Office manual for health care professionals
Northeast Regional section
Capitated programs: primary care physician (PCP) selection of capitated specialty providers*

In some health maintenance organization (HMO)-based markets, primary care providers (PCPs) (including those who are newly credentialed) must select one specialty care provider to deliver care to all of their patients in HMO-based benefits plans. Specialists 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 at 1-888-632-3862 (TTY: 711).

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

Note: For claims addresses and phone numbers, please see the “Contacts” section on page 4.

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
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</thead>
<tbody>
<tr>
<td>Allergy extract vendor</td>
<td>Our <a href="#">provider portal</a></td>
</tr>
<tr>
<td>Behavioral health</td>
<td>Our <a href="#">provider portal</a></td>
</tr>
<tr>
<td>Dental</td>
<td>Our <a href="#">provider portal</a></td>
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<td>Durable medical equipment</td>
<td>Our <a href="#">provider portal</a></td>
</tr>
<tr>
<td>Home health</td>
<td>Our <a href="#">provider portal</a></td>
</tr>
<tr>
<td>Home infusion</td>
<td>Our <a href="#">provider portal</a></td>
</tr>
</tbody>
</table>
| Laboratory                   | The Aetna® network offers your patients access to nationally contracted, full-service laboratories. Our patient service centers are conveniently located throughout the Northeast. Quest Diagnostics® and LabCorp are our national preferred laboratories. They provide tests and services to all Aetna members. To get started, visit [QuestDiagnostics.com](#) or [LabCorp.com](#). There, you can:  
  • Get requisitions and schedule lab appointments for your patients  
  • Schedule specimen pickup and to 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, visit our [provider portal](#). |
| New Jersey provider appeals process | Aetna HMO-based and Aetna Medicare Advantage plans: 1-800-624-0756 (TTY: 711)  
All other plans: 1-888-MD-Aetna (TTY: 711) or 1-888-632-3862 (TTY: 711) |
| Nonparticipating provider and special services request | 1-800-245-1206 (TTY: 711) |
| Paper claims address for Aetna | Aetna  
PO Box 981106  
El Paso, TX 79998-1106 |
Contacts

Physical therapy and occupational therapy precertification

Connecticut:
OrthoNet
• Phone: 1-800-771-3205
• Fax: 1-800-477-4310

Delaware, New Jersey, New York, Pennsylvania, West Virginia:
National Imaging Associates
Precertification and Customer Service:
Phone: 1-866-842-1542

Pre-authorization programs
For more details, see the “Enhanced Clinical Review program” section on page 6.

Connecticut, Delaware, Maine, Massachusetts, Pennsylvania, Southern New Jersey (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer and Salem counties), Vermont and West Virginia:
eviCore healthcare
• Phone: 1-888-693-3211
• Fax: 1-844-822-3862
• Website: eviCore.com

New York:
eviCore healthcare
Precertification and Customer Service:
• Phone: 1-888-622-7329
• Fax: 1-800-540-2406
• Website: eviCore.com

Northern New Jersey:
eviCore healthcare
Precertification and Customer Service:
• Phone: 1-888-647-5940
• Fax: 1-800-540-2406
• Website: eviCore.com

Delaware, New Jersey, New York, Pennsylvania, West Virginia:
National Imaging Associates
Precertification and Customer Service:
Phone: 1-866-842-1542

Rehabilitation provider network
Our provider portal

Respiratory therapy
Our provider portal

Speech therapy
Our provider portal
## 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 Jersey, New York, Pennsylvania, Rhode Island and West Virginia</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: • Behavioral health benefits plans that we administer but do not manage • Self-funded plans that have plan sponsors that have expressly purchased precertification requirements and those services noted on the Behavioral Health Precertification List</td>
</tr>
<tr>
<td>Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and West Virginia</td>
<td>Obstetrics and gynecology</td>
<td>All</td>
<td>Women’s Health Programs and Policies Manual</td>
</tr>
<tr>
<td>All states</td>
<td>Routine eye care (ophthalmology and optometry)</td>
<td>All</td>
<td>Our provider portal</td>
</tr>
</tbody>
</table>

## Enhanced Clinical Review program

### New York, Northern New Jersey

eviCore healthcare manages pre-authorization for certain outpatient services for your Aetna patients with all commercial and Medicare plans, except Traditional Choice® indemnity plans, in the northern New Jersey and New York markets.

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

Pre-authorization is required for the following:
- Elective inpatient and outpatient cardiac rhythm implant devices
- Elective outpatient magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA), nuclear cardiology, positron emission tomography (PET) scans, computed tomography (CT) and computed tomography angiography (CTA)
- Elective outpatient stress echocardiography, and diagnostic left- and right-heart catheterization
- Elective inpatient and outpatient hip and knee arthroplasties
- Interventional pain management
- Facility-based sleep studies
- Nuclear medicine imaging
- Radiation therapy: complex and 3D conformal, stereotactic radiosurgery (SBS) and stereotactic body radiotherapy (SBRT), brachytherapy, hyperthermia therapy, intensity-modulated radiation therapy (IMRT) and image-guided radiation therapy (IGRT), proton beam therapy, neutron beam therapy, and radiopharmaceuticals

The following services won’t be impacted by this relationship:
- Inpatient services (except cardiac rhythm implant devices and hip and knee arthroplasties)
- Emergency room services
- Outpatient services, other than those referenced above
How to send pre-authorization requests to eviCore healthcare:

• Call between 7 AM and 7 PM ET, or as required by federal or state regulations.
  - New York members: 1-888-622-7329
  - New Jersey members: 1-888-647-5940
• Fax: 1-800-540-2406
• Website: eviCore.com

Note:
All providers should send claims for these services to us for all plans. Obtaining an approved pre-authorization does not guarantee payment. Claims payment is also dependent upon the member’s eligibility and benefits plan.

