Office Manual for Health Care Professionals
Northeast Regional Section
Welcome to Aetna’s health care professional office manual for participating physicians and office staff.

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Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).
**Capitated programs: primary care physician (PCP) selection of capitated specialty providers**

In some HMO-based markets, PCPs (including those newly credentialed) must select one specialty care provider to deliver care to all of their patients in HMO-based benefits plans. Specialist should redirect these members back to their selected PCP for referrals to the appropriate capitated provider. To select a capitated provider, PCPs should call our Provider Service Center.

<table>
<thead>
<tr>
<th>State/group name</th>
<th>Specialty</th>
<th>Participating counties</th>
<th>Benefits plans</th>
<th>Claims address or phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts Laboratory/Pathology</td>
<td>Laboratory/Pathology</td>
<td>All</td>
<td>HMO-based plans</td>
<td>See “Contacts”</td>
</tr>
<tr>
<td>North Shore–LIJ Laboratory Lab</td>
<td>Lab</td>
<td>Nassau, Queens, Suffolk</td>
<td>HMO-based plans</td>
<td>See “Contacts”</td>
</tr>
<tr>
<td>Staten Island University Laboratory</td>
<td>Lab</td>
<td>Staten Island</td>
<td>HMO-based plans</td>
<td>See “Contacts”</td>
</tr>
<tr>
<td>Podiatry (check with PCPs)</td>
<td>Podiatry</td>
<td>All metro New York counties, Northern New Jersey, Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Ocean, Passaic Somerset, Sussex, Union, Warren</td>
<td>HMO-based plans</td>
<td>Aetna PO Box 981109 El Paso, TX 79998-1109</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Chiropractic</td>
<td>New Jersey, New York</td>
<td>HMO-based plans</td>
<td>See “Contacts”</td>
</tr>
<tr>
<td>Radiology (selected provider)</td>
<td>Radiology</td>
<td>Delaware, Maine, Massachusetts, metro New York, New Jersey, Pennsylvania</td>
<td>HMO-based plans</td>
<td>See “Contacts”</td>
</tr>
<tr>
<td>Physical therapy (selected provider)</td>
<td>Physical therapy</td>
<td>Delaware, metro New York, New Jersey, Pennsylvania</td>
<td>HMO-based plans</td>
<td>See “Contacts”</td>
</tr>
<tr>
<td>Foot care (selected provider)</td>
<td>Foot care</td>
<td>Southeastern Pennsylvania (SEPA); Berks, Carbon, Monroe counties in Pennsylvania; Delaware; metro New York; New Jersey</td>
<td>HMO-based plans</td>
<td>See “Contacts”</td>
</tr>
</tbody>
</table>

*All members enrolled in HMO-based plans in which referrals are required (see Aetna Benefit Products Booklet) must be referred by their PCP. Exceptions are MRI/MRA, PET scan, nuclear medicine and mammography.*
Aetna’s network offers your patients access to a nationally contracted, full-service laboratory. It has conveniently located patient service centers.

**Quest Diagnostics** is our national preferred laboratory. It provides tests and services to all Aetna members.

Find a convenient location, schedule an appointment and get testing reminders by visiting **Quest Diagnostics** or calling 1-888-277-8772.

Your market may also have contracted with local laboratory providers.

For a complete list of participating labs available in your area, visit our **DocFind** online provider directory.

### Outpatient preauthorization programs

- **CareCore National**
  - High-tech radiology
  - Facility-based sleep studies
  - Elective outpatient stress echocardiography, and diagnostic left and right heart catheterization
  - Elective inpatient and outpatient cardiac rhythm implant devices
  - Radiation/oncology*

- **MedSolutions**
  - High-tech radiology**
  - Facility-based sleep studies
  - Elective outpatient stress echocardiography, and diagnostic left and right heart catheterization
  - Elective inpatient and outpatient cardiac rhythm implant devices

*For northern New Jersey Small Group notification only.

**CT scans don’t require preauthorization in Delaware, Pennsylvania and southern New Jersey.
<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td>Visit <a href="#">DocFind</a>, our online provider directory.</td>
</tr>
<tr>
<td><strong>Home infusion</strong></td>
<td><strong>Metro New York</strong></td>
</tr>
<tr>
<td></td>
<td>Phone: 1-877-417-5383</td>
</tr>
<tr>
<td></td>
<td>Fax: 1-877-417-5385</td>
</tr>
<tr>
<td></td>
<td>Visit <a href="#">DocFind</a>, our online provider directory.</td>
</tr>
<tr>
<td><strong>Allergy extract vendor, dental, home health, rehab provider network, respiratory therapy, speech therapy</strong></td>
<td>Visit <a href="#">DocFind</a>, our online provider directory.</td>
</tr>
<tr>
<td><strong>Behavioral health</strong></td>
<td><strong>Metro New York and northern New Jersey</strong></td>
</tr>
<tr>
<td></td>
<td>Visit <a href="#">DocFind</a>, our online provider directory.</td>
</tr>
<tr>
<td><strong>Paper claims address</strong></td>
<td><strong>Aetna</strong></td>
</tr>
<tr>
<td></td>
<td>PO Box 981106</td>
</tr>
<tr>
<td></td>
<td>El Paso, TX 79998-1106</td>
</tr>
<tr>
<td><strong>New Jersey provider appeal process</strong></td>
<td><strong>HMO-based and Medicare Advantage plans:</strong></td>
</tr>
<tr>
<td></td>
<td>1-800-624-0756</td>
</tr>
<tr>
<td></td>
<td><strong>All other plans:</strong></td>
</tr>
<tr>
<td></td>
<td>1-888-MD-Aetna (1-888-632-3862)</td>
</tr>
<tr>
<td><strong>Nonparticipating provider and special services request</strong></td>
<td><strong>1-800-245-1206</strong></td>
</tr>
</tbody>
</table>
## Direct-access specialties

