Office manual for health care professionals

Southeast Regional section

Aetna.com

23.20.805.1 K (12/20)

aetna®

Welcome to your provider manual

Contacts

Chiropractic services in Georgia

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

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

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

Referral process for primary care physicians (PCPs)

If the member's plan requires a referral, you should submit an electronic referral to ASH prior to the member's visit to the chiropractor.

You can use ASH's existing electronic data interchange vendor or our **provider portal**. Include the appropriate ASH provider ID on your referral:

Georgia: **9210671**

You should contact ASH with questions about referral status.

Contact **ASH** at **1-800-972-4226**.

Continued on next page

Physical therapy (PT) and occupational therapy (OT) services in North Carolina and South Carolina

OptumHealth administers components of the network physical and occupational therapy benefits to all Aetna® products (including Aetna Medicare Advantage) except:

- Aetna Signature Administrators® plans
- Cofinity® plans
- Coventry Workers' Compensation Network plans
- Aetna Coventry plans
- Meritain Health® plans
- Traditional Choice® plans

You should refer Aetna members enrolled in these plans to participating OptumHealth physical and occupational therapists. For a list of participating OptumHealth physical and occupational therapists, use our **provider portal.**

OptumHealth's responsibilities include:

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

Referral process for PCPs

If the member's plan requires a referral, they can access participating physical and occupational therapists after you submit an electronic referral. OptumHealth will then coordinate utilization management directly with the physical and occupational therapists.

You can submit your referral electronically using OptumHealth's existing electronic data interchange vendor or our provider website. Include the appropriate OptumHealth provider ID on your referral:

- North Carolina: **9024979**
- South Carolina: **9064980**

You should contact OptumHealth with questions about referral status after the initial visit and once you have sent in the patient summary form.

Contact **OptumHealth** at **1-800-344-4584**.

Continued on next page

Enhanced clinical review program

You must obtain pre-authorization for the following procedures:

- Elective outpatient stress echocardiography and diagnostic left and right heart catheterization
- Elective outpatient magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), positron emission tomography (PET) scans, computed tomography (CT), computed tomography angiogram (CTA) and nuclear cardiology
- Facility-based sleep studies
- Elective inpatient and outpatient cardiac rhythm implant devices
- Elective inpatient and outpatient hip and knee arthroplasties
- Interventional pain management
- Nuclear cardiology
- 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 members enrolled in our commercial and Aetna Medicare Advantage benefits plans in the following areas:

- Alabama
- Arkansas
- Florida
- Georgia
- Louisiana
- Maryland
- Mississippi
- North Carolina
- South Carolina
- South Dakota
- Tennessee
- Virginia
- Washington, DC

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**, 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**

Laboratories

Offer your patients access to the Aetna network, which has nationally contracted, full-service laboratories. We have conveniently located patient service centers.

Quest Diagnostics® and LabCorp are our national preferred laboratories. They provide tests and services to all Aetna members.

Visit **QuestDiagnostics.com** or **LabCorp.com** to get started. On both sites, you can:

- Get requisitions and schedule lab appointments for your patients
- Schedule specimen pickup and set up patient results delivery
- Order supplies
- Find a patient service center

Your market may also have contracted with local laboratory providers.

For a complete list of participating labs available in your area, use our **provider portal**.

Nonparticipating provider and special services requests

- **For HMO-based and Medicare Advantage plans: 1-800-624-0756 (TTY: 711)**
- **For all other benefits plans**: **1-888-MD-Aetna (TTY: 711)** or **1-888-632-3862 (TTY: 711)**

Paper claims addresses for Aetna

Maryland, Virginia and Washington, DC:

Aetna
PO Box 981106
El Paso, TX 79998-1106

Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina and Tennessee:

Aetna
PO Box 14079
Lexington, KY 40512-4079

Physical therapy and occupational therapy in these Florida counties:

- **Charlotte**
- **Citrus**
- **Collier**
- **Hernando**
- **Highlands**
- **Hillsborough**
- **Lee**
- **Manatee**
- **Pasco**
- **Pinellas**
- **Polk**
- **Sarasota**

Termination note and instructions
The American Therapy Administrators (ATA) program was terminated, effective 12/31/2019.

Dates of service	Where to send claims
After 12/31/2019	Aetna (Do not submit claims to ATA.)
Prior to 1/1/2020	ATA

American Therapy Administrators (ATA) administered components of the in-network freestanding facilities for PT/OT benefits to all Aetna products, including Aetna Medicare Advantage.

Submit claims electronically to ATA. If you're unable to submit claims electronically, send your claims to:

American Therapy Administrators of Florida
PO Box 2278
Hallandale, FL 33008-2278

Contact **American Therapy Administrators of Florida** at **1-888-550-8800**.