Connecticut, Delaware, Massachusetts, Maine, Pennsylvania, Southern New Jersey, Vermont and West Virginia

eviCore healthcare manages pre-authorization for certain outpatient procedures for all commercial and Medicare plans (except indemnity Traditional Choice plans) in Connecticut, Delaware, Massachusetts, Maine, Pennsylvania, Southern New Jersey, Vermont and West Virginia.

Pre-authorization is required for the following:*  
• Elective inpatient and outpatient cardiac rhythm implant devices  
• Elective outpatient magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA), positron emission tomography (PET) scans, and computed tomography (CT) and computed tomography angiography (CTA)  
• Elective outpatient stress echocardiography, and diagnostic left- and right-heart catheterization  
• Facility-based sleep studies  
• Elective inpatient and outpatient hip and knee arthroplasties  
• Interventional pain management

• Nuclear cardiology  
• Radiation therapy: complex and 3D conformal, stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT), brachytherapy, hyperthermia therapy, intensity-modulated radiation therapy (IMRT) and image-guided radiation therapy (IGRT), proton beam therapy, neutron beam therapy, and radiopharmaceuticals

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

How to send pre-authorizations to eviCore healthcare:

• Phone: 1-888-693-3211  
  Monday through Friday, 7 AM to 8 PM CT  
• Fax: 1-844-822-3862  
• Website: eviCore.com

For radiation therapy:

• Phone: 1-888-622-7329  
  Monday through Friday, 8 AM to 9 PM ET  
• Fax: 1-888-693-3210  
• Website: eviCore.com, and then select the “CareCore National” tab.

National Imaging Associates (NIA)

• Physical therapy services performed by any provider  
• Occupational services performed by any provider  
• Chiropractic services performed by any provider

How to send pre-authorizations to NIA:

Delaware, Southern New Jersey, New York, Pennsylvania and West Virginia

National Imaging Associates

Precertification and Customer Service:
Phone: 1-866-842-1542

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*eviCore will precertify the implant device and hip and knee procedures. We will precertify the inpatient stay.
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**

We offer members:

- Health risk assessments (HRAs)
- Annual reassessments
- An individualized care plan (ICP) with documented problems, goals, interventions and follow-ups

The D-SNP care management team uses HRAs to understand health challenges and develops ICPs to address them.

Providers can view and download their patients’ HRAs and ICPs using the sites listed below.

- AL, FL, GA, IA, KS, LA, MO, NE, NC, OH, PA, TX and WV: Aetna-PRD.AssureCare.com/provider/
- VA: AetnaBetterHealth.com/virginia-hmosnp/providers/portal

**Interdisciplinary care team**

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

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

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

**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 Dual-Eligible Special Needs plans (D-SNPs) must complete this training. CMS requires it. Training must be done:

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

Take the [online mandatory Medicare D-SNP MOC training](#).

If you need access to the site, have questions about the training or would like a printed copy of the training presentation, just contact us.

- AL, FL, GA, IA, KS, LA, MO, NE, NC, OH, PA, TX and WV: 1-833-570-6670 (TTY: 711)
- VA: 1-855-463-0933 (TTY: 711)
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 Reviews (CPTII: 1159F and 1160F) must both be submitted on the same claim and on the same day
• Pain Screening (CPTII: 1125F, 1126F)

D-SNP payments and billing

<table>
<thead>
<tr>
<th>Medicare Savings Program levels</th>
<th>Cost sharing and Medicaid benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB)</td>
<td>Medicare Parts A&amp;B are cost-sharing protected</td>
</tr>
</tbody>
</table>
| 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 and B services. Cost-sharing-protected members are protected from liability for Medicare Parts A and 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 and B cost sharing. Further, QM and QMB+ members cannot elect to pay Medicare cost-sharing rates. Providers that bill QMB or QMB+ members for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions.

Note:
If a member is cost-sharing protected, the provider shall bill any cost-sharing obligations to the state Medicaid agency, the member’s Medicaid managed care organization, or Aetna. Go to Aetna.com/healthcare-professionals/assets/documents/2020-dnsp-cost-share-grid.pdf to find state-specific information on which organization to bill for cost sharing.

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

Access and availability: Connecticut requirements

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

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

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

We periodically assess participating networks for adequacy in order to meet the health care needs of current membership. Many factors impact the adequacy of the network: network composition, geographic distribution of providers, practitioners and members, types and numbers of practitioners, and available providers and specialties. A member’s perception of the network is another key driver of member satisfaction with the health plan and the member’s assessment of health plan quality. An adequate network facilitates appropriate and efficacious treatment.

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

Provider Termination Patient List

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

Aetna
PO Box 981106
El Paso, TX 79998-1106

Please reference in your mailing “CT Provider Termination Patient List.” For a termination due to cause, we ask the list be sent upon receipt of the termination notice.

Surprise bills

Connecticut law protects members covered under fully insured plans that are written in Connecticut from surprise out-of-network bills (claims). As a contracted provider, you play an important role in preventing our members from incurring surprise bills. So be sure to select participating providers when coordinating care for our members (for example, anesthesiology, radiology, laboratory or an assistant surgeon, etc). This will help avoid a surprise bill and any administrative hassles members and nonparticipating providers may face to address them.