<table>
<thead>
<tr>
<th>State</th>
<th>Specialty</th>
<th>Products</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New York, New Jersey, Pennsylvania, Rhode Island</td>
<td>Ob/gyn</td>
<td>All</td>
<td>Women’s Health Programs and Policies Manual, which is available at <a href="http://www.AetnaEducation.com">www.AetnaEducation.com</a>.</td>
</tr>
<tr>
<td>Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island</td>
<td>Behavioral health</td>
<td>All</td>
<td>All Aetna members have direct-access benefits for individual outpatient behavioral health visits with the following exceptions:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Behavioral health benefits plans that we administer but do not manage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Self-funded plans that have plan sponsors who have expressly purchased precertification requirements and those services noted on the Behavioral Health Precertification List.</td>
</tr>
<tr>
<td>Connecticut, New Jersey, Rhode Island</td>
<td>Routine eye care (ophthalmology and optometry)</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>Metro New York</td>
<td>Laboratory</td>
<td>All</td>
<td>Use the Lab Requisition Form in lieu of referral.</td>
</tr>
<tr>
<td>Metro New York and northern New Jersey</td>
<td>Physical therapy</td>
<td>HMO-based plans</td>
<td>Certain procedures require precertification. See “Contacts.”</td>
</tr>
<tr>
<td>Metro New York and northern New Jersey</td>
<td>Radiology</td>
<td>HMO-based plans</td>
<td>Certain procedures require precertification. See “Contacts.”</td>
</tr>
</tbody>
</table>
Immunization policy

Massachusetts and New Hampshire
As part of our immunization program, we are committed to working closely with participating primary care physicians to improve the overall immunization rate for our pediatric membership. Massachusetts and New Hampshire are universal vaccine distribution states that provide most recommended childhood vaccines free of charge, including tetanus-diphtheria (TD) vaccines, to their residents.

All state-supplied immunizations and vaccines should be billed with the SL modifier. Our reimbursement policy covers only the administration fee for recommended childhood vaccines and TD that can be supplied by either the Massachusetts Immunization Program (MIP) or the New Hampshire Immunization Program (NHIP).

To enroll and obtain these free vaccines for your patients, call one of the following, depending on your location:
• Massachusetts Immunization Program: 617-983-6828
• New Hampshire Immunization Program: 603-271-4634

To be reimbursed for the administration fee, submit claims electronically or on a HCFA 1500 form with the appropriate vaccine code.

Note: Claims for all members should be submitted to:
Aetna
PO Box 981109
El Paso, TX 79998-1109

Electronic claims should be sent using payer ID 60054.

If you have questions about the information above, contact our Provider Service Center at 1-800-624-0756 (for HMO-based plans) or 1-888-632-3862 (for traditional/PPO-based plans).

Outpatient imaging

Metro New York, northern New Jersey
CareCore National manages preauthorization for outpatient imaging services for your Aetna patients with all commercial and Medicare plans, except indemnity Traditional Choice® plans, in the northern New Jersey and metro New York markets.

Northern New Jersey counties include: Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union and Warren

Metro New York counties include: Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster and Westchester

Preauthorization is required for the following:
• Cardiac rhythm implant devices
• CT scan
• Elective outpatient stress echocardiography, and diagnostic left and right heart catheterization
• Facility-based sleep study
• MRI/MRA
• Nuclear medicine
• PET scan
• Radiation/oncology

The following services won’t be impacted by this relationship:
• Inpatient services (except cardiac rhythm implant devices)
• Emergency room services
• Outpatient imaging services, other than those referenced above

How to send preauthorization requests to CareCore National:
• Call between 7 a.m. and 7 p.m., or as required by federal or state regulations.
  - New York members: 1-888-622-7329
  - New Jersey members: 1-888-647-5940
• Fax requests to 1-800-540-2406 (radiology and cardiology studies) or 1-888-444-1562 (sleep studies).
• Go to the CareCore National website.

Important note: Radiology providers who are not directly contracted with CareCore National should send claims for radiology services to Aetna as usual. Radiology providers who are contracted with CareCore National should bill claims directly to CareCore National For HMO-based, Aetna Health Network and Medicare Advantage (northern New Jersey members only) plans only. All other claims should be sent to Aetna. Obtaining an approved preauthorization does not guarantee payment. Claims payment is also dependent upon the member’s eligibility and benefits plan.
Pennsylvania, southern New Jersey, Delaware and West Virginia

MedSolutions (MSI) manages preauthorization for high-tech radiology for your Aetna patients in all our Medicare and network-based benefits plans in Delaware, southeastern Pennsylvania and southern New Jersey.