Physical therapy and occupational therapy in these states: North Carolina, South Carolina, Virginia and Washington, DC

OptumHealth administers components of the in-network freestanding facilities for PT/OT benefits to all Aetna products (including Aetna Medicare Advantage) except:

- Aetna Signature Administrators plans
- Cofinity plans
- Aetna Coventry plans
- Indemnity (traditional) plans
- Meritain Health plans
- Strategic Resource Company (SRC, an Aetna company) plans
- Coventry Workers' Compensation Network plans

You should refer Aetna members enrolled in these plans to participating OptumHealth PT/OT providers. For a list of participating OptumHealth PT/OT providers, use our **provider portal**.

OptumHealth's responsibilities include:

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

Referral process for PCPs

Members can access OptumHealth PT/OT providers without an electronic referral by their PCP. However, a script from the referring provider is required. The initial visit does not require a referral. OptumHealth will receive the information needed for visits after the first one from the PT/OT provider.

You should contact OptumHealth with questions about referral status after the initial visit and once you have sent in the patient summary form.

Contact **OptumHealth** at **1-800-344-4584**.

Note: Bill all speech therapy claims directly to Aetna. We will process these claims.

Maryland provider terminations (quarterly report)

To comply with Maryland Insurance Code 15-112 — provider panels, we're providing you with access to the **Maryland provider terminations (quarterly report)**.

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

Maryland Uniform Consultation Referral Form

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

North Carolina specialist care

In-network specialist care

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

Out-of-network specialist care

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

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

Primary Care Physician Initial Lab Designation and Change Request forms

Refer to the forms library on **Aetna.com** to access the Primary Care Physician Initial Lab Designation and Change Request forms for Florida, Georgia, North Carolina, South Carolina and Tennessee.

Specialty programs

Group name	Specialty	Participating counties	Benefits plans	Claims address
ATA	Freestanding • PT • OT • Speech therapy	Florida counties of: • Charlotte • Citrus • Collier • Hernando • Highlands • Hillsborough • Lee • Manatee • Pasco • Pinellas • Polk • Sarasota	All benefits plans	**The ATA program was terminated, effective 12/31/19.** • For dates of service after 12/31/19, send claims to Aetna. (Do not submit claims to ATA.) • For dates of service prior to 1/1/20, submit claims electronically to ATA. If you're unable to submit claims electronically, send your claims to: ATA PO Box 2278 Hallandale, FL 33008-2278. Contact **ATA** at **1-888-550-8800**.

Physician accessibility standards

Primary care physicians

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

• Urgent complaint: same day or within 24 hours

• Routine care: within 7 calendar days

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

Specialist physicians

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

• Urgent complaint: same day or within 24 hours

• Routine care: within 30 calendar days

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

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

• Audiologists

• Chiropractors

• Dietitians

• Midwives

• Occupational therapists

• Optometrists

• Physical therapists

• Podiatrists

• Respiratory therapists

• Speech therapists

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

Additional physician accessibility requirements

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

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. A provider referral is one way members can gain access to the program. To make a referral, call the phone 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

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

- **AL, CA, CT, FL, GA, IA, KS, KY, LA, ME, MI, MO, MS NC, NE, NV, NY, 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 the numbers below.

- **AL, CA, CT, FL, GA, IA, KS, KY, LA, ME, MI, MO, MS NC, NE, NV, NY, 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)

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 at **1-800-624-0756 (TTY: 711)**.

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*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, QMB and QMB+ members cannot elect to pay Medicare cost-sharing rates. Providers that bill QMB or QMB+ members for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions.

Note: If a member is cost-sharing protected, the 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.

District of Columbia supplement

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

- **HMO-based and Medicare Advantage plans: 1-800-624-0756 (TTY: 711)**
- **All other plans: 1-888-632-3862 (TTY: 711)** or just use our **provider portal**

Maryland supplement

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

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

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

- **HMO-based and Medicare Advantage plans: 1-800-624-0756 (TTY: 711)**
- **All other plans: 1-888-632-3862 (TTY: 711)** or just use our **provider portal**

Virginia supplement

In accordance with Virginia law, providers may submit claims to us once they have completed credentialing. In order to ensure that claims are paid at the contracted rate during initial claim processing, we ask that providers hold claims until their contract with us has been fully executed and our systems have been updated.

Once the system is updated, we will pay claims at your contracted rate, retroactive back to the date that we received your credentialing application from CAQH®. To verify participation status, providers should contact our Provider Service Center.

- **HMO-based and Medicare Advantage plans: 1-800-624-0756 (TTY: 711)**
- **All other plans: 1-888-632-3862 (TTY: 711)** or just use our **provider portal**

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