A surprise bill is a bill for covered nonemergency health services rendered:

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

(b) At an out-of-network clinical laboratory, upon the referral of an in-network provider.

Note:

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

Claims processing

In accordance with Maine 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 claims 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 to the date that we received your credentialing application from CAQH. To verify participation status, providers should contact us via one of the methods below.

• Aetna® HMO-based plans: Call the Aetna Provider Contact Center at 1-800-624-0756 (TTY: 711).
• Aetna non-HMO-based plans: Call 1-888-632-3862 (TTY: 711).
• All Aetna plans: Visit our provider portal.

Subluxation chiropractic care

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 the conditions listed below are met.

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

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 12th treatment visit, whichever occurs first. At the end of this initial treatment period, the chiropractic provider will determine whether the services provided during this initial treatment period have improved the member’s condition. We will not cover self-referred acute chiropractic treatment provided after the point at which the chiropractic provider determines that the member’s condition is not improving from the services. At this point, the chiropractic provider must discontinue treatment and refer the member to the member’s primary care physician.

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

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

Women’s Health and Cancer Rights Act of 1998

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

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

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

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

Based on Maine law, we are required to allow a referral from a direct primary care (DPC) provider to a network provider.

DPC providers do not submit referrals or claims to Aetna®. In the event that a DPC refers a member to a participating provider, the claim may initially be denied because the referral must be made by an in-network provider. Therefore, if a DPC refers a member to an in-network provider and the claim is denied, contact us at the toll-free phone number on the Aetna member ID card and we will reevaluate the claim.

System limitations prevent Aetna from processing referrals from non-participating DPCs upon initial receipt. Accordingly, we address these limitations by reviewing, on a monthly basis, claims denied for no referral, to identify whether a DPC is listed as the referring physician. If a DPC is listed as the referring physician, we will reprocess the claim at the appropriate benefit level.

Massachusetts supplement

Demographic data quarterly attestation

To address guidance from both the Centers for Medicare & Medicaid Services (CMS) and the commonwealth of Massachusetts regarding provider directory accuracy, we use a vendor — currently Availity® — to make quarterly outreach to every Medicare Advantage and/or commercial provider to request validation of their demographic information listed in our directory.

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

Massachusetts-only requirement for Massachusetts General Laws (MGL) Chapter 175 in Sec. 47FF, 47GG MGL Chapter 176G in Sec. 4Z, and in the 4AA Bulletin 2015-15

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

1. Precertification: Sometimes, we will pay for care only if we have given an approval before a member receives care. We call that “precertification” or “pre-authorization.” The Aetna PCP or network provider is responsible to get this approval for covered in-network services.

2. To get started, call the precertification number on the member’s Aetna ID card. You can find our precertification requirements, our concurrent review policies and procedures, and this notice on our website.

3. We do not require precertification or authorization for routine behavioral health therapy or routine behavioral health outpatient medical visits (psychopharmacology visits, for example).
4. You can find the Aetna® precertification list on our website. Or you can call Member Services to find the behavioral health outpatient services that require authorizations.

5. Providers (facilities or individual providers) certified or licensed by the Massachusetts Department of Public Health (DPH) are not required to request pre-authorization or precertification for substance abuse treatment. But the DPH does expect providers to notify carriers of the initial treatment plan within 48 hours of an admission or the start of services.

   Providers should notify us in the same way they do for services that require precertification.

6. We’ll cover medically necessary (as determined by the treating clinician) inpatient acute treatment services* and clinical stabilization services** for substance abuse for up to a total of 14 days. Any days beyond that are subject to utilization review.

   **Clinical stabilization services: 24-hour clinically managed, post-detoxification treatment for adults or adolescents, as defined by the Department of Public Health. These services usually follow acute treatment services for the disordered use of drugs. This may include intensive education and counseling regarding the nature of the disordered use of drugs and its consequences, as well as relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from a disordered use of drugs.

   *Acute treatment services: 24-hour medically supervised treatment for adults or adolescents for disordered use of drugs. This care is provided in a medically managed or medically monitored inpatient facility, as defined by the Department of Public Health. These services provide evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

   Pain management access plan

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

   To check whether Aetna considers a non-medication Opiate Alternative to be medically necessary, please refer to the Aetna Clinical Policy Bulletins (CPBs). Relevant CPBs may include Acupuncture (#0135), Biofeedback (#0132), Physical Therapy (#0325) and Chiropractic Services (#0107). Coverage for a nonmedication Opiate Alternative, even if medically necessary, is subject to applicable benefits plan limitations and exclusions.

   Refer to the Find a Medication page to check whether a medication Opiate Alternative is covered by an Aetna formulary. Relevant medications may include Acetaminophen, NSAIDs, Muscle Relaxants, Anticonvulsants, Antidepressants, Topical Analgesics and Corticosteroids. Coverage for a medication Opiate Alternative is subject to applicable benefits plan limitations and exclusions.

   New Jersey provider appeals process

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

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

   Visit the Disputes & Appeals Overview page for further information on our general process for disputes and appeals.
New York state supplement

Provider responsibilities

The provider shall perform all of the duties listed below.

1. Provide complete, current information concerning a diagnosis, treatment and prognosis to an enrollee in terms the enrollee can be reasonably expected to understand.

2. Advise enrollees, prior to initiating an uncovered service, that the service is uncovered and of the cost of the service.