Preauthorization is required for the following:

• Cardiac CTA
• Cardiac rhythm implant devices
• Elective outpatient stress echocardiography, and diagnostic left and right heart catheterization
• Facility-based sleep studies
• MRI/MRA
• Nuclear cardiology
• PET scan

The following services won’t be impacted by this relationship:

• Inpatient services (except cardiac rhythm implant devices)
• Emergency room services
• Outpatient imaging services, other than those referenced above

How to send preauthorizations to MSI:

• Call 1-888-693-3211, 7 a.m. to 8 p.m. CT, Monday through Friday.
• Fax your request to 1-888-693-3210. Fax forms are available online or by calling MedSolutions Customer Service at 1-888-693-3211.
• Go to the MedSolutions website.

Connecticut, Maine and Massachusetts

MedSolutions manages preauthorization for all high-tech outpatient diagnostic imaging procedures for all commercial and Medicare plans (except indemnity Traditional Choice plans) in Connecticut, Maine and Massachusetts.

Preauthorization is required for the following:

• Cardiac imaging
• Cardiac rhythm implant devices
• CT scan
• Elective outpatient stress echocardiography, and diagnostic left and right heart catheterization
• Facility-based sleep studies
• MRI/MRA
• Nuclear cardiology
• PET scan

The following services won’t be impacted by this relationship:

• Inpatient radiology services (except cardiac rhythm implant devices)
• Emergency room radiology services
• Outpatient radiology services, other than MRI/MRA, CT scan, PET scan and nuclear cardiology

How to send preauthorizations to MedSolutions:

• Call MedSolutions at 1-888-693-3211, Monday through Friday, during normal business hours, or as required by federal or state regulations.
• Fax 1-888-693-3210, Monday through Friday, during normal business hours, or as required by federal or state regulations.

*MedSolutions will precertify the implant device. Aetna will precertify the inpatient stay.
**Provider appeal process: New Jersey**

Visit [New Jersey Provider Appeal Procedure](#) for the New Jersey Provider Appeal Process (which is available to all providers, both participating and nonparticipating) and the [New Jersey Department of Banking and Insurance Health Care Provider Application to Appeal a Claims Determination Form](#).

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**Subluxation chiropractic care**

**Maine**

For 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 these conditions 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.

**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.

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 twelfth 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 fifth week from the member’s first further treatment visit, or the twelfth 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.
New York State supplement

Provider responsibilities

Provider shall:

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 the cost of the service.

3. Recognize the definition of “emergency condition” as follows: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment of such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

4. Along with the HMO, 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 HMO operations. For minors, the period shall be six years from date of majority.

5. If serving as a PCP, deliver primary care services and coordinate and manage care.

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

Provider contracting information

1. 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 HMO’s network.

2. The HMO is 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.

3. The provider may request application procedures and minimum qualification requirements used by the HMO.

4. 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 the HMO to improve performance.

5. Provider’s contract shall not be terminated unless the HMO provides 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 the HMO, (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.)

6. 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.
7. Provider may request a hearing or review before a panel
appointed by the HMO upon being terminated by the HMO.
Such a hearing panel will be comprised of three persons
appointed by the HMO. 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 the HMO, 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 HMO 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 the HMO’s policies and procedures, including referrals and
obtaining preauthorization and a treatment plan approved by
the HMO.

8. The provider shall agree, or if the Agreement is between
the MCO and an 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 HIV confidentiality requirements of Article
27-F of the Public Health Law.

Confidentiality of HIV-related information
Requires each health care provider to develop policies and
procedures to assure confidentiality of HIV-related
information. Policies and procedures must include:

- a. Initial and annual in-service education of staff, contractors
- b. Identification of staff allowed access and limits of access
- c. Procedure to limit access to trained staff (including contractors)
- d. Protocol for secure storage (including electronic storage)
- e. Procedures for handling requests for HIV-related information
- f. Protocols to protect persons with or suspected of having
  HIV infection from discrimination

Requires HIV pre-test 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.
(Note: Applicable only to qualified providers of ob/gyn care).

Policies
The policies and procedures promulgated by Company which
relate to this Agreement, including, but not limited to: (a)
quality improvement/management; (b) utilization
management, including, but not limited to: preauthorization
of elective admissions and procedures, concurrent review of
services and referral processes or protocols; (c) pre-admission
testing guidelines; (d) claims payment review; (e) member
grievances; (f) physician credentialing; (g) electronic
submission of claims and other data required by Company;
and (h) any applicable participation criteria as set forth in the
participation criteria schedules.

Policies/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.

Utilization review information
1. A provider shall not be required to preauthorize emergency
services for prior approval.

2. Adverse determinations are made by a clinical peer reviewer.
For the purposes of utilization review, “medically necessary
services” are defined as follows: Health care services that a
physician, exercising prudent clinical judgment, would
provide to a patient for the purpose of preventing, evaluating,
diagnosing or treating an illness, injury, disease or its
symptoms, and that are (a) in accordance with generally
accepted standards of medical practice; (b) clinically
appropriate, in terms of type, frequency, extent, site and
duration, and considered effective for the patient’s illness,
injury or disease, and (c) not primarily for the convenience of
the patient, physician or other health care provider, and not
more costly than an alternative service or sequence of
services at least as likely to produce equivalent therapeutic
or diagnostic results as to the diagnosis or treatment of that
patient’s illness, injury or disease. For these purposes
“generally accepted standards of medical practice” means
standards that are based on credible scientific evidence
published in peer-reviewed medical literature generally
recognized by the relevant medical community, or otherwise
consistent with the standards set forth in (b) above.

