when they have a life-threatening, degenerative, or disabling disease or condition and that is subject to the terms of a treatment plan. When this happens the Specialist

*FOR PROVISIONALLY CREDENTIALED PROVIDER SOURCE: NY Ins Law § 4803. Available at: **nysenate.gov/legislation/laws/ISC/4803**. Accessed December 30, 2024.

functioning as the PCP receives the PCP cost share and can refer to other Specialists just as a PCP would.

Standing referrals

A health carrier shall have a procedure by which an enrollee who needs ongoing care from a specialist may receive a standing referral to such specialist.

Required disclosure relating to out-of-network service and referrals

Help your patients avoid surprise out-of-network claims and coordinate their planned nonemergent services with participating providers. New York law has specific notification requirements providers must give to their patients prior to performing services.* A summary is provided below.

- Physicians must tell patients which plans they participate in. This includes detailed information about any referrals they make to ancillary providers, like anesthesiologists or assistant surgeons. This applies to both office and hospital settings. A physician is required to provide a patient or prospective patient with the name, practice name, mailing address and telephone number of any health care provider scheduled to perform anesthesiology, laboratory, pathology, radiology or assistant surgeon services in connection with care to be provided in the physician's office for the patient or with care coordinated or referred by the physician for the patient at the time of referral to or coordination of services with such provider.
- A physician is also required to notify patients scheduled for hospital admission or scheduled for outpatient hospital services of the name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician and are scheduled at the time of the preadmission testing, registration or admission at the time nonemergency services are scheduled; and information as to how to determine the health care plans in which the physician participates.
  - If the patient asks, nonparticipating providers must provide an estimate of the amount they will bill the patient for services. They must also give the patient an insurance claim form.
- Hospitals must post the following on their websites:
  - Standard charges for services
  - Health plan participation
  - Detailed information relating to physicians employed or contracted with the hospital
  - Information to help the patient see whether the physician participates in the patient's health plan

Reminder: You can help your patients save money by referring them to in-network providers.

A new enrollee whose health care provider is not a member of the Aetna® network may request to continue an ongoing course of treatment with the enrollee's current provider, subject to provider agreement where (a) the period of transition is up to 60 days if the enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition; or (b) if the enrollee has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include provision of postpartum care related to the delivery.

Our members may change their primary care physician (PCP) selection by calling Member Services at the number listed on their ID card. Or a member may change his or her PCP selection online using their **member website**.

The PCP arranges any necessary, appropriate specialty care for Aetna members by issuing a referral as may be required under the member's benefits plan. If a member wishes to change specialty providers after the initial referral is issued, this should also be coordinated by contacting the PCP.

Adverse reimbursement change*

Providers who are considered health care professionals under Title 8 of the New York Education Law must receive written notice from Aetna at least 90 days prior to an adverse reimbursement change ("Material Change") to the provider agreement with Aetna (the "Agreement"). If the health care professional objects to the Material Change that is the subject of the notice by Aetna, the health care professional may, within 30 days of the date of the notice, give written notice to Aetna to terminate the Agreement effective upon the implementation of the

*FOR DISCLOSURE REQUIREMENT SOURCE: NY Ins Law § 3217-a and NY Ins Law § 4324. Available at: **nysenate.gov/legislation/laws/ISC/3217-A** and **https://www.nysenate.gov/legislation/laws/ISC/4324**. Accessed December 30, 2024.

*FOR ADVERSE REIMBERSEMENT CHANGE SOURCE: NY Ins Law § 3217-b(g)(1). Available at: **nysenate.gov/legislation/laws/ISC/3217-B**. Accessed December 24, 2024.

Material Change. A Material Change is one that "could reasonably be expected to have an adverse impact on the aggregate level of payment to a health care professional."

The statutory exceptions to this notice requirement are listed below:

1. The change is otherwise required by law, regulation or applicable regulatory authority, or is required due to changes in Fee Schedules, reimbursement methodology or payment policies by the state or federal government or by the American Medical Association's Current Procedural Terminology (CPT) Codes, Reporting Guidelines and Conventions.
2. The change is provided for in the contract between the MCO and the provider or the IPA and the provider through inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

In addition, there is no private right of action for a health care professional relative to this provision.

Claims processing time frames*

Claims submitted electronically must be paid within 30 days, and paper or facsimile claim submissions must be paid within 45 days. There is a 30-day time frame for Aetna to request additional information or to deny the claim.

Coordination of Benefits (COB)*

We cannot deny a claim, in whole or in part, on the basis that it is coordinating benefits and the member has other insurance, unless Aetna has a "reasonable basis" to believe that the member has other health insurance coverage that is primary for the claimed benefit. In addition, if Aetna requests information fr om the member regarding other coverage and does not receive the information within 45 days, Aetna must adjudicate the claim. The claim cannot be denied by Aetna on the basis of nonreceipt of information about other coverage.

Claims practices: provider claims submission time period*

Providers must initially submit claims within 120 days after the date of the service to be valid and enforceable against Aetna, unless a time frame more favorable to the provider was agreed to by the provider and Aetna or unless a different time frame is required by law.

Participating providers are permitted to request a reconsideration of a claim that was denied solely because it was untimely. Where the provider can demonstrate that the late claim resulted from an unusual occurrence and the provider has a pattern of timely claims submissions, Aetna must pay the claim. However, Aetna may reduce the reimbursement of a claim by up to 25% of the amount that would have been paid had the claim been submitted in a timely manner. Nothing precludes Aetna and the provider from agreeing to a reduction of less than 25%. The right to reconsideration shall not apply to a claim submitted 365 days after the service, and in such cases, Aetna may deny the claim in full.

Aetna® has developed a process to determine what constitutes an unusual occurrence. Examples of an unusual occurrence include, but are not limited to:

- A disaster outside of control of the provider (tornado, flood, etc.)
- Proof submitted by the provider that the provider has a pattern of timely filing

Overpayment recovery: provider challenges and extension to all providers*

You may request an appeal of any overpayment decision by contacting Aetna Provider Services at **1-800-624-0756 (TTY: 711)** or by sending your request for an appeal with a copy of the overpayment letter to PO Box 14020, Lexington, KY 40512. Some important aspects of the process are noted below.