3. Recognize the definition of “emergency condition” as follows: “Emergency condition” means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person; or a condition described in § 1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.

4. Along with us, grant access to patient-specific medical information and encounter data to the New York State Department of Health, which records shall be maintained for a period of six years after the date of services to enrollees or cessation of Aetna® operations. For minors, the period shall be six years from the date of majority.

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

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

Discharge plans following inpatient substance use disorder treatment

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

Provider contracting information

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 Aetna® network.

2. We are legally obligated to report to the appropriate professional disciplinary agency within 30 days of the occurrence of the following:
   a. Termination of a health care provider for reasons relating to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare
   b. Voluntary or involuntary termination of a contract or employment or other affiliation with such organization to avoid the imposition of disciplinary measures
   c. Termination of a health care provider contract in the case of a determination of fraud or in a case of imminent harm to patient health; We are legally obligated to report to the appropriate professional disciplinary agency within 60 days of obtaining knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct as defined in the New York Education Law

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

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 us to improve performance.

5. The provider’s contract shall not be terminated unless we provide to the provider a written explanation of the reasons for the proposed contract termination and an opportunity for a review of hearing pursuant to PHL 4406-d 2.(b). The provider termination notice shall include: (a) the reasons for the proposed action, (b) notice that the provider has the right to request a hearing or review, at the provider’s discretion, before a panel appointed by us, (c) a time limit of not less than 30 days in which a health care professional may request a hearing, and (d) a time limit for a hearing date which must be held within 30 days after the date of receipt of a request for a hearing. (If a provider’s contract is nonrenewed, this is not considered as a termination under PHL 4406-d and thus the requirements described above do not apply.)
6. The provider shall not be prohibited from the following actions, nor shall a provider be terminated or refused a contract renewal solely for the following reasons: (a) advocating on behalf of an enrollee, (b) filing a complaint against a managed care organization, (c) appealing a decision of the managed care organization, (d) providing information or filing a report pursuant to PHL 4406 c regarding prohibitions of plans, or (e) requesting a hearing or review.

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

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

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

**Hospital nonbinding mediation**

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

**Confidentiality of HIV-related information**

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

1. An initial and annual in-service education of staff (including contractors)
2. Identification of staff who are allowed access and a description of the limits of that access
3. A procedure to limit access to trained staff (including contractors)
4. A protocol for secure storage (including electronic storage)
5. Procedures for handling requests for HIV-related information
6. 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 substance use disorder services. (Note: this is applicable only to qualified providers of obstetric or gynecologic 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: pre-authorization 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 and procedures also include those set forth in the Company’s manuals, including the office manual, or their successors (as modified from time to time); Clinical Policy Bulletins made available via Company’s public
4. A provider or enrollee shall be notified by telephone and in writing of utilization review determinations involving health care services that require pre-authorization within three business days after receipt of the necessary information.

5. If our determination about whether to approve coverage for a requested drug is made within 72 hours of the request for services while the utilization review determination is pending.

a. The required prescription drug or drugs is contraindicated, will likely cause an adverse reaction by or physical or mental harm to the enrollee.

b. The required prescription drug or drugs are expected to be ineffective based on the known clinical history and conditions of the enrollee and the enrollee’s prescription drug regimen.

c. The enrollee has tried the required prescription drug or drugs while under their current or a previous health insurance or health benefit plan, or another prescription drug or drugs in the same pharmacologic class or with the same mechanism of action and such prescription drug or drugs was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

d. The enrollee is stable on a prescription drug or drugs selected by their health care professional for the medical condition under consideration, provided that this shall not prevent a utilization review agent from requiring an insured to try an AB-rated generic equivalent prior to providing coverage for the equivalent brand name prescription drug or drugs.

e. The required prescription drug or drugs are not in the best interest of the enrollee because it will likely cause a significant barrier to the enrollee’s adherence to or compliance with the enrollee’s plan of care, will likely worsen a comorbid condition of the enrollee, or will likely decrease the covered enrollee’s ability to achieve or maintain reasonable functional ability in performing daily activities.

6. 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.
7. A provider and member shall receive notification of adverse utilization review determinations in writing, which shall include all of the following items:
   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.

8. We may reverse a pre-authorized treatment, service or procedure on retrospective review only when the pre-authorization was based on inaccurate or incomplete information provided by the enrollee or provider AND had the enrollee or provider provided the accurate or complete information, the pre-authorization would not have been granted.

9. A provider may request a referral for a member to a nonparticipating provider, if we have 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 us, 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.

10. 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 us after consultation with the primary care provider and specialist and shall be pursuant to a treatment plan approved by us 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.

11. 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, us and the specialist, and care shall be rendered pursuant to a treatment plan.

12. 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 us 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 us, 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 Aetna® 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.

13. 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.

14. Failure by us to make a utilization review determination within the prescribed time frames shall be deemed to be an adverse determination subject to appeal, provided, however, that failure to meet such time periods for determining if a step therapy protocol was met shall be deemed to be an override of the step therapy protocol.

15. 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:


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 Aetna requires information necessary to conduct an expedited appeal, Aetna 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 2 business days of receipt of necessary information, except for expedited appeals related to inpatient substance use disorder. Expedited appeals related to inpatient substance use disorder will be resolved in 24 hours of receipt of the appeal if the initial request was submitted at least 24 hours before discharge. 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 the Employee Retirement Income Security Act of 1974 (ERISA) regulations, the period to file is 180 days
d. We must acknowledge the appeal within 15 days.
e. If we require information necessary to conduct a standard internal appeal, Aetna 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, Aetna shall request the missing information, in writing, within 5 business days of receipt of the partial information.

g. We 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 2 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 the items listed below.

