



Provider and facility participation criteria

Our network is the gold standard

Here you'll find everything you need to know about participation in the Aetna® provider network. If you want to find the standards and criteria for a specific service, just look in the index. It's divided into these categories:

- Ancillary
- Facility
- Provider, including nurse practitioner and physician assistant
- Other provider
- Behavioral health services

For these services, a core set of criteria apply. In some cases, additional criteria apply.

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Ancillary

Ancillary core participation criteria and additional criteria

Ancillary core participation criteria

These criteria apply to each provider for the duration of the agreement. They'll be enforced at the sole discretion of Aetna®.

A. Applicability

1. If applicable, each provider must complete a facility credentialing questionnaire and will periodically supply all of the requested information to Aetna.

B. Office standards (applies to providers that have an office setting)

Each provider's office must:

1. Have a visible sign and title listing the names of all providers practicing in the office.
2. Have all areas accessible to all members, including, but not limited to, its entrance, parking lot and bathroom.

3. Have a clean, properly equipped and accessible patient toilet and hand-washing facility.
4. Have a waiting room sufficient to accommodate members.
5. Have at least two examining rooms that are clean, properly equipped and private.
6. Have an office assistant in office during scheduled hours.
7. Require a medical assistant to attend sensitive (for example, gynecological) examinations, unless the member declines assistant's presence.
8. If immunization services are offered, follow the vaccine safety and refrigeration guidelines in the U.S. Centers for Disease Control (CDC) Vaccine Storage and Handling Toolkit. Go to **[CDC.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf](https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf)** to download it.
9. Have a robust infection control and prevention program that operates in accordance with nationally recognized standards (e.g., CDC), that includes provisions to report unexpected events and to have regular staff training on appropriate hand hygiene and injection safety protocols.
10. Have appropriate protocol immediately available to treat medical emergencies. And they must have documented medical emergency procedures addressing treatment, transportation and disaster evacuation plans for members' safety. Additionally, the office/business must have generators to provide power in case of a power failure, when appropriate. For example, the generator requirement applies to offices that perform procedures or store biologics or supplies of vaccines.
6. Have an established process to ensure that medical records are protected from public access.
7. Have written policies addressing documentation about advance directives (whether executed or not) in each member's record (except for under age 18).
8. Comply with current Aetna® policies and all applicable legal requirements regarding use of allied health professionals.
9. Maintain evidence of current licenses for all providers practicing, including state professional license, federal Drug Enforcement Agency (DEA) certification and state controlled drug substance registration (where applicable).
10. Keep on file and make available to Aetna any state-required practice protocols or supervising agreements for allied health professionals.
11. Designate by age, according to Aetna guidelines, those members for whom provider will provide care.

D. Access and availability of services

If applicable, each provider's office/business must:

1. Offer a reliable mechanism for members and other health care professionals to be reached 24/7.
2. Ensure that they render coverage for members 24/7 or else arrange to have another Aetna participating provider available.
3. Be geographically accessible for outpatient services and consistent with local community patterns of care for the geographic area. This helps ensure that a member doesn't have to travel more than 30 minutes from the member's regular provider's office/business to get to the covering provider's services.
4. For workers' compensation members/patients, provide services within a reasonable time frame or, where applicable, within the time frame required by workers' compensation law.

E. Subcontractors

To the extent the provider intends to subcontract some of its services under the agreement, the provider will provide Aetna with a list of all subcontractors intended to be used to provide services to members. In all cases where provider subcontracts for any services under the agreement:

1. Provider represents and warrants that subcontractor(s) will abide by the provisions set forth in the agreement.

C. Business standards

Each provider's business must:

1. Be clean, presentable and professional and prohibit smoking.
2. Maintain controlled substances, if provided, in a secure and concealed location.
3. Have a quality assurance program and provide, upon request, documentation of such program.
4. Have a secure and confidential filing system.
5. Have written policies protecting member confidentiality, including the maintenance of medical records and verbal and electronic submission of their information.

2. Aetna® has the right to require a designation of payment schedule from all subcontractors in a form approved by Aetna. Provider shall indemnify and hold company and its members harmless for payment of all compensation owed the subcontractor for services provided under the agreement.
3. Aetna's prior written approval is required if the provider intends to perform covered services through employees or agents, including a subcontractor, if physically located outside of the United States of America.

F. Copies

Unless allowed by state law or regulatory requirement, provider agrees not to charge members for copies of medical records/reports or to require deposits for the release of these copies to members.