- We may not initiate an overpayment recovery effort more than 24 months after the provider's receipt of the original payment, except when the recovery efforts are based on a reasonable belief of fraud or other intentional misconduct or abuse.
- For recoveries other than those involving duplicate payments, Aetna must provide a health care provider with written notice 30 days prior to engaging in overpayment recovery efforts. Such notice must state the patient name, service date, payment amount, proposed adjustment and a reasonably specific explanation of the proposed adjustment.

*FOR CLAIMS PROCESSING TIME FRAME SOURCE: NY Ins Law § 3224-a. Available at: **nysenate.gov/legislation/laws/ISC/3224-A**. Accessed December 30, 2024.

*FOR COORDINATION OF BENEFITS SOURCE: NY Comp. Codes R. & Regs. tit. 11 § 52.23. Available at: **dfs.ny.gov/insurance/ogco2011/rg110501.htm** Accessed December 30, 2024.

*FOR CLAIMS SUBMISSION TIME PERIOD NOTE: Within the bounds of Department of Financial Services guidance.

*FOR OVERPAYMENT RECOVERY SOURCE: NY Ins Law § 3224-b. Available at: **nysenate.gov/legislation/laws/ISC/3224-B**. Accessed December 30, 2024.

- The **Aetna Provider Disputes & Appeals Overview page** explains our procedure for processing a provider's appeal of an overpayment recovery decision. You can access a copy of the process on our website at the above or call Provider Services at **1-800-624-0756 (TTY: 711)** to request a copy. The appeal process involves the following:
  - Other than recovery for duplicate payments, we will provide thirty days' written notice before requesting an overpayment recovery. Our notice will list: (i) the patient name, (ii) service date, (iii) payment amount, (iv) adjustment sought and (v) an explanation for the adjustment.
- You can dispute an overpayment recovery and share relevant claims information. You should explain your specific reasons why you feel the overpayment recovery is incorrect.
- We will not initiate overpayment recovery efforts more than 24 months after the original payment was received by a health care provider. However, no such time limit shall apply to overpayment recovery efforts that are: (i) based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, (ii) required by, or initiated at the request of, a self-insured plan, or (iii) required or authorized by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members. Notwithstanding the aforementioned time limitations, in the event that a health care provider asserts that a health plan has underpaid a claim or claims, the health plan may defend or set off such assertion of underpayment based on overpayments going back in time as far as the claimed underpayment. For purposes of this paragraph, "abusive billing" shall be defined as a billing practice which results in the submission of claims that are not consistent with sound fiscal, business, or medical practices and at such frequency and for such a period of time as to reflect a consistent course of conduct.

Participating provider and participating hospital reimbursement

Aetna is prohibited from treating a claim from a network hospital as out of network solely on the basis that a nonparticipating health care provider treated the member. Likewise, a claim from a participating provider cannot be treated as out of network solely because the hospital is nonparticipating with Aetna. "Provider" in this section means an individual licensed, certified, or registered under Title 8 of the Education Law or comparably licensed, registered or certified by another state.

Participating hospital coding adjustments*

If we adjust payment on a claim based upon a coding decision, you have the right to submit medical records and request the payment adjustment be reviewed.

You should submit your request within 30 days of receipt of our payment using the address on your Explanation of Benefit/Payment statement.

Provider external appeals right*

External appeal rights to providers have been extended to include concurrent adverse determinations. A provider will be responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of Aetna®; Aetna is responsible for the full cost of an appeal that is overturned; and the provider and Aetna must evenly divide the cost of a concurrent adverse determination that is overturned in part. The fee requirements do not apply to providers who are acting as the member's designee, in which case the cost of the external appeal is the responsibility of us.

In cases where providers request an external appeal of a concurrent adverse determination on their own behalf, or on behalf of the member as the member's designee, providers are prohibited from seeking payment, except applicable copays, from members for services determined to be not medically necessary by the external appeal agent. Members are to be held harmless in such cases. For the provider to claim that the appeal of the final adverse determination is made on behalf of the member, the completion of the external appeal application and the designation will be required. The superintendent has the authority to confirm the designation or to request additional information from the member. Where the member has not responded, the superintendent will inform the provider to file an appeal. A provider responding within the time frame will be subject to the external appeal payment provisions described above. If the provider is unresponsive, the appeal will be rejected.

*FOR CODING ADJUSTMENT SOURCE: NY Ins Law § 3224-a. Available at: **nysenate.gov/legislation/laws/ISC/3224-A**. Accessed December 30, 2024.
*FOR EXTERNAL APPEALS RIGHT SOURCE: NY Ins Law § 4910. Available at: **nysenate.gov/legislation/laws/ISC/4910**. Accessed December 30, 2024.

Surprise out-of-network claim*

New York law protects members from surprise out-of-network bills (claims). As a contracted provider, you play an important role in keeping our members from incurring surprise bills. Please select participating providers when coordinating care for our members. This will help avoid the generation of surprise bills and any administrative issues required to address them.

Note: *A surprise bill is not a bill for services received when a network provider was available and a member knowingly selected an out-of-network provider. Learn more about* **insurance regulations by state** *on our website.*

Capitated programs

Medicare Dual Eligible Special Needs Plans (D- SNPs)

NORTH CAROLINA

Specialist care

In-network specialist care
For members with serious or chronic degenerative, disabling or life-threatening diseases or conditions requiring long-term specialist care, the primary care physician (PCP) may submit a referral request to Provider Services for multiple visits for up to 12 months.

Out-of-network specialist care
For members with serious or chronic degenerative, disabling or life-threatening diseases or conditions requiring long-term specialist care, the PCP may submit a referral request for multiple visits for up to 12 months.