3. A provider and the enrollee shall be notified by telephone
and in writing of utilization review determinations involving
health care services that require preauthorization within
three business days after receipt of the necessary
information.
4. A provider and the enrollee shall be notified by telephone and in writing of utilization review determinations involving (a) continued or extended health care services, (b) additional services for an enrollee undergoing a course of continued treatment, or (c) home health care services following an inpatient admission, within one business day after receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within 72 hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. If a request for home health care services and all necessary information is provided to Aetna prior to a member’s member’s inpatient hospital discharge, Aetna cannot deny the home care coverage request on the basis of a lack of medical necessity or a lack of prior authorization while the utilization review determination is pending.

5. A provider and the enrollee shall be notified of utilization review determinations involving health care services that have been delivered within 30 days after receipt of necessary information.

6. A provider and member shall receive notification of adverse utilization review determinations in writing, which shall include:
   a. The reasons for the determination, including the clinical rationale, if any.
   b. Instructions on how to initiate standard and expedited appeals and external appeals.
   c. Notice of the availability, upon request of the enrollee, or the enrollee’s designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal.

7. Aetna may reverse a pre-authorized treatment, service or procedure on retrospective review in accordance with New York law when:
   a. Relevant medical information presented to Aetna upon retrospective review is materially different from the information that was presented during the pre-authorization review.
   b. The information existed at the time of the pre-authorization review but was withheld or not made available.
   c. Aetna was not aware of the existence of the information at the time of the pre-authorization review.
   d. Had Aetna been aware of the information, coverage would have been denied for the treatment, service or procedure under review. This determination would be made using the same specific standards, criteria or procedures as used during the pre-authorization review.

8. A provider may request a referral for a member to a nonparticipating provider, if the HMO has determined that it does not have a health care provider with appropriate training and experience in its network to meet the particular health care needs of an enrollee. The referral shall be made pursuant to an approved treatment plan by the HMO, the referring provider and the nonparticipating physician. A provider may not refer an enrollee to a nonparticipating specialist unless there is no specialist in the network.

9. A provider may request a standing referral to a specialist for an enrollee who needs ongoing care from such specialist. Such a request may only be approved by the HMO after consultation with the primary care provider and specialist and shall be pursuant to a treatment plan approved by the HMO in consultation with the primary care provider, the specialist and the enrollee or the enrollee’s designee. Such treatment plan may limit the number of visits or the period during which such visits are authorized and may require the specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

10. A provider may request that a specialist be allowed to coordinate an enrollee’s primary and specialty care. The enrollee must be diagnosed as having a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time. Such a request shall be approved only upon agreement of the primary care provider, the HMO and the specialist, and care shall be rendered pursuant to a treatment plan.

11. A provider may request a referral to a specialty care center for an enrollee with (a) a life-threatening condition or disease, or (b) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time. Such a request may only be approved by the HMO in consultation with the primary care provider or the specialist and shall be pursuant to a treatment plan developed by the specialty care center and approved by the HMO, in consultation with the primary care provider, if any, or specialist and the enrollee or the enrollee’s designee. If such specialty care center does not participate in the HMO’s network, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network. Specialty care centers shall be accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.
12. A provider may request a reconsideration of an adverse determination in the event that an adverse determination was made without attempting to discuss such matter with the enrollee’s health care provider who specifically recommended the health care service, procedure or treatment under review. The reconsideration shall occur within one business day of receipt of the request and shall be conducted by the enrollee’s health care provider and the clinical peer reviewer making the initial determination.

13. Failure by the HMO to make a utilization review determination within the prescribed timeframes shall be deemed to be an adverse determination subject to appeal.

14. An enrollee, an enrollee’s designee, or a provider may file a request for an expedited appeal of an adverse determination involving: (a) continued or extended health care services, procedures or treatments or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider; (b) home health care services following discharge from an inpatient hospital admission; or (c) an adverse determination in which the health care provider believes an immediate appeal is warranted, except any retrospective determination. To file the appeal, contact Aetna at one of the phone numbers or addresses below:

- Expedited appeals telephone number: **1-888-408-7485**
- Dedicated fax number for member appeals: **859-425-3379**
- Aetna Small Group
  PO Box 14462
  Lexington, KY 40512
- Aetna Middle Market (Key/Select)
  PO Box 14464
  Lexington, KY 40512
- Aetna National Accounts
  PO Box 14463
  Lexington, KY 40512