- Health service that was denied, including the facility or provider and the developer or manufacturer of the service as available.
- Statement that the enrollee may be eligible for external appeal and the time frames 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.

16. 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.

17. 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. An enrollee or provider may request an external appeal of an adverse determination only if we have rendered a final decision on the determination through our internal-appeal process, Aetna and the enrollee waive any internal appeal, OR the enrollee
is deemed to have exhausted or is not required to complete any internal appeal. Additionally, the adverse determination must be a denial of coverage that meets one of the following descriptions:

- A service was denied that is otherwise covered under the enrollee’s plan that we have determined to not satisfy the plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness.

- A service was denied that is otherwise covered under the enrollee’s plan that we have determined to be experimental or investigational.

The enrollee’s attending physician must have certified that the enrollee has a condition or disease for which standard services have been ineffective or would be medically inappropriate, for which there does not exist a more beneficial standard health service covered by the enrollee’s plan, or for which there exists a clinical trial or rare-disease treatment. The attending physician also must have recommended either: (i) a clinical trial for which the enrollee is eligible; OR (ii) a service that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the enrollee than any covered standard service or procedure or, in the case of a rare disease, based on the physician’s certification, that the requested service is likely to benefit the enrollee in the treatment of the rare disease and that such benefit to the enrollee outweighs the risks of such health service.

The attending physician referred to in this section must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the service sought.

Any physician certification provided under this section must include a statement of the evidence relied upon by the physician in certifying his or her recommendation.

- An out-of-network service was denied that is otherwise covered under the enrollee’s plan for which Aetna® has determined there is an in-network alternative. The enrollee’s attending physician must have certified that the out-of-network service: (1) is materially different from the in-network alternative; (2) is, based on two documents from the available medical and scientific evidence, likely to be more clinically beneficial than the in-network alternative; AND (3) does not substantially increase the service’s adverse risk, as compared to the in-network alternative. The attending physician referred to in this section 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 service sought.

- An out-of-network referral was denied because there is an in-network provider who has the appropriate training and experience to meet the enrollee’s health care needs and who is able to provide the requested service. The enrollee’s attending physician must have certified that the in-network provider does not have the appropriate training and experience to meet the enrollee’s health care needs and must have recommended an out-of-network provider who has the appropriate training and experience to meet the enrollee’s health care needs and who is able to provide the requested service.

The attending physician referred to in this section must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the service sought.

c. For concurrent care denials, the provider must agree to hold the member harmless if the denial is upheld by the external appeal agent because the service is not medically necessary.

18. The period of time to make an appeal determination begins upon Aetna’s receipt of necessary information.

19. Failure by us to make an appeal determination within the prescribed time frames shall be deemed to be a reversal of Aetna’s adverse determination.

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

Quality management (QM) program

The QM program focus is the ongoing assessment and improvement of clinical care, service and safety. Among the benefits derived from the implementation and maintenance of a QM 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 team work and a multi-departmental approach to quality improvement
- The provision to the health plan of comparative information (internal and external)
Quality strategy statement

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

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

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

We are committed to Health Plan and Managed Behavioral Healthcare Organization (MBHO) accreditation by the National Committee for Quality Assurance (NCQA) as one means of demonstrating a commitment to CQI and meeting customer expectations. HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS)* reports are produced annually and submitted to NCQA for public reporting and accountability. HEDIS is audited in accordance with NCQA specifications by NCQA-Certified HEDIS auditors. CAHPS and the QHP Enrollee Experience Survey are executed by approved survey vendors according to published technical specifications.

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

QM process

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

Our Achieving Business eXcellence (ABX) vision is to drive a culture of continuous improvement (CI) and everyday problem-solving, where all associates are focused on improving the work they do, which increases their own engagement, while driving value to our customers and shareholders.

Finally, we develop relationships with various professional entities and provider organizations that may provide feedback regarding structure and implementation of QM program activities or work collaboratively on quality improvement projects.

QM program goals

QM program goals include the following:

• To operate the QM program in compliance with and responsive to applicable requirements of plan sponsors, federal and state regulators and appropriate accrediting bodies
• To promote the principles and spirit of CQI and ABX
• To institute company-wide initiatives to improve the safety of members and our communities and to foster communications about the programs
• To implement a standardized and comprehensive QM program that addresses and is responsive to the health needs of our population including, but not limited to, serving members with complex health needs across the continuum of care
• To increase the knowledge and skills base of staff and to facilitate communication, collaboration and integration among key functional areas relative to implementing a sound and effective QM program
• To measure and monitor previously identified issues, evaluate the QM program, and to improve performance in key aspects of quality and safety of clinical care, including BH), quality of service for members, customers, and participating practitioners and providers
• To maintain effective, efficient and comprehensive practitioner and provider selection and retention processes through credentialing and recredentialing activities
• To ensure collaboration with behavioral healthcare networks to improvecontinuity and coordination of care between BH specialists and primary care practitioners
• To encourage the development and use of services and activities that support public health goals

*CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
QM program scope

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

- Review and evaluation of preventive and BH services; ambulatory, inpatient, primary and specialty care; high volume and high-risk services; and continuity and coordination of care
- Development of written policies and procedures reflecting current standards of clinical practice
- Development, implementation and monitoring of patient safety initiatives, and preventive and clinical practice guidelines
- Monitoring of medical, BH, case and disease management programs
- Achievement and maintenance of regulatory and accreditation compliance
- Evaluation of accessibility and availability of network providers
- Evaluation of network adequacy
- Establishing standards for, and auditing of medical and BH record documentation
- Monitoring for over and underutilization of services (Medicare)
- Performing credentialing and recredentialing activities
- Oversight of delegated activities
- Evaluation of member experience and practitioner satisfaction
- Supporting initiatives to address racial and ethnic disparities in health care
- Development of provider performance programs: standardization and sound methodology; transparency; collaboration; and taking action on quality and cost

External practitioners provide input into the QM program through review and feedback on quality improvement studies and surveys, clinical indicators, member and practitioner and provider initiatives, practitioner and provider communications, the QM Program Description, and the QM Work Plan.

A variety of mechanisms are used to encourage providers to participate in CMS and Health & Human Services (HHS) QI initiatives. These activities are promoted through several mechanisms including but not limited to provider contract provisions, the provider manual and provider newsletters.

Accountability and committee structure

A. Board of directors

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

B. National Quality Oversight Committee (NQOC)

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

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

- Approving the following documents:
  - QM/BH Program Description with State Amendments
  - QM Work Plan
  - HMO/PPO QM Program Evaluations
  - Care Management Program Description
  - Clinical Claim Review Program Description
  - BH QM Work Plan
  - BH QM/Care Management Program Evaluations
  - Patient Safety Strategy
  - Population Health Management Strategy
- Adopting clinical criteria and protocols with consideration of recommendations from the National Quality Advisory Committee (NQAC) and, as appropriate, the BH QAC
- Establishing goals, monitoring, evaluating and prioritizing QM and Care Management program activities
- Reviewing and adopting QM, NCS and selected policies and procedures and approving state amendments (as outlined in QM 01, Policy and Procedure Development and Review Policy and Procedure and NCS 501-01/02, Policy Development Policy and Procedure)
- Reviewing and approving, as applicable, regular reports from national workgroups and committees for discussion and feedback as necessary
- Evaluating identified Potential Quality of Care (PQoC) concerns related to facilities and vendors
- Adopting medical and BH clinical practice guidelines (CPGs) and preventive services guidelines (PSGs)
- Overseeing, coordinating and establishing company-wide initiatives to improve the safety of our members and our communities
- Fostering communications about our safety programs to members, employees, physicians, hospitals, other health care professionals and plan sponsors
- Reviewing and approving Quality Improvement initiatives
The NQOC meets at least 10 times a year. The NQOC is a multidisciplinary committee composed of department representatives that include but is not limited to the following areas:

- Medical director, chairperson
- Office of chief medical officer
- Medical directors
- National quality management
- Behavioral health quality management
- Pharmacy management
- Clinical services
- Network management
- Customer service
- Claims
- Complaints, grievance and appeals
- National accounts
- Medicare compliance
- Medicare service operations
- Plan enrollees (as state regulations require)
- Participating practitioners (as state regulations require)

The NQOC delegates authority to the:

- National Quality Advisory Committee (NQAC) and the Behavioral Health Quality Advisory Committee (BHQAC) to provide 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 render decisions on professional review hearings
- BH QOC to provide guidance and direction on Behavioral Health administrative, clinical and quality issues and utilization management activities
- National Quality Management Policy Committee (NQMPC) and the National Clinical Services Policy Committee (NCSPC) for policy development and approval
- National Guideline Committee (NGC) to review and approve clinical practice guidelines (CPGs) and preventive services guidelines (PSGs)

The NQAC, NVDOC and BH QOC provide reports to the NQOC at least semi-annually.

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

The Aetna® Pharmacy Health Plan Quality Oversight Committee (APHPQOC) is the designated committee to provide guidance and direction on pharmacy administrative, clinical, service and quality issues. It provides annual program documents as informational to the NQOC.

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

**C. National Quality Advisory Committee (NQAC)**

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

- Provide input into the QM program through review and feedback on quality improvement studies and surveys, clinical indicators, member, practitioner, and provider initiatives, practitioner and provider communications, the QM Program Description, and the QM Work Plan
- Review clinical criteria, such as UM criteria, medical clinical policy bulletins and protocols for adoption by the NQOC
- Make recommendations to the NGC regarding medical clinical practice and preventive services guidelines
- Share feedback, as appropriate, with the BH QAC regarding the integrated medical and behavioral care health programs
- Provide quarterly, or more frequent, reports to the NQOC

The NQAC meets at least four times a year and membership includes the following:

- Medical director, chairperson
- 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)
- Plan Enrollee (as state regulations require)

**D. National Vendor Delegate Oversight Committee (NVDOC)**

The NVDOC has oversight of the following:

- Delegation oversight
- Vendor policies, procedures and processes
- Review and approval of delegated credentialing, claims, customer service, medical management programs (such as utilization management, case management and disease management), access, availability and member experience, which includes approval of delegate’s program descriptions
- Review of delegates related to general controls, finance and network management, as appropriate
• Review of oversight activities required by CMS, including but not limited to fraud, waste and abuse (FWA), business conduct and integrity (BCI) or code of conduct (COO), and other regulators
• Overall monitoring and reporting of risk and delegate performance
• Review and approval of delegated, national claims arrangements, claims pass-through arrangements, third-party administrator arrangements, customer service, telesales and marketing
• Approval and oversight activities delegated to external (nonAetna®) entities under national delegation
• Provision of semi-annual reports to NQOC

