Office manual for health care professionals

Mid-America Regional section

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Welcome to your provider manual

Contacts

Allergy extract vendor	**Nelco Lab** **1-800-541-0790**
Complaints and appeals address	Aetna Complaints and Appeals PO Box 14020 Lexington, KY 40512
Dental	Our **provider portal**
Durable medical equipment	Our **provider portal**
Enhanced Clinical Review program	**Pre-authorization is required for the following procedures:** • Elective outpatient magnetic resonance imaging (MRI)/ magnetic resonance angiography (MRA), nuclear cardiology, positron emission tomography (PET) scans, computed tomography (CT)/computed tomography angiography (CTA) • Facility-based sleep studies • Elective outpatient stress echocardiography and diagnostic left and right heart catheterization • Elective inpatient and outpatient cardiac rhythm implant devices • Nuclear cardiology • Elective inpatient and outpatient hip and knee arthroplasties • Interventional pain management • Radiation therapy: complex and 3D conformal, stereotactic radiosurgery (SRS)/stereotactic body radiation therapy (SBRT), brachytherapy, hyperthermia, intensity-modulated radiation therapy (IMRT)/image-guided radiation therapy (IGRT), proton beam therapy, neutron beam therapy and radiopharmaceuticals **Pre-authorization is required for all Aetna® members enrolled in our commercial and Medicare Advantage benefits plans in the following areas:** • Iowa • Illinois • Indiana • Kansas • Kentucky • Michigan **Continued on next page**

Enhanced Clinical Review program (continued)	• Missouri • Nebraska • Ohio • Oklahoma • South Dakota • Wisconsin **Pre-authorization requests:** contact **MedSolutions (doing business as "eviCore healthcare")** via: • Phone: **1-888-693-3211** from 7 AM to 8 PM CT, Monday through Friday • Fax: 1-844-822-3862 • Website: **eviCore.com** • Radiation therapy phone: **CareCore National (doing business as "eviCore healthcare")** at **1-888-622-7329**, from 7 AM to 8 PM CT, Monday through Friday • Radiation therapy fax: 1-888-693-3210 • Radiation therapy website: **eviCore.com**, and then select the **CareCore National tab**
Home health	• **Michigan and Ohio: CSI Network Services** at **1-888-873-7888** • **All other markets: Aetna.com**
Home infusion	• **Michigan and Ohio: CSI Network Services** at **1-888-873-7888** • **All other markets: Aetna.com**
Hospice	• **Michigan and Ohio: CSI Network Services** at **1-888-873-7888** • **All other markets**: **Aetna.com**
Laboratories	The Aetna network offers your patients access to nationally contracted, full-service laboratories with conveniently located patient service centers. Visit **QuestDiagnostics.com** or **LabCorp.com** to get started. Online, you can: • Get requisitions and schedule lab appointments for your patients • Schedule specimen pickup and set up patient results delivery

Laboratories (continued)	• Order supplies • Find a patient service center Your market may also have contracted with local laboratory providers. Visit **Aetna.com** to get a complete list of participating labs available in your area.
Nonparticipating provider and special services request	**HMO-based products:** **1-800-624-0756 (TTY: 711)** **PPO-based products:** **1-888-MD-Aetna (TTY: 711)** or **1-888-632-3862 (TTY: 711)**
Paper claims address for Aetna	Aetna PO Box 981106 El Paso, TX 79998-1106
Physical therapy and occupational therapy (PT and OT)	· **HMO-only plans in Kansas and portions of Missouri; all plans in Oklahoma City and Tulsa, Oklahoma**: **American Therapy Administrators** at **1-888-560-6855** · **Ohio only:** **Rehab Provider Network (RPN)** at **1-888-256-2248** · **All other markets:** **Aetna.com**
Radiology	**Aetna.com**
Respiratory therapy	**Aetna.com**
Vision networks	· **EyeMed** at **1-888-581-3648** · **Participating providers:** **Aetna.com**

Utilization review policies

We do not reward physicians or other individuals who conduct utilization reviews for issuing denials of coverage or for creating barriers to care or service. Financial incentives for utilization management decision-makers do not encourage denials of coverage or service.

Rather, we encourage the delivery of appropriate health care services. In addition, we train utilization review staff to focus on the risks of underutilization and overutilization of services. We do not encourage utilization-related decisions that result in underutilization.