Information from the enrollee’s health care provider and the utilization review agent may be shared by telephone or by fax. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Such clinical peer reviewer shall be other than the clinical peer reviewer who rendered the adverse determination. If the HMO requires information necessary to conduct an expedited appeal, the HMO shall immediately notify the enrollee and the enrollee’s health care provider by telephone or fax to identify and request the necessary information, followed by written notification. Expedited appeals shall be determined within two business days of receipt of necessary information. Written notice of the final adverse determination concerning an expedited utilization review appeal shall be transmitted to the enrollee within 24 hours of rendering the determination. Expedited appeals which do not result in a resolution satisfactory to the appeal party may be further appealed through the standard appeal process, as follows:

a. May be filed by enrollee or an enrollee’s designee, which can include a provider
b. May be filed in writing or by telephone
c. Period to file must be at least 60 days after notification of the utilization review decision to the enrollee; under ERISA regulations, the period to file is 180 days
d. HMO must acknowledge the appeal within 15 days
e. If the HMO requires information necessary to conduct a standard internal appeal, the HMO shall notify the enrollee and the enrollee’s health care provider, in writing, within 15 days of receipt of the appeal to identify and request the necessary information
f. In the event that only a portion of the necessary information is received, the HMO shall request the missing information, in writing, within 5 business days of receipt of the partial information
g. HMO must make a standard appeal determination within 15 days of receipt of a pre-service appeal (one for which a benefit must be approved before receipt of medical care) 30 days after receipt of other appeals
h. Written notification of a standard appeal determination will be sent within two business days of the date Aetna makes the decision. The notice must include the reasons for the determination provided; however, where the adverse determination is upheld on appeal, the final adverse determination shall include:
   - Health service that was denied, including facility/provider and developer/manufacturer of service as available.
   - Statement that the enrollee may be eligible for external appeal and timeframes for appeal.
   - If the member’s health plan offers two levels of appeal, Aetna will not require the member to exhaust both levels. Our notice will explain that the member has four months from the final adverse determination to request an external appeal.
   - Standard description of external appeals process.
   - Name and number for the contact person handling the appeal.
   - Coverage type of the member’s health plan.

15. A provider may request a standard appeal of an adverse determination; such appeal shall be conducted by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

16. A provider may submit a request for an external appeal, in connection with a concurrent or retrospective final adverse determination. The following conditions apply to the external appeal process:

a. A provider must request an external appeal within **60 days** of receipt of the final adverse determination of the first-level appeal (regardless of whether or not a second-level internal appeal is available or requested). An enrollee or an enrollee’s designee must request the
external appeal within four months of the final adverse determination.

b. The enrollee has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefits program, denied on appeal, in whole or in part on the grounds that such health care service:
   - Does not meet criteria for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit.
   - Is experimental or investigational.
   - The covered service is denied because it was rendered out of network; the insured has had an out-of-network referral denied on the grounds that the health care plan has a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service. The insured’s attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, must certify that the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service.
   - The health care plan has upheld the denial upon appeal and rendered a final adverse determination with respect to such health care service.
   - Both the plan and the enrollee have jointly agreed to waive any internal appeal.

c. The enrollee has had coverage of a health care service denied on the basis that such service is experimental or investigational, and (a) such denial has been upheld on appeal, or both the plan and enrollee have jointly agreed to waive any internal appeal, (b) and the enrollee’s attending physician has certified that the enrollee has a life-threatening or disabling condition or disease, must have recommended either a health service or procedure [including a pharmaceutical product within the meaning of PHL 4900 5.(b)(B)], that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the enrollee than any covered health service or procedure, or a clinical trial for which the enrollee is eligible. Any physician certification shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and (d) the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health plan’s determination that the health service or procedure is experimental or investigational.

17. The period of time to make an appeal determination begins upon the HMO’s receipt of necessary information.

18. Failure by the HMO to make an appeal determination within the prescribed timeframes shall be deemed to be a reversal of the HMO’s adverse determination.

19. If the enrollee and HMO jointly agree to waive the internal appeal process, the HMO must provide a written letter with information regarding filing an external appeal to the enrollee within 24 hours of the agreement to waive the HMO’s internal appeal process.

Quality Management Program

Our Quality Management (QM) Program for HMO-based products is focused on the ongoing assessment and improvement of clinical care and service. Among the benefits derived from the implementation and maintenance of a comprehensive quality management program are:

• The impetus to work toward continuous quality improvement (CQI) as a means to conduct business
• A framework by which to monitor and strengthen all functional processes of the organization
• The measurement of performance in service and quality of care
• An emphasis on teamwork and a multi-departmental approach to quality improvement
• The availability of comparative information (internal and external)

We’re committed to Health Plan and Managed Behavioral Healthcare Organization (MBHO) accreditation by the National Committee for Quality Assurance (NCQA). This is one way of demonstrating a commitment to CQI, meeting
customer expectations, and establishing a competitive advantage among HMOs and PPOs. HEDIS® and CAHPS® reports are produced annually and sent to NCQA for public reporting and accountability. NCQA-certified HEDIS auditors audit HEDIS according to NCQA specifications.

Aetna has the right to access confidential medical records of Aetna members, for the purpose of claims payment, assessing quality of care, including medical evaluations and audits, and performing utilization management functions. Medical records may be requested as a part of Aetna’s participation in HEDIS. HIPAA privacy regulations allow for sharing of personal health information for purposes of making decisions around treatment, payment or health plan operations.