Out-of-network standing referrals follow standard out-of-network approval processes.

Specialists as the PCP
For members with serious or chronic degenerative, disabling or life-threatening diseases or conditions requiring specialized medical care, requests for a specialist as a PCP may be submitted. If approved, the specialty referral will be consistent with the treatment plan agreed to by the member's PCP, the specialist, and the member or the member's designee and us.

Standing referrals
Standing referrals to a specialist may be made if the insured has a serious or chronic degenerative, disabling, or life-threatening disease or condition, which in the opinion of the insured's primary care physician in consultation with the specialist, requires ongoing specialty care.

Physician accessibility standards

Primary care physicians (PCPs)
We have established standards for member access toprimary care services. Each PCP is required to have appointment availability within the following time frames:

- **Routine care:** within 7 business days
- **Urgent complaint:** same day or within 24 hours

In addition, all participating PCPs must have a reliable answering service or machine with a beeper or paging system 24 hours a day, 7 days a week. A recorded message or answering service that refers the member to the emergency room is not acceptable.

Specialist physicians
We have established standards for member access to specialty care services. Each specialty care practitioner is required to have appointment availability within the following time frames:

- **Routine care:** within 30 calendar days
- **Urgent complaint:** same day or within 24 hours

In addition, all participating specialty care physicians must have an answering service or machine with a beeper or paging system 24 hours a day, 7 days a week.

A recorded message or answering service that refers the member to the emergency room is not acceptable.

For North Carolina, the previously mentioned standards, with the exception of after-hours care, also apply to the following nonphysician providers:

- Audiologists
- Chiropractors
- Dietitians
- Midwives
- Occupational Therapists
- Optometrists
- Physical Therapists
- Podiatrists
- Respiratory Therapists
- Speech Therapists

For these North Carolina nonphysician providers, a recorded message or answering service that refers the member to the emergency room is acceptable.

Affordable Care Act (ACA) Individual and Family Plans (IFP)

Medicare Dual Eligible Special Needs Plans (D-SNPs)

OHIO

Affordable Care Act (ACA) Individual and Family Plans (IFP)

Medicare Dual Eligible Special Needs Plans (D-SNPs)

*FOR SURPRISE OUT-OF-NETWORK CLAIM SOURCE: NY Fin Serv L § 603. Available at: **nysenate.gov/legislation/laws/FIS/A6**. Accessed December 30, 2024.

OKLAHOMA

Specialist as Principal Physician Direct Access (SPPDA) program

The voluntary SPPDA program provides eligible members suffering from serious or complex medical conditions with direct access to covered specialty care.

Program details

HMO-based members with serious or complex medical conditions who require ongoing specialty care are eligible to join in the program. "Serious or complex medical conditions" are medical conditions or diseases that are:

- Life-threatening
- Degenerative
- Disabling

Examples include: acquired immune deficiency syndrome (AIDS), cancer, chronic and persistent asthma, diabetes with target organ involvement, emphysema and organ failure that may require transplant.

To help promote continuity of care for members participating in the SPPDA program, these members' PCPs will continue to play an active role in coordinating member care. PCPs will:

- Help, where appropriate, in drafting any necessary treatment plans
- Treat problems unrelated to those that caused the member to enroll in the program
- Receive periodic updates concerning the care their patients have received through the program

The SPPDA program is offered in addition to existing programs by which eligible members may directly access covered obstetric/gynecologic, mental health, substance abuse disorder, or routine vision services or treatment. The program is not available to members suffering from conditions that are not serious or complex. Members with such conditions may, however, request limited-standing referrals from their PCPs.

The member must meet specific medical criteria for chronicity and severity of a chronic condition as defined below.

- The PCP must have seen the patient within three months prior to requesting the direct access authorization.
- The primary diagnosis must be based on a chronic disease.
- There may or may not be a secondary diagnosis (comorbidity).
- The patient has evidence of severe disease or progression despite treatment.

For help, call the number on the member's ID card.

OREGON

Obtaining fee schedule information

For fee schedule/allowable rate information, please register with Availity® and then go to Fee Schedules on the Availity Reference Center website. **Note:** Only medical doctors (MDs) or doctors of osteopathy (DOs) who have direct contracts with us can get their fee schedules through Availity. No other type of provider can access their fee schedule via Availity.

If you need allowable fees for 10 codes or less, the Provider Contact Center (PCC) can provide that information over the phone at **1-888-632-3862 (TTY: 711)**. If you need allowable fees for 11 codes or more, please put the codes on an Excel® spreadsheet and email it to **FeeSchedule@aetna.com**. On the spreadsheet, include the following information:

- Contact phone number
- Current Procedure Terminology (CPT) code
- Modifiers
- Tax identification number (TIN)

You will receive the results within 30 business days.

Performance programs

We use practitioner and provider performance data to help improve the quality of service and clinical care our members receive if certain thresholds are met. To learn more, see the Performance Programs section in our **Provider Manual**.

PENNSYLVANIA

Specialist as a PCP

Members can elect to have a participating Specialist function as their PCP, without a referral, to coordinate their care including referrals, procedures and tests when they have a life-threatening, degenerative or disabling disease or condition and that is subject to the terms of a treatment plan. When this happens the Specialist functioning as the PCP receives the PCP cost share and can refer to other Specialists just as a PCP would.

Standing referrals

A health carrier shall have a procedure by which an enrollee who needs ongoing care from a specialist may receive a standing referral to such specialist.

D-SNP and HIDE programs

You can find the Pennsylvania Department of Human Services online Provider Community HealthChoices training at :

PA.gov/agencies/dhs/resources/medicaid/chc/chc-provider-trainings.html

Scroll down to the "Community HealthChoices Trainings: section and select "CHC Overview Training."