Case management referrals

Refer patients to our Complex Case Management program

Patients with complex cases often need extra help understanding their health care choices and benefits. They may also need support navigating the community services and resources available to them. Our Complex Case Management program is a collaborative process that involves the member, their provider and us.

It aims to produce better health outcomes while efficiently managing health care costs. Members can gain access to the program through a provider referral. To make a referral, just call the number on the member's ID card. Our case management staff will call the member, explain the program to them and then ask them to join.

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.

Program goals

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
- An individualized care plan (ICP) with documented problems, goals, interventions and follow-ups
- Pain Screening (CPTII: 1125F, 1126F)

Providers can view and download their patients' HRAs and individualized care plans using the sites listed below.

- **AL, FL, GA, IA, KS, LA, MO, NE, NC, OH, PA, TX and WV: Aetna-PRD.AssureCare.com/provider/**
- **VA: AetnaBetterHealth.com/Virginia-HMOSNP/Providers/Portal**

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 in a timely and cost-effective manner. The nurse care manager acts as a health coach and serves as a liaison between the member and the rest of their ICT. You can reach your patient's nurse care manager by calling one of the numbers listed below.

- **AL, FL, GA, IA, KS, LA, MO, NE, NC, OH, PA, TX and WV: 1-800-241-9379 (TTY: 711)**
- **VA: 1-855-463-0933 (TTY: 711)**

Healthcare Effectiveness Data and Information Set measures

To support Healthcare Effectiveness Data and Information Set (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 older is in the member's chart.

Requirements

- Advance Care Planning (CPTII: 1157F, 1158F)
- Functional Status Assessment (CPTII: 1170F)
- Medication Review (CPTII: 1159F and 1160F must both be submitted on the same claim and on the same day)
- Pain Screening (CPTII: 1125F, 1126F)

Mandatory Medicare D-SNP Model of Care training

We have developed a model of care (MOC) to make sure D-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 D-SNP members.

This training is mandatory. All network providers and their employees who serve members of Aetna Medicare D-SNPs must complete this training. CMS requires it.

Training must be done:

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

Take the **online mandatory Medicare D-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.

- **AL, FL, GA, IA, KS, LA, MO, NE, NC, OH, PA, TX and WV: 1-833-570-6670 (TTY: 711)**
- **VA: 1-855-463-0933 (TTY: 711)**

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

D-SNP payments and billing

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

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. Cost-sharing-protected members are protected from liability for Medicare Part A&B charges, even when the amounts that the provider receives from Medicare and Medicaid are less than the Medicare rate or less than the provider's customary charges.

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. Further, QM 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 provider shall bill any cost-sharing obligations to the state Medicaid agency, the member's Medicaid managed care organization, or Aetna. Go to **Aetna.com/healthcare-professionals/assets/documents/2020-dnsp-cost-share-grid.pdf** to find state-specific information on which organization to bill for cost sharing.

Illinois provider vs. member appeals

In order to file a provider appeal, you must complete our Practitioner and Provider Complaint and Appeal Request form. You must submit your appeal to us in writing with any supporting documents you wish to provide, such as medical records.

If you file an appeal for a denial of services that required prior authorization and have yet to be rendered to your patient — in other words, pre-service — that appeal will be treated as a member appeal in all instances. No Member Authorization form is required.

If you wish to file an appeal on behalf of your patient for a denial of services that have already been rendered — in other words, post-service — you should use our Member Complaint and Appeal form. You must clearly indicate you are acting for the member in your request, and also include a signed written authorization from the member. This is in order for it to be processed as a member appeal. Failure to provide a signed written authorization form from the member will result in processing a post-service appeal as a provider appeal.

Hospitalist programs in Kansas City and St. Louis

Hospitalists can act as referring physicians for the coordination of adult medical and surgical inpatient services. They may admit members, evaluate members in the emergency room and coordinate all clinical services that members require.

They also work closely with our Case Management department to help with continuity of care upon discharge or transfer to an alternate level of care.

As part of their obligation to you and our members, hospitalists will provide notification and written documentation of your patient's status on admission, during the stay and upon discharge. They will also contact members upon discharge to check on their post-discharge progress. And they will check if the member is receiving appropriate follow-up care.