The scope and content of the QM Program are designed to continuously monitor, evaluate and improve the quality and safety of clinical care and service given to members. Specifically, the QM Program includes, but isn’t limited to:

- Reviewing and evaluating preventive and behavioral health services; ambulatory, inpatient, primary and specialty care; high-volume and high-risk services; and continuity and coordination of care
- Developing written policies and procedures that reflect current standards of medical practice
- Developing, implementing and monitoring of patient safety initiatives, and preventive and clinical practice guidelines
- Monitoring of medical, behavioral health, case and disease management programs
- Achieving and maintaining regulatory and accreditation compliance
- Evaluating accessibility and availability of network providers
- Establishing standards for, and auditing of, medical record documentation
- Monitoring for over and under-utilization of services (Medicare)
- Performing credentialing and recredentialing activities
- Overseeing delegated activities
- Evaluating member and practitioner satisfaction
- Supporting initiatives to address racial and ethnic disparities in health care
- Following these guidelines in the development of provider performance programs: standardization and sound methodology; transparency and collaboration — also, taking action on quality and cost, or quality only, but never cost data alone, except in unique situations where there aren’t standardized measures of quality, and/or there is insufficient data

We use Continuous Quality Improvement (CQI) techniques and tools to improve the quality and safety of clinical care and service delivered to members. Quality improvement is implemented through a cross-functional team approach, as shown by multidisciplinary committees. Examples of our quality committees include the National Quality Oversight Committee (NQOC) and the National Quality Advisory Committee (NQAC). We empower the NQOC to oversee and address quality improvement activities and the NQAC to set direction for clinical quality improvement initiatives. We use quality reports to monitor, communicate and compare key indicators. Finally, we develop relationships with various professional entities and provider organizations. They may give feedback about structure and implementation of QM program activities, or work with us on quality improvement projects.

QM Program goals include the following:
- To share the principles and spirit of CQI.
- 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 address racial and ethnic disparities in health care that could negatively impact quality health care.
- To introduce company-wide initiatives to improve the safety of members and our communities, and foster communications about the programs.
- To have a standardized and complete 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 range of care.
- To increase the knowledge/skill base of staff and to facilitate communication, collaboration and integration with key functional areas. These relate to implementing a sound and effective QM program.
- To measure and monitor (previously identified issues, evaluate the QI program), and improve performance in key aspects of quality and safety of clinical care. These include behavioral health, 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.

Accountability and Committee Structure

The following national committees, national work groups and regional committees support the Quality Management (QM) Program:

A. Board of Directors: Aetna Life Insurance Company
Board of Directors (ALIC) (PPO Commercial and Medicare) and the HMO Boards of Directors (HMO Commercial and Medicare)

The ALIC and HMO Boards of Directors have delegated ultimate accountability for the management of the quality of clinical care and service given to members to the chief
medical officer (CMO). The CMO is responsible for providing national strategic direction and oversight of the QM Program for Aetna members.

B. National Quality Oversight Committee (NQOC)

The chief medical officer (CMO) referenced above delegates authority for oversight of the national Quality Management (QM) Program to the National Quality Oversight Committee (NQOC). It facilitates the sharing of QM best practices for accreditation, survey management and other areas, as appropriate. Delegated responsibility includes, but is not limited to, development, implementation and evaluation of the QM Program.

The NQOC is a multi-disciplinary committee of representatives from the following areas:

- Health Care Management (HCM) medical director, chairperson
- Office of chief medical officer
- HCM regional medical director staff
- National Quality Management
- Regional Quality Management
- National Complaints, Grievance and Appeals
- National Medicare Medical Management
- Behavioral Health
- Aetna Pharmacy Management
- National Precertification
- Patient Management
- Network Management
- Compliance
- Customer Service/Claims
- Marketing/Sales
- Medicare Compliance
- Texas HMO enrollee
- Texas HMO participating practitioner
- Texas EPO participating practitioner

The role of the NQOC includes the following:

- Approval of the following documents:
  - QM/Behavioral Health (BH) Program Description
  - QM Work Plan
  - HMO/PPO QM Program Evaluation (includes Exchanges and Texas fully insured EPO)
  - Aetna Care Management Program Description
  - BH QM Work Plan
  - BH QM Program Evaluation
- Adopt clinical criteria and protocols with consideration of recommendations from the National Quality Advisory Committee (NQAC) and as appropriate the Behavioral Health Quality Advisory Committee (BH QAC)
- Monitor QM and Aetna Care Management activities for consistency with both national and regional program goals
- Establish priorities for the regional QM and Aetna Care Management program, evaluate clinical and operational quality, and integrate quality improvement activities among all departments
- Adopt QM, National Care Management (NCM) and selected national policies and procedures and approval of state amendments, as outlined in QM-01, Policy and Procedure Development and Review Procedure and the NCM 501-01/02, National Care Management Policy Development Policy and Procedure
- Review regular reports from national workgroups and committees for discussion and feedback as necessary; approve as applicable
- Evaluate identified potential quality of care concerns related to facilities/vendors
- Adopt medical and clinical practice guidelines (CPG) and preventive services guidelines (PSG)

The NQOC meets at least 10 times a year.

The NQOC delegates authority to the:

- NQAC and the BH QAC to give direction on clinical quality
- 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 give decisions on professional review hearings
- BH QOC to give guidance and direction on Behavioral Health administrative, clinical and quality issues and utilization management activities
- National Quality Management Policy Committee (NQMPC) and the National Care Management Policy Committee (NCMPC) for policy development and approval
- National Guideline Committee (NGC) to review and approve CPGs and PSGs

The NQAC, NVDOC and BH QOC give reports to the NQOC at least annually.