Capitated programs

Direct-access specialties

Medicare Dual Eligible Special Needs Plans (D-SNPs)

RHODE ISLAND

Claims processing

In accordance with Rhode Island law, providers may submit claims to us once their credentialing application has been approved. In order to ensure that claims are paid at the contracted rate during initial claim processing, we ask that providers hold claims until their contract with us has been fully executed and our systems have been updated. Once the system is updated, we will pay claims at your contracted rate, retroactive back to the date of your approved credentialing application. To verify participation status, providers should go to our provider referral directory or contact our Provider Service Center.

- HMO-based and Medicare Advantage plans: **1-800-624-0756 (TTY: 711**)
- Aetna non-HMO-based plans: **1-888-632-3862 (TTY: 711)**

Demographic data changes

Demographic changes that are submitted via our secure provider website on Availity® and that do not require intervention will be processed within seven business days of receipt, in accordance with Rhode Island regulations.

Direct-access specialties

SOUTH CAROLINA

Medicare Dual Eligible Special Needs Plans (D- SNPs)

SOUTH DAKOTA

Medicare Dual Eligible Special Needs Plans (D- SNPs)

TENNESSEE

Primary care physicians (PCPs)

We have established standards for member access to primary care services. Each PCP is required to have appointment availability within the following time frames:

- **Routine care:** within 7 calendar days
- **Urgent complaint:** same day or within 24 hours

In addition, all participating PCPs must have a reliable answering service or machine with a beeper or paging system 24 hours a day, 7 days a week. A recorded message or answering service that refers the member to the emergency room is not acceptable.

Specialist physicians

We have established standards for member access to specialty care services. Each specialty care practitioner is required to have appointment availability within the following time frames:

- **Routine care:** within 30 calendar days
- **Urgent complaint:** same day or within 24 hours

In addition, all participating specialty care physicians must have an answering service or machine with a beeper or paging system 24 hours a day, 7 days a week.

A recorded message or answering service that refers the member to the emergency room is not acceptable.

For Tennessee, the previously mentioned standards, with the exception of after-hours care, also apply to the following nonphysician providers:

- Audiologists
- Chiropractors
- Dietitians
- Midwives
- Occupational Therapists
- Optometrists
- Pharmacists
- Physical Therapists
- Podiatrists
- Respiratory Therapists
- Speech Therapists

For these Tennessee nonphysician providers, a recorded message or answering service that refers the member to the emergency room is acceptable.

Additional physician accessibility requirements

In Tennessee, we have established a goal for reasonable in-office wait time and after-hours telephone call-back response time of within 15 minutes.

TEXAS

Access standards

The regulations combined with our provider access standards require that our contracted providers meet the following time frames:

- **Urgent care appointments for medical conditions:** within 24 hours of the request for appointment
- **Urgent care for behavioral health services:** within 24 hours of the request for appointment
- **Routine appointments for primary care:** within seven calendar days of the request for appointment
- **Routine appointments for medical conditions:** within three weeks of the request for appointment
- **Routine appointments for behavioral health conditions:** within two weeks of the request for appointment
- **After-hours care:** Each primary care and specialist physician must have a reliable answering service or machine with a beeper or paging system 24 hours a day, 7 days a week. A recorded message or answering service that refers members to emergency rooms is not acceptable. The same standard applies to behavioral health practitioners who are physicians with hospital admitting privileges.

Gynecologists as principal physicians for the Women's Health Care Program

This direct-access program allows female members to visit any participating gynecologist for women's health-related care without a referral. We're expanding the program to allow the gynecologist to issue referrals for women's health and nonwomen's health conditions detected during a visit.* In this instance, the gynecologist can refer the member to the appropriate specialist and continue overseeing the member for that condition. Or the gynecologist can request that the member's primary care physician (PCP) follow up and provide oversight.

In addition, in keeping with Aetna's expanded laboratory and radiology policy, the gynecologist can order any necessary laboratory or radiological testing without a referral. (This excludes pregnant women who are participating in our Aetna Maternity Program.) The member should be referred to the appropriate capitated or contracted labs, if applicable.

How to bill

The gynecologist or PCP who performs the annual gynecologic primary and preventive visits should bill using the evaluation and management (E&M) codes for preventive visits (99384-7 and 99394-7). All other visits to the gynecologist should be coded using standard E&M codes. The gynecologist will collect the standard specialist copayment. When a woman uses both a gynecologist and a PCP for her care, the physicians should work together to coordinate her care. They should use their standard processes to communicate the treatment plans, services rendered and summaries of visits. Parts of the Aetna® gynecologist as principal physician for Women's Health Care Program allow the following:

- The gynecologist can act as the principal physician for all of a woman's health care. This empowers the woman to choose either her gynecologist or her PCP to care for her needs at that particular time in her life based on the expertise of the physician she chooses.
- The woman can be evaluated by her gynecologist without a referral from the PCP.
- The gynecologist can perform and be paid for diagnostic testing that can be done in their office. This includes studies on the "Automatic List" as well as screening and diagnostic mammography, pelvic ultrasounds,* urodynamic testing and bone density testing.
- The gynecologist can refer the member for all laboratory and radiological studies needed without requiring a referral from her PCP. All laboratory or radiological testing should continue to be performed at the capitated facility to the woman's PCP, or if there is no capitated network, at any participating laboratory or radiology facility in the relevant network.
- The gynecologist can refer members to any participating specialist or PCP in our network (except in IPA networks) for evaluation and treatment of any condition detected during a gynecological visit.
- Follow-up care by a specialist physician can be coordinated through either the PCP or the gynecologist.
- The gynecologist can precertify, an admission when the patient needs to be admitted to a short procedure unit or hospital for surgery, and the gynecologist is the admitting physician. This precertification process will automatically generate the referral for the procedure to ensure payment without the need for the member to get a referral from a PCP. Precertification for the site of therapeutic abortions may be dependent on regional facilities and the participation of doctors who perform these procedures in their office or in cost-effective facilities.

*FOR REFERRAL NOTE: Depending on a member's plan, referrals to out-of- network providers may not be covered or may result in substantial out-of-pocket costs to the member. Certain providers may be affiliated with an IPA, physician medical group, integrated delivery system or other provider group. Members who select these providers will generally be referred to specialists and hospitals affiliated within or otherwise affiliated with those groups.