The use of any participating hospitalist physician's services is strictly voluntary. In any case where a member objects to the hospitalist attending to his or her care, the PCP will be informed so that they can reassume direction of the patient's care.

Radiology accreditation requirements

Aetna has radiology accreditation requirements for our commercial and Medicare Advantage business.

To be eligible for reimbursement for the technical part of advanced diagnostic imaging procedures, the following types of providers must be accredited by the **American College of Radiology (ACR)** and/or the **Intersocietal Accreditation Commission (IAC)**:

- Freestanding imaging centers
- Independent diagnostic testing facilities
- Nonphysician practitioners
- Office-based imaging facilities
- Physicians
- Suppliers of advanced diagnostic imaging procedures

This accreditation requirement applies to the technical part of advanced diagnostic imaging procedures. For these purposes, advanced diagnostic imaging procedures exclude X-ray, ultrasound, fluoroscopy and mammography.

Included are:

- MRI
- MRA
- CT
- Echocardiograms
- Nuclear medicine imaging, such as PET
- Single photon emission computed tomography (SPECT)

Note:

- This requirement will not apply to patients who are in the hospital or in hospital emergency departments.
- This policy will not apply to hospitals, unless they own one of the above-listed providers.
- The accreditation process can take 9 to 12 months.

Specialist as Principal Physician Direct Access (SPPDA) program in Oklahoma

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 their 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 in addition to existing programs by which eligible members may directly access covered obstetric/gynecologic, mental health, substance abuse, 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 Patient Management at the number on the member's ID card.

Provider vs. member appeals

Reconsideration of adverse determination (peer-to-peer review time frames in Missouri only)

Providers may request reconsideration (peer-to-peer review) of an adverse determination of a request for authorization. This does not include reconsideration of appeals. See the time frames for submitting peer-to-peer review requests to the right.

- **Time frame to request peer-to-peer review**
  Within 14 calendar days of the denial letter date
- **Time frame to expect a response to request**
  Within one business day of the request

Note: If the provider is not available for the peer-to-peer review within the one-business-day time frame, we will accommodate the provider's schedule to allow for a review of the request.

Missouri and Illinois

Specialty networks and narrow networks

St. Louis metro area: Carelink St. Louis
Carelink St. Louis is a patient-centric model of care powered by a high-performance network (HPN). It's available to members located in the Missouri and Illinois counties listed here.

The network is the result of an enhanced relationship between us, Mercy, SSM Health, St. Elizabeth's in Belleville, IL, and Saint Anthony's Health Center in Alton, IL. The network that supports Carelink is made up of the systems and their affiliated providers named in this section and therefore, by the nature of the HPN concept, will not support inclusion of all Aetna-contracted providers.

Missouri counties
- Franklin
- Jefferson
- St. Charles
- St. Louis City
- St. Louis County

Carelink criteria for Missouri residents
- Members are encouraged to choose a PCP.
- HPN members who live in Missouri do not need a specialist referral.
- Carelink Specialist claims will *not* deny without a referral from their PCP.
- Prior authorization rules apply.

Illinois counties
- Madison
- Monroe
- St. Clair

Carelink criteria for Illinois residents
- Members must choose a PCP.
- Members need a referral from their PCP to see a specialist.
- Prior authorization rules apply.

Central Illinois region: Carelink St. John's Hospital, Springfield, IL

Carelink St. John's is a patient-centric model of care powered by a high-performance network (HPN). It is available to members listed here. The network is the result of an enhanced relationship between us, Hospital Sisters Health System and St. John's Hospital.

Central Illinois counties
- Macon
- Mason
- Sangamon
- Shelby

Carelink St. John's criteria
- Members must choose a PCP.
- Members need a referral from their PCP to see a specialist.
- Prior authorization rules apply.

Lab services

Carelink members may use Quest-, Mercy-, or SSM-affiliated providers for lab services.

Verifying in-network participation

To verify if you are participating in the Carelink network, just visit our **Directory of Health Care Professionals**.

Carelink plans include out-of-network benefits. Members have a deductible and coinsurance, and services are subject to usual and customary charges. Guidelines noted apply to fully insured plans only.

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.

Provider manuals
Visit our **Provider Education & Manuals** page to find manuals and other resources.

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