The NVDOC meets monthly and membership includes the following:
Voting members:
• National quality management director of delegation and chairperson
• Medical director
• Quality management managers over credentialing and medical management oversight (for example, oversight of UM, CM, DM and clinical programs)
• Senior manager, finance or senior finance auditor
• Claims audit manager
• Network market head and senior network managers
• Medicare compliance
• Manager, national delegation management (co-chairperson)
• Counsel, law department
• Compliance director, law and regulatory compliance

Attendees representing the following areas:
• Network
• Care management
• Medical directors
• Quality management (credentialing and medical management delegation oversight)
• Finance
• National delegation team

E. Credentialing and Performance Committee (CPC)
The CPC makes determinations for those applicants being considered for exceptions to Aetna’s 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 for the purpose of evaluating continued participation in the Aetna network.

The CPC meets at least every 45 days and membership includes the following:
• Medical Director, Facilitator
• Representatives from a range of participating practitioners in specialties that include primary care and high volume specialists (other specialty practitioners may be included as necessary for peer review, e.g., dentists, chiropractors)
• Behavioral health practitioners including a psychiatrist, a psychologist and a masters level behavioral health clinician

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

G. Practitioner Appeals Committee (PAC)
The PAC is responsible for practitioner appeals and hearings of adverse determinations related to quality-of-care concerns and credentialing decisions from CPC determinations.

The PAC meets on an ad hoc basis and is facilitated by a medical director.

The committee is composed of three to seven participating network practitioners:
• A majority of members are peers of the affected practitioner.
• At least one peer must be licensed in the same state as each practitioner reviewed by the committee.
• At least one voting member of the PAC shall practice in a specialty substantially similar to the specialty of the practitioner, if specialty knowledge is required by the nature of the appeal.

No voting member of the PAC may have had substantial prior involvement in the matter under appeal. However,
PAC members may vote if they have participated in prior appeals by the same practitioner.

**H. Behavioral Health Quality Oversight Committee (BH QOC)**

The BH QOC is a multidisciplinary committee that provides guidance and direction to the BH 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 also facilitates the integration of behavioral health with primary medical services.

The role of the BH QOC includes the following:

- Establish priorities for BH related QM and Care Management activities, evaluate clinical and operational quality and integrate quality improvement activities across BH.
- Review and approve BH clinical and service quality indicators and monitors and quality improvement initiatives.
- Identify, select and monitor BH screening and prevention programs and oversee their implementation.
- Review and approve BH Condition Management program reports.
- Monitor BH related activities for consistency with national program goals.
- Review and evaluate feedback from the BH QAC.
- Review regular reports from BH national workgroups and committees for discussion and feedback, as necessary.
- Oversee BH QM department review of annual Care Management and QM Program Descriptions, and preparation and review of the BH QM Work Plan and BH QM/Care Management Program Evaluation for submission to the NQOC for approval.
- Adopt BH clinical criteria and protocols based on recommendations from BH QAC.
- Review an assessment of the application of BH clinical criteria.
- Provide semi-annual summary reports on BH related activities to the NQOC.
- Review and recommend adoption of all BH CPGs and PSGs.
- Approve and provide oversight of behavioral health delegated activities.
- Review activities and recommendations of workgroups.
- Review patient safety activities.
- Review and adopt applicable QM and NCS policies and procedures and state amendments as outlined in the QM-01 Policy and Procedure Development and Review Policy and Procedure and NCS 501-01/02 Policy Development Policy and Procedure.

The BH QOC meets at least 10 times a year. Committee membership includes the following:

- Behavioral health chief medical officer, co-chairperson
- Senior director, health care quality management or designee, co-chairperson
- Behavioral health senior medical directors
- Directors of clinical health services
- Behavioral health national head of network/director, network management or designee(s)
- Behavioral health quality management staff
- Behavioral health complaints and appeals supervisor, as applicable
- Manager of customer service and call operations or designee
- National quality management representatives, as applicable

**I. BH Quality Advisory Committee (BH QAC)**

The BH QOC delegates the following functions to the BH QAC:

- Manage and provide direction on BH clinical quality improvement initiatives.
- Provide input into the QM program through review and feedback on BH quality improvement studies and surveys; clinical indicators; member, practitioner and organizational provider initiatives; screening and preventive health programs; practitioner and organizational provider communications, and the BH QM Work Plan.
- Review BH clinical criteria and protocols and CPGs for the BH QOC.
- Provide feedback to the NQAC regarding medical CPGs that include a BH component.
- Make recommendations to the NGC on BH CPGs.

The BH QAC meets at least twice a year and membership includes the following:

- Behavioral health chief medical officer, chairperson (or designee)
- Senior director, health care quality management
- Behavioral health medical directors
- Behavioral health QM managers
- Directors of clinical health services
- Six to eight participating behavioral health practitioners, to include at least one:
  - Psychiatrist
  - Psychologist
Social worker
- Other master’s-degreed clinician
- Representative from a behavioral health organizational provider
- Primary care physician
- Other specialty practitioners may be included, as necessary, for clinical input

Other quality management committees and work groups are also established to support and augment various processes. These include national guideline development, pharmacy and therapeutic management, and appeals.