*FOR ULTRASOUNDS NOTE: Obstetrical ultrasounds performed in the office do not require an authorization and are paid on a fee-for-service basis. Austin, Corpus Christi and San Antonio markets do not participate in the nonstress test enhancement program and are paid on a fee-for-service basis.

Note: *The term "precertification," used here and throughout the office manual, means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets our clinical criteria for coverage. It does not mean precertification as defined by Texas law, which is a reliable representation of payment of care or services to fully insured HMO and preferred provider organization members.*

Specialists as PCPs

A full-risk HMO member may apply to the health plan to use a non-primary-care specialist as a PCP.

The written request must include:

- Certification by the non-PCP specialist of the medical need for the member to use the non-PCP specialist as a PCP
- A statement signed by the non-PCP specialist saying that they are willing to accept responsibility for the coordination of all of the member's health care needs
- The signature of the member

The non-PCP specialist must meet the health plan's requirements for PCP participation, including credentialing. The contractual obligations of the non-PCP specialist must be consistent with the contractual obligations of the health plan's PCPs.

For help, call the number on the member's ID card.

Standing referrals

A health carrier shall have a procedure by which an enrollee who needs ongoing care from a specialist may receive a standing referral to such specialist.

Peer-to-peer process

Prior to an adverse determination being issued verbally or in writing to a provider, a provider is given an opportunity to discuss the plan of treatment for the enrollee with a physician reviewer. This is the only opportunity to speak with the reviewing doctor to potentially alter a determination.

Note: The issuance of an adverse determination is defined as when an adverse determination is communicated to the provider of record, either verbally or in writing. If an adverse determination has been issued verbally or in writing to a provider the physician reviewer may not alter or overturn the denied service. Any request for reconsideration or submission of additional clinical information received after an adverse determination has been issued verbally or in writing to a provider must be an appeal request.

Utilization management timelines

Type of decision	Aetna will issue response within:
Approval notice	3 calendar days from receipt of a complete request, or 2 working days of receipt and all necessary information to decide
Preauthorization adverse determinations notice	3 working days
Post stabilization care, emergency treatment or life-threatening conditions	Within the time appropriate to the circumstances, but not to exceed 1 hour
Appeal of adverse determination	As soon as practical, but no later than 30 days after the date the appeal is received
Expedited appeal (life-threatening conditions, continued stays for hospitalized patients)	In accordance with the medical immediacy of the case, but not to exceed 1 working day

For determinations concerning acquired brain injury, a utilization review agent (URA) must provide notification of the determination through a direct telephone contact to the individual making the request. This must not be later than 3 business days after the date on which an individual requests utilization review or requests an extension of coverage based on medical necessity or appropriateness. This requirement does not apply to a determination made for coverage under a small employer health benefits plan.

If an appeal is denied, health care providers may request a review by a provider in the same or similar specialty — one who typically manages the condition. They can do this by submitting a written request for review of the appeal within 10 working days of receiving the adverse determination.

Direct-access specialties

Affordable Care Act (ACA) Individual and Family Plans (IFP)

Medicare Dual Eligible Special Needs Plans (D- SNPs)

UTAH

Utah networks

In order to provide our members, the care they want, Aetna offers five different networks in Utah. Please be sure to check the member's network and make in-network referrals.

You can check a member's network through Availity and get other information you need about Aetna. Not registered yet? Go to the **Aetna provider portal** on Availity. Call Availity Client Services at **1-800-282- 4548** between the hours of 8 AM and 8 PM ET, Monday through Friday.

Aetna Choice® Network
The Aetna Choice Network is the standard network for Utah. It does not have a specific symbol or wording that identifies it on the ID card, other than the Aetna® logo. If your client has supplemental access to networks outside of Utah, you may see other network symbols (for example, First Health®). The Aetna Choice® Network includes:

- University of Utah
- HCA/Mountain Star
- CommonSpirit/Holy Cross hospitals
- Intermountain Primary Children's Hospital
- Intermountain Healthcare facilities and providers outside of Salt Lake, Utah, Weber and Davis counties

Peak Preference Network
The member ID card will display "Peak Preference Network", which includes:

1. **Maximum Savings (Level 1) Hospitals:**

- HCA/Mountain Star
- CommonSpirit/Holy Cross hospitals
- Intermountain Health – Primary Children's Hospital
- Intermountain Health facilities and providers outside of Salt Lake, Utah, Weber and Davis counties

2. **Standard Savings (Level 2) Hospitals:**

- University of Utah
- All hospitals outside of Salt Lake, Utah, Weber, and Davis counties

Aetna Whole Health℠ – Connected Utah
The member ID card is gold and will display "Aetna Whole Health – Connected Utah", which includes:

- All Intermountain Health facilities and providers
- University of Utah
  - Department of Pediatrics
  - Division of Dermatology
  - Behavioral Health
  - Huntsman Mental Health Institute (formerly University of Utah Neuropsychiatric Institute)
- All hospitals outside of Salt Lake, Utah, Weber, and Davis counties (except for Brigham City and Cache Valley hospitals)

Utah Connected Network
The member ID card will display "Utah Connected Network", which includes:

- All Intermountain Health facilities and providers
- HCA/Mountain Star
  - University of Utah
  - Department of Pediatrics
  - Division of Dermatology
  - Behavioral Health
- Huntsman Mental Health Institute (formerly University of Utah Neuropsychiatric Institute)
- All hospitals outside of Salt Lake, Utah, Weber, and Davis counties

Aetna Extended Network
The member ID card will display "Aetna Extended Network", which includes:

- All Intermountain Health facilities and most Intermountain Health providers
- University of Utah
- HCA/Mountain Star
- CommonSpirit/Holy Cross hospitals
- All hospitals outside of Salt Lake, Utah, Weber, and Davis counties

Please also refer to the **June 2024 Office Link article** in the state specific section under "Utah" for network information.