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

We give complete reports on QM and the Aetna Care Management Program activities to the respective boards at least annually. State laws/regulations may exceed the requirements of the QM Program Description. When there are state regulations that apply to the QM Program, we document them in the state amendment.
C. National Quality Advisory Committee (NQAC)
The NQAC activities include, but are not limited to, the following:
• Give input into the Quality Management (QM) program through review and feedback on quality improvement studies and surveys, clinical indicators, member and practitioner/provider initiatives, practitioner/provider communications, QM Program Description, QM Work Plan, the HMO/PPO QM Program Evaluation (includes Texas fully insured EPO) (Executive Summaries).
• Review of clinical criteria such as: utilization management criteria, Pharmacy and Medical Clinical Policy Bulletins and protocols for NQOC adoption.
• Make recommendations to the National Guideline Committee about medical clinical practice and preventive services guidelines.
• Give feedback to the National Pharmacy and Therapeutics Committee about the Preferred Drug Lists.
• Give feedback to the Behavioral Health Quality Advisory Committee about the integrated medical and behavioral care health programs.
The NQAC meets at least five times a year. Membership includes the following:
• Health Care Management medical director, facilitator.
• A behavioral health practitioner.
• 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 clinical input.

D. National Vendor Delegation Oversight Committee (NVDOC)
The NVDOC has oversight of the following:
• Delegation and vendor policies, procedures and processes
• Review and approval of Delegated Credentialing, Claims, Customer Service, Utilization Management, Case Management and Disease Management. These include approval of delegate’s program descriptions.
• Review of delegates related to General Controls, Finance and Network Management, as appropriate
• Review of oversight activities that the Centers for Medicare & Medicaid Services and other regulators require
• Overall monitoring and reporting of risk and delegate performance
The NVDOC meets monthly. Membership includes the following voting members:
• Head of National Quality Management over Delegation chairperson
• National Care Management (NCM) regional medical director staff
• Quality Management managers over Credentialing and Medical Management (UM, CM, DM, clinical programs, etc.) oversight
• Senior manager finance/senior finance auditor
• Claims audit manager
• Network market head/senior network managers
• Medicare compliance
And attendees representing the following areas:
• Finance
• NCM regional medical director staff
• National Delegation Team
• Network
• Patient Management
• Quality Management (Credentialing, and Medical Management Delegation Oversight)

E. Credentialing and Performance Committee (CPC)
The CPC makes determinations for those applicants being considered for exceptions to our established 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. They do this to evaluate continued participation in our network.
The CPC meets at least every 45 days. 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 and/or chiropractors).
• Behavioral health practitioners, including a psychiatrist, a psychologist and a master’s-level behavioral health clinician.
Within 90 days of receiving a practitioner’s application to participate in the network, we will notify the practitioner as to whether the practitioner is credentialed or if additional time is necessary to make a determination.

F. Provisionally credentialed provider (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, joins a group practice of health care professionals each of whom participates in an Aetna network, is not approved or declined within 90 days, the health care professional shall be deemed “provisionally credentialed” and may participate in the network provided. However, that provisionally credentialed physician may not be designated as an enrollee’s PCP 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 90th 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.

G. 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 Credentialing and Performance Committee determinations.
The PAC meets on an ad-hoc basis and a Health Care Management medical director facilitates. The committee has three to seven participating network practitioners:

• A majority of members are the affected physician’s peers.
• At least one peer must be licensed in the same state as each practitioner that the committee reviews.
• At least one voting member of the PAC shall practice in a specialty substantially similar to the specialty of the practitioner, if the nature of the appeal requires specialty knowledge.

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

H. Behavioral Health Quality Oversight Committee (BH QOC)
The BH QOC is a multidisciplinary committee. It gives guidance and direction to the Aetna National Care Management Behavioral Health staff and senior management who are accountable for behavioral health administrative, clinical and quality issues and utilization management activities. The BH QOC provides an environment for collaborative initiatives. It facilitates the joining of behavioral health with primary medical care services.

The role of the BH QOC includes the following:

• Establish priorities for behavioral health–related quality management (QM) and care management (CM) activities, evaluate clinical and operational quality, and integrate quality improvement activities across behavioral health.
• Review and approval of behavioral health clinical and service quality indicator/monitors and quality improvement initiatives.
• Identify, select and monitor behavioral health prevention programs and oversee their implementation.
• Review and approval of behavioral health clinical specialty program reports.
• Monitor behavioral health–related QM and CM activities for consistency with national program goals.
• Review and evaluate feedback from the Behavioral Health Quality Advisory Committee (QAC).
• Review regular reports from behavioral health’s national workgroups and committees for discussion and feedback as necessary.

• Oversee BH QM department review of annual Aetna CM and QM Program Descriptions. Preparation and review of the BH QM Work Plan and BH Program Evaluation to send to the National Quality Oversight Committee (NQOC) for approval.
• Give summary reports on behavioral health–related activities to the NQOC semi-annually.
• Adopt behavioral health clinical criteria and protocols based on recommendations from BH QAC.
• Review and adopt all behavioral health clinical practice guidelines.
• Approve and give oversight of behavioral health–delegated activities.
• Review activities and recommendations of workgroups, including the National Patient Safety Work Group.
• Review and adopt QM, National Care Management and selected policies and procedures. These are outlined in the QM-01 Policy and Procedure Development and Review Procedure, and the NCM 501-01/02 Policy and Procedure Development and Review Procedure.
• Reviews and adopts applicable state–specific amendments.