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

• Physicians must tell patients the plans in which they participate. This includes detailed information about any referrals they make to ancillary providers, like anesthesiology or assistant surgeons. This applies to both office and hospital settings. A physician is required to provide a patient or prospective patient with the name, practice name, mailing address, and telephone number of any health care provider scheduled to perform anesthesiology, laboratory, pathology, radiology or assistant surgeon services in connection with care to be provided in the physician’s office for the patient or coordinated or referred by the physician at the time of referral to or coordination of services with such provider.

A physician is also required to notify patients prior to any scheduled hospital admission or scheduled outpatient hospital services, of the name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician and are scheduled at the time of the pre-admission testing, registration or admission at the time non-emergency services are scheduled; and information as to how to determine the healthcare plans in which the physician participates.

• If the patient asks, nonparticipating providers must provide an estimate of the amount they will bill the patient for services. They must also give the patient an insurance claim form.

• Hospitals must post the following on their 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 Aetna® network may request to continue an ongoing course of treatment with the enrollee’s current provider, subject to provider agreement where: (a) the period of transition is up to 60 days if the enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition; or (b) if the enrollee has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include provision of postpartum care related to the delivery.

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

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

Adverse reimbursement change
Providers who are considered health care professionals under Title 8 of the New York Education Law must receive written notice from Aetna at least 90 days prior to an adverse reimbursement change (“Material Change”) to the provider agreement with Aetna (the “Agreement”). If the health care professional objects to the Material Change that is the subject of the notice by Aetna, the health care professional may, within 30 days of the date of the notice, give written notice to us 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 statutory exceptions to this notice requirement are listed below.
1. The change is otherwise required by law, regulation or applicable regulatory authority, or is required due to changes in fee schedules, reimbursement methodology or payment policies by the state or federal government or by the American Medical Association’s Current...

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 time frames**

Claims submitted electronically must be paid within 30 days and paper or facsimile claim submissions must be paid within 45 days. The 30-day time frame for us to request additional information or for denying the claim was not changed.

**Coordination of benefits**

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

**Claims practices: provider claim submission time period**

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

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

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

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

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

**Overpayment recovery: provider challenges**

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

- We may not initiate an overpayment recovery effort more than 24 months after the provider’s receipt of the original payment, except when the recovery efforts are based on a reasonable belief of fraud or other intentional misconduct or abuse.
- For recoveries other than those involving duplicate payments, we 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.
- The Aetna 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 (TTY: 711) to request a copy. The appeal process involves the following:
  - Other than recovery for duplicate payments, we will provide 30 days, written notice before requesting an overpayment recovery. Our notice will list: (i) the patient name, (ii) service date, (iii) payment amount, (iv) adjustment sought, and (v) an explanation for the adjustment.
  - You can dispute an overpayment recovery, and share relevant claims information. You should explain your specific reasons why you feel the overpayment recovery is incorrect. We will not initiate overpayment recovery efforts more than 24 months after the original payment was received by a health care provider. However, no such time limit shall apply to overpayment recovery efforts that are: (i) based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, (ii) required by, or initiated at the
request of, a self-insured plan, or (iii) required or authorized by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members.

Notwithstanding the aforementioned time limitations, in the event that a health care provider asserts that a health plan has underpaid a claim or claims, the health plan may defend or set off such assertion of underpayment based on overpayments going back in time as far as the claimed underpayment.

Note:
For purposes of the preceding paragraphs, “abusive billing” shall be defined as a billing practice which results in the submission of claims that are not consistent with sound fiscal, business or medical practices and at such frequency and for such a period of time as to reflect a consistent course of conduct.

Participating provider and participating hospital reimbursement
We are prohibited from treating a claim from a network hospital as out of network solely on the basis that a nonparticipating health care provider treated the member.

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

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

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

A “coding decision” refers to our payment adjustment to codes billed, including the application of diagnosis and procedure codes for a particular patient.

Rare disease treatment
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
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 us; we are responsible for the full cost of an appeal that is overturned; and the provider and we must evenly divide the cost of a concurrent adverse determination that is overturned in part. The fee requirements do not apply to providers who are acting as the member’s designee, in which case the cost of the external appeal is the responsibility of us.

In cases where providers request an external appeal of a concurrent adverse determination on their own behalf, or on behalf of the member as the member’s designee, providers are prohibited from seeking payment, except applicable copays, from members for services determined to be not medically necessary by the external appeal agent. Members are to be held harmless in such cases. For the provider to claim that the appeal of the final adverse determination is made on behalf of the member, the completion of the external appeal application and the designation will be required.

The superintendent has the authority to confirm the designation or to request additional information from the member. Where the member has not responded, the superintendent will inform the provider to file an appeal. A provider responding within the time frame will be subject to the external appeal payment provisions described above. If the provider is unresponsive, the appeal will be rejected.

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

Note:
A surprise bill is not a bill for services received when a network provider was available and a member knowingly selected an out-of-network provider. Learn more on Aetna.com > Explore Aetna Sites > For Providers > Insurance regulations by state.
Claims processing
In accordance with Rhode Island law, providers may submit claims to us once their credentialing application has been approved. In order to ensure that claims are paid at the contracted rate during initial claim processing, we ask that providers hold claims until their contract with us has been fully executed and our systems have been updated. Once the system is updated, we will pay claims at your contracted rate, retroactive back to the date of your approved credentialing application. To verify participation status, providers should contact us via one of the methods.

• Aetna HMO-based plans:
  Call the Aetna Provider Contact Center at 1-800-624-0756 (TTY: 711).
• Aetna non-HMO-based plans:
  Call 1-888-632-3862 (TTY: 711).
• All Aetna plans:
  Visit our provider portal.

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