Affordable Care Act (ACA) Individual and Family Plans (IFP)

Medicare Dual Eligible Special Needs Plans (D-SNPs)

VIRGINIA

Claims submission

In accordance with Virginia law, providers may submit claims to us once they have completed credentialing if the provider:

- Is employed by or a member of the group practice
- Has applied for acceptance on the carrier's provider panel and the carrier has notified the provider of the carrier's intent to continue to process the provider's application to obtain necessary credentialing information
- Has a valid license issued by a health occupations board to practice in the state
- Is currently credentialed by an accredited hospital in the state or has professional liability insurance

In order to ensure that claims are paid at the contracted rate during initial claim processing, we ask that providers hold claims until their contract with us has been fully executed and our systems have been updated. Once the system is updated, we will pay claims at your contracted rate, retroactive back to the date that we received your credentialing application from CAQH®. To verify participation status, providers should go to our **provider referral directory** or contact our Provider Service Center.

- HMO-based and Medicare Advantage plans: **1-800-624-0756 (TTY: 711)**
- All other plans: **1-888-632-3862 (TTY: 711)**

Medicare Dual Eligible Special Needs Plans (D-SNPs)

WASHINGTON

Obtaining fee schedule information

For fee schedule/allowable rate information, please register with Availity® and then go to Fee Schedules on the Availity Reference Center website. Note: Only medical doctors (MDs) or doctors of osteopathy (DOs) who have direct contracts with us can get their fee schedules through Availity. No other type of provider can access their fee schedule via Availity.

If you need allowable fees for 10 codes or less, the Provider Contact Center (PCC) can provide that information over the phone at **1-888-632-3862 (TTY: 711)**. If you need allowable fees for 11 codes or more, please put the codes on an Excel® spreadsheet and email it to **FeeSchedule@aetna.com**. On the spreadsheet, include the following information.

- Contact phone number
- Current Procedure Terminology (CPT) code
- Modifiers
- Tax identification number (TIN)

You will receive the results within 30 business days.

Performance programs

We use practitioner and provider performance data to help improve the quality of service and clinical care our members receive, if certain thresholds are met. To learn more, see the Performance Programs section located in our **Provider Manual**.

Use of the substitute provider notification process

Background

In accordance with Washington Administrative Code (WAC) 284-170-380 Standards for Temporary Substitution of Contracted Network Providers — "Locum Tenens" Providers, we permit the following categories of contracted network providers in Washington state to arrange for temporary substitution by a substitute provider:

- Doctor of medicine
- Doctor of osteopathic medicine
- Doctor of dental surgery
- Doctor of chiropractic
- Podiatric physician and surgeon
- Doctor of optometry
- Doctor of naturopathic medicine
- Advanced registered nurse practitioners (for 90 days, every calendar year)

Per the above WAC regulation, at the time of substitution, the substitute provider must:

- Have a current Washington license and be legally authorized to practice in this state
- Provide services under the same scope of practice as the contracted network provider
- Not be suspended or excluded from any state or federal health care program
- Have professional liability insurance coverage
- Have a current drug enforcement certificate, if applicable

Workflow

1. Providers must notify their Aetna® network account manager of their intent to use substitute providers at least 10 business days prior to the beginning of the substitution period using the Intent to Use a Substitute Provider form.
2. An Aetna medical director will review each Intent to Use a Substitute Provider form submission, accept or reject it, and then return the submission to the provider.
3. If a provider wants to propose a change to an accepted submission, the provider should mark the changes on the original accepted form and then submit it at least 10 business days in advance of the proposed change.
4. A medical director will review the marked-up form, accept it or reject it, and then return the submission to the provider.

To obtain a copy of the Intent to Use a Substitue Provider form, go to **Aetna.com**, select the Resources tab, then "Forms" and then "State-specific forms"

Contact information:

Seattle Network Management
Phone: **1-800-720-4009 (TTY: 711)**
Fax: **1-860-262-9619**

Surprise out-of-network claim

Washington law protects members from surprise out- of-network bills (claims). As a contracted provider, you play an important role in keeping our members from incurring surprise bills. Please select participating providers when coordinating care for our members. This will help avoid the generation of surprise bills and any administrative issues required to address them.

Washington Vaccine Association (WVA)

In compliance with WA RCW 70.290.010 –.900, the WVA is an independent, nonprofit organization that allows Washington State to provide vaccines for all children under the age of 19. Health plans and other payers reimburse WVA for vaccines. The WVA collects these payments and transfers the funds to the State Department of Health, where its Childhood Vaccine Program purchases vaccines at federal contract rates and distributes vaccines to physicians, hospitals and other providers at no charge. Read more about the program and access the **assessment grid**.

WEST VIRGINIA

Access standards

Regulations, combined with our provider access standards, require that our contracted providers meet the following time frames:

Provider/facility specialty type appointments	Time frame
Behavioral Health	10 business days
Primary Care (Routine)	5 business days
Specialty Care (Non-urgent)	30 business days

Prior authorization

Prior authorization requests, along with any related communications, must be submitted electronically using our provider portal, Availity®. Submitting electronically allows for faster reviews and greater transparency around the status of authorization requests.

Direct-access specialties

Medicare Dual Eligible Special Needs Plans (D-SNPs)

Affordable Care Act (ACA) Individual and Family Plans (IFP)

The product gives members access to a high-quality network of health care providers and telemedicine services, and it provides members with convenient and affordable health care offerings at MinuteClinic®, CVS® and CVS Pharmacy® locations across the country.

The plan uses the reach of CVS Health® — its health insurance, pharmacy benefits, retail-based health services, mental well- being programs, telehealth services, digital capabilities and more — to provide greater value for individual consumers.

Individual & Family Plans are available in the below states. Look for "QHP" (qualified health plan) on member ID cards. Selection of a PCP and referrals may be required for these plans.