The BH QOC meets at least 10 times a year. It has the following members:

• Chief medical officer, Aetna Behavioral Health
• Behavioral Health national quality director, chair
• Behavioral Health senior medical directors
• Clinical Services heads
• Behavioral Health national head of Network or designee
• Behavioral Health Quality Management staff
• Head of Customer Service and Call Operations or designee
• Regional QM representatives
• National QM representatives

I. Behavioral Health Quality Advisory Committee (BH QAC)
The Behavioral Health Quality Oversight Committee (BH QOC) delegates the following functions to the BH QAC:

• Manage and give direction on behavioral health clinical quality improvement initiatives.
• Give input into the Quality Management (QM) Program through review and feedback on the following: behavioral health quality improvement studies and surveys; clinical indicators; member, practitioner and organizational provider initiatives; preventive health programs; practitioner and organizational provider communications; BH QM Work Plan and Program Evaluation (Executive Summary).
• Review behavioral health clinical criteria and protocols for BH QOC adoption.
• Give feedback to the National Quality Advisory Committee about medical clinical practice guidelines (CPG) related to behavioral health.
• Make recommendations to the National Guideline Committee, which manages, gives direction and recommends behavioral health CPGs and behavioral health
referring to in-network providers.

As a reminder, you can help your patients save money by

• Hospitals must post the following on their website:
  • If the patient asks, nonparticipating providers must provide
  • Physicians must tell patients in which plans they participate.
certain information to their patients. Specifically:
The new law also requires all physicians and hospitals to tell
certain information to their patients. Specifically:
• Physicians must tell patients in which plans they participate. This includes detailed information about any referrals they make to ancillary providers, like anesthesiology or assistant surgeons. This applies to both office or hospital settings.
• 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 website:
  - 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
As a reminder, you can help your patients save money by referring to in-network providers.

A new enrollee, whose health care provider is not a member of the HMO’s 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/her PCP selection online using our DocFind online provider directory.

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.

Notice to New York providers: changes to New York law
Chapter 237 of the Laws of 2009 amended the New York State Laws and Public Health Law statutes related to claims processing; credentialing procedures; utilization review and external appeal procedures; and reimbursements arrangements in provider contract. Below outlines the changes associated with the amended statutes and Aetna’s requirements to its participating providers and providers’ responsibilities.

Adverse reimbursement change
Effective January 1, 2010, 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 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 following statutory exceptions to this notice requirement are:

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

Claims processing timeframes
Effective January 1, 2010, claims submitted electronically must be paid within 30 days and paper or facsimile claim submissions must be paid within 45 days. The 30-day timeframe for Aetna to request additional information or for denying the claim was not changed.

Coordination of benefits
Effective January 1, 2010, Aetna 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 from 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 non-receipt of information about other coverage.

Claims practices: provider claim submission time period
Effective for dates of service on or after April 1, 2010, providers must initially submit claims within 120 days after the date of the service to be valid and enforceable against Aetna, unless a timeframe more favorable to the provider was agreed to by the provider and Aetna, or a different timeframe is required by law.

Also for effective dates of service on or after April 1, 2010, 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 percent 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 percent. 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 he has a pattern of timely filing

**Note:** The provider would need to demonstrate/explain the above.

Overpayment recovery: provider challenges/extension to all providers
Effective January 1, 2010, the overpayment recoveries provisions have been extended to apply to all health care professionals under Title 8 of State Education Law, and providers licensed or certified pursuant to PHL Articles 28, 36, or 40 or Mental Hygiene Law Articles 19, 31, and 32. Aetna is required to extend the opportunities for challenges to overpayment recovery to such providers. This does not apply to providers who are pharmacies, durable medical equipment vendors, or clinical laboratories. You may request an appeal of any overpayment decision by contacting Aetna Provider Services at **1-800-624-0756** 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:

- Aetna 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.
- Aetna’s **Provider Dispute & Appeal Process** 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 link or call Provider Services at **1-800-624-0756** to request a copy.

**Participating Provider and Participating Hospital Reimbursement**
Effective January 1, 2010, 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.

Aetna will be amending its grievances and claims payment policies and procedures to assure claims are not denied or reduced in instances solely because the service was provided by a participating health care provider at a nonparticipating hospital, or a nonparticipating health provider rendered services to a member at a participating hospital.

**Rare disease treatment**
Effective January 1, 2010, external appeal rights for a final adverse determination involving a rare disease treatment was added to Section 4910 of the Public Health Law. Aetna will be updating its utilization review policies and procedures, and all notices will be reviewed to assure that the rights afforded to members seeking rare disease treatment are addressed.
Provider external appeal rights

Effective January 1, 2010, 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 Aetna.

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 timeframe will be subject to the external appeal payment provisions described above. If the provider is unresponsive, the appeal will be rejected.

Hold harmless

Effective January 1, 2010, a provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member’s designee, is prohibited from seeking payment, except applicable copays, from a member for services determined not medically necessary by the external appeal agent. Members will be held harmless in such cases.