For additional information, please visit us at:
AetnaCVSHealth.com

States with Individual and Family Plans (IFP)		
Arizona (Banner Health)	Kansas	Texas
California	Maryland	Utah
Delaware	Missouri	
Florida	Nevada	
Georgia	New Jersey	
Illinois	North Carolina	
Indiana	Ohio	

Capitated programs: Primary care physician (PCP) selection of capitation specialty providers

In some health maintenance organization (HMO)-based markets, PCPs (including those who are newly credentialed) must select one specialty care provider to deliver care to all their patients in HMO-based benefits plans.

Specialists should redirect these members back to their PCP for referrals to the appropriate capitated provider. To select a capitated provider, PCPs should call our Provider Service Center at **1-888-632-3682 (TTY: 711)**.

Group name	Specialty	Participating counties	Benefits plans
Northwell Health Laboratories	Laboratory	Nassau, Queens and Suffolk in New York	Medicare Advantage HMO-based plans
Staten Island University Laboratory	Laboratory	Staten Island in New York	Medicare Advantage HMO-based plans
Radiology (selected provider)	Radiology	Southern New Jersey and select counties in Delaware and Pennsylvania	HMO-based plans
Physical therapy (selected provider)	Physical therapy	Select counties in Delaware and Pennsylvania	HMO-based plans
Podiatry (selected provider)	Podiatry	Select counties in Delaware and Pennsylvania	HMO-based plans

Note: *All members enrolled in HMO-based plans in which referrals are required (see the Aetna® Benefits Products Booklet) must be referred by their PCP. Exceptions include magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) scans, positron emission tomography (PET) scans, nuclear medicine, and mammography.*

Direct-access specialities

Specialities					
Service type	Behavioral health*	OB/GYN*	Routine Eye Care (Ophtalomogy and Optometry)	Radiology*	Laboratory*
Products	All	All	All	Capitated FFS direct access HMO-based plans	All
States					
Connecticut	X	X	X		
Delaware	X	X	X	X	X
District of Columbia	X	X	X		
Maine	X	X	X		
Maryland	X	X	X		
Massachusetts	X	X	X		
New Hampshire	X	X	X		
New Jersey	X	X	X	X	
New York				X	X
Pennsylvania	X	X	X	X	X
Rhode Island	X	X	X		
Texas		X			
Virginia	X	X	X		
West Virginia	X	X	X		

*FOR BEHAVIORAL HEALTH NOTE: All Aetna® members have direct-access benefits for individual outpatient behavioral health visits unless they have a behavioral health benefits plan that we administer but do not manage, or self-funded plans that have plan sponsors who have expressly purchased precertification requirements and those services noted on the Behavioral Health Precertification List.

*FOR OB/GYN NOTE: View the Women's Health Programs and Policies manual on Aetna.com for more information.

*FOR RADIOLOGY NOTE: Certain procedures require precertification. Applicable Radiology services include CT scans, Mammograms, MRI/MRA scans, OB ultrasounds, Radiation therapy (Specialty RO only).

*FOR LABORATORY NOTE: Use the Lab Requisition form in lieu of referral.

Enhanced clinical review program

EviCore healthcare manages prior authorization for certain outpatient procedures for all commercial and Medicare plans (except indemnity Traditional Choice® plans). Some exceptions may apply. Please contact EviCore healthcare for details. Prior authorization is required for all Aetna® members enrolled in our commercial and Medicare Advantage benefits plans (except Traditional Choice® indemnity plans) in the following states:

Commercial only	Medicare and commercial			
Alaska	Alabama	Illinois	Missouri	South Dakota
Kentucky	Arizona	Indiana	Nebraska	Tennessee
Montana	Arkansas	Iowa	Nevada	Texas
Vermont	California (PPO only)	Kansas	New Jersey	Utah
Wyoming	Colorado	Louisiana	New York	Virginia
	Connecticut	Maine	North Carolina	Washington
	Delaware	Maryland	Ohio	Washington, D.C.
	Florida	Massachusetts	Oklahoma	West Virginia
	Georgia	Michigan	Pennsylvania	Wisconsin
	Idaho	Mississippi	South Carolina	

These outpatient procedures, equipment and services include:

- Brachytherapy
- Computed tomography (CT)
- Computed tomography angiography (CTA) scans
- Disease (PVD)
- Elective inpatient and outpatient cardiac rhythm implant devices
- Elective inpatient and outpatient hip and knee arthroplasties. Hip and knee arthroplasties are managed by Aetna®
- Elective outpatient magnetic resonance imaging (MRI)
- Elective outpatient stress echocardiography and diagnostic left and right heart catheterization
- Facility-based sleep studies
- Hyperthermia therapy
- Image-guided radiation therapy (IGRT)
- Intensity-modulated radiation therapy (IMRT)
- Interventional pain management
- Magnetic resonance angiography (MRA) scans
- Neutron beam therapy
- Nuclear cardiology
- Peripheral Arterial
- Positron emission tomography (PET) scans
- Proton beam therapy
- Radiation therapy: complex and 3D conformal, stereotactic radiosurgery (SRS)
- Radiopharmaceuticals
- Stereotactic body radiation therapy (SBRT)

The following services are not affected:

- Inpatient services (except cardiac rhythm implant devices and hip and knee arthroplasties). Hip and knee arthroplasties are managed by Aetna®.
- Emergency room services
- Outpatient services, other than those referenced above

Note: *Prior authorization is required for outpatient angioplasty, iliac, femoral/popliteal, tibial/peroneal, stenting, and ultrasound.*

How to send prior authorization requests to EviCore Healthcare

Phone: **1-800-420-3471 (TTY: 711)**

Fax: **800-540-2406** for all radiology, cardiology, PVD, and radiation therapy requests

Fax: **1-866-999-3510** for sleep requests

Fax: **855-774-1319** for interventional pain requests

Website: **Evicore.com**

Note*: All providers should send claims for these services to us for all plans. Obtaining an approved preauthorization does not guarantee payment. Claims payment is also dependent on member's eligibility and benefits plan.*

Medicare Dual Eligible Special Needs Plans (D-SNPs)

We offer Aetna®-branded D-SNPs to Medicare beneficiaries who live within the program's service area, as long as they meet dual-eligibility requirements.

These include:

Eligibility to enroll in a federal Medicare plan, based on age and/or disability status

Potential eligibility for assistance from the state, based on income and assets

Note: *All D-SNP members are automatically enrolled in our D-SNP care management program.*

D-SNP care management program

The D-SNP care management program goes beyond traditional case and disease management programs.

It provides care management, care coordination, health education and promotion, and nutrition education. Plus, the program gives useful information about coordinating community-based home services.

Our program goals are to:

- Improve member health and quality of life through early intervention, education and use of preventive services
- Increase access to care and essential services, including medical, behavioral health and social services
- Improve access to affordable care
- Integrate and coordinate care across specialties
- Encourage appropriate use of services and cost-effective approaches

Health risk assessments and individualized care plans

The D-SNP care management team uses health risk assessments to understand health challenges and develops individualized care plans to address them. We offer members:

- Health risk assessments (HRAs)
- Annual reassessments
- Individualized care plans (ICPs) that document problems, goals, interventions and follow-up

Providers can view and download their patient's HRAs and individualized care plans using the following sites:

Aetna Better Health of Virginia site for providers in Virginia.

AssureCare provider site for providers in Alabama, Arkansas, California, Connecticut, Florida, Georgia, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas and West Virginia.

Interdisciplinary care team

Each member enrolled in a D-SNP is assigned an interdisciplinary care team (ICT). This helps ensure that the member's medical, functional, cognitive and psychosocial needs are considered in care planning. The team includes the member's PCP, a social services specialist, a pharmacist, a nurse care manager, a care coordinator and a behavioral health specialist. The ICT supports the member's needs and is timely and cost effective. The care manager acts as a health coach and serves as a contact between the member and the rest of their ICT.

You can reach your patient's care manager by calling one of the numbers listed below:

- Those outside of Virginia can call **1-800-241-9379 (TTY: 711)**.
- Those in Virginia can call **1-855-463-0933 (TTY: 711)**.

Healthcare Effectiveness Data and Information Set (HEDIS®) measures

To support HEDIS initiatives, be sure to submit encounter data for the Care for Older Adults (COA) measure. That way, the supporting documentation for all D-SNP members ages 65 and above is in the member's chart.

Requirements

- Advance Care Planning (CPTII: 1157F, 1158F)
- Medication Review (CPTII: 1159F and 1160F must both be submitted on the same claim and on the same day)
- Functional Status Assessment (CPTII:1170F)

Mandatory Medicare SNP Model of Care (MOC) training

We have developed a MOC training to make sure all Special Needs Plans (SNP), including D-SNP, I-SNP and C-SNP, members receive comprehensive care management and care coordination. The Centers for Medicare & Medicaid Services (CMS) requires us to provide MOC-compliance training to providers who care for our SNP members.

This training is mandatory. All network providers and their employees who serve members of Aetna® Medicare SNPs must complete this training as required by CMS.

Training must be done:

- When a new provider or employee is hired
- Thereafter, each calendar year

Take the **online mandatory Medicare SNP MOC training**.

If you need access to the site, have questions about the training or would like a printed copy of the training presentation, just contact us at **1-800-624-0756 (TTY: 711)**.

D-SNP payments and billing

The chart below breaks down program levels and cost-sharing benefits.

Medicare Savings Program levels	Cost sharing and Medicaid benefits
Qualified Medicare Beneficiary (QMB)	Medicare Parts A & B are cost-sharing protected
Qualified Medicare Beneficiary Plus (QMB+)	• Medicare Parts A & B are cost-sharing protected • Full Medicaid benefits
Specified Low-Income Medicare Beneficiary (SLMB)	No cost-sharing protection
Specified Low-Income Medicare Beneficiary Plus (SLMB+)	• Medicare Parts A & B may or may not be cost-sharing protected (dependent on state policy) • Full Medicaid benefits
Qualifying Individual (QI)	No cost-sharing protection
Qualified Disabled Working Individual (QDWI)	No cost-sharing protection
Full Benefit Dual-Eligible (FBDE)	• Medicare Parts A & B may or may not be cost-sharing protected (dependent on state policy) • Full Medicaid benefits

Network providers may not bill cost-sharing-protected members for either the balance of the Medicare rate or the provider's charges for Medicare Parts A & B services. In some states, members may be subject to a Medicaid copay. Network provider must accept the payment from Aetna® and Medicaid and, where applicable, the Medicaid copayment as payment in full.

In addition, federal law prohibits Medicare providers from billing individuals who have QMB or QMB+ status. All Medicare providers and suppliers, not only those that accept Medicaid, must not charge individuals enrolled in the QMB or QMB+ program for Medicare Parts A & B cost sharing. Furthermore, QMB and QMB+ members cannot elect to pay Medicare cost-sharing rates. Providers that bill QMB or QMB+ members for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions.

Note: *If a member is cost-sharing protected, the network provider shall bill any cost-sharing obligations to the state Medicaid agency, the member's Medicaid managed care organization, or Aetna. Find state-specific information on which organization to bill for cost sharing.*

For general MOC attestation questions, please email us at DSNPMOC@aetna.com or call 1-800-624-0756 (TTY: 711).

For Care Management, email:

- All D-SNP markets (except NJ and VA): **MCRDSNP@aetna.com**
- NJ: **NJ_FIDE_SNP_CM@aetna.com**
- VA: **ABH_VA_DSNP@aetna.com**

To request access to the secure provider portal, email:

- All D-SNP markets (except NJ and VA): **MCRDSNP@aetna.com**
- NJ: **NJ_FIDESNP_Providers@aetna.com**
- VA: **AetnaBetterHealth-VAProviderRelations@aetna.com**

Aetna, CVS Pharmacy® and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health® family of companies.

Aetna.com

4274231-01-01 (2/25)