G. Insurance

Provider will maintain general and professional liability and other insurance according to state requirements. If there are no specific state requirements, then the amount should be what is typically maintained by providers in your state or region.

The insurance coverage will cover provider and its/their agents and employees.

Provider will give Aetna proof of insurance coverage upon request.

Provider must give company at least thirty (30) days' advance notice of any cancellation or material changes to these policies, and must post notice of malpractice insurance (existing, cancellation or exemption) in a prominent location in the office.

National adult immunization provider additional criteria

If you are an **adult immunization provider**, the following additional criteria apply:

A. Provider requirements

1. Provider must forward a complete report within 14 days of rendering services to the usual source of medical care for each individual to whom care is delivered.
2. Provider must direct individuals to whom care is delivered to their usual source of medical care or other appropriate source of ongoing medical care for any further care for the condition that was treated.

Durable medical equipment provider additional criteria

If you are a **durable medical equipment provider**, the following additional criteria apply:

A. Provider requirements

1. If provider offers respiratory therapy, then provider must employ a full-time certified respiratory therapist.
2. Provider must refill oxygen cylinders according to U.S. Food and Drug Administration (FDA) standards.
3. Provider must educate patients in self-care techniques and home care management, including, but not limited to, providing written patient education materials on how to operate and maintain equipment.
4. Provider must maintain adequate inventory of respiratory and durable medical equipment and supplies to meet the needs of patients on an ongoing basis.
5. Provider must report to referring physician or primary care physician according to Medicare regulations.
6. Provider must tell appropriate public utility companies, including without limitation, the electric power company, about a member's "priority status" when they're provided with home respiratory equipment.
7. If providing services for Medicare or Medicaid members, provider will supply company with information regarding durable medical equipment, prosthetics, orthotics, and supply accreditation and surety bond.

B. Access and availability of services

1. Provider's registered respiratory therapists, clinicians and home medical equipment technicians must be available 24/7.
2. Provider must be able to deliver equipment and initiate services within two hours of the referral call.

Home health provider additional criteria

If you are a **home health provider**, the following additional criteria apply:

A. Provider standards

1. Provider must have services that meet Aetna's approved accreditation agency standards, which may include services of each of the following: registered nurses, licensed practical nurses, physical therapists, occupational therapists, registered dietitians and a pharmacist on consult.

2. Home health agency's primary location must be either accredited or Centers for Medicare & Medicaid Services (CMS) certified. If the home health agency moves the primary location, a new accreditation or CMS certification must be obtained.
3. Each additional branch must be included in the primary location's accreditation or CMS certification.

B. Provider requirements

1. Provider must educate patients in self-care techniques and home care management, including, but not limited to, providing written member education materials.
2. Provider must maintain adequate staff to meet the needs of members.
3. Upon request by Aetna®, if provider conducts patient satisfaction surveys, survey responses shall be made available to Aetna at the same time and with the same frequency.
4. Services provided by an employee to a household member or his or her spouse's family member is not a covered expense.

C. Access and availability of services

1. Provider must have availability of provider's registered nursing staff 24/7. Other clinical staff must be available Monday through Friday, 8 a.m. to 5 p.m.
2. Provider must be able to initiate a therapy within 3 hours of the referral call for urgent services and within 24 hours of the referral call for routine services.

Home health infusion provider additional criteria

If you are a **home health infusion provider**, the following additional criteria apply:

A. Applicability

1. Provider must adhere to the guidelines established by the National Alliance for Infusion Therapy, the Centers for Disease Control and Prevention, and the Occupational Safety and Health Administration (OSHA).

B. Provider standards

1. Provider must have the following comprehensive services:
 - a. Full-time registered nursing staff employed by provider and trained in infusion therapy
 - b. Full-time registered pharmacists employed by provider

- c. Certified mixing facility in each provider location
- d. Equipment and supplies appropriate to the high-volume treatment modalities ordered by provider

2. Home health agency's primary location must be either accredited or CMS certified. If the home health agency moves the primary location, a new accreditation or CMS certification must be obtained.
3. Each additional branch must be included in the primary location's accreditation or CMS certification.

C. Provider requirements

1. Provider must educate members in self-care techniques and home care management, including, but not limited to, providing written patient education materials.
2. Provider must have a comprehensive therapy portfolio, including, but not limited to:
 - a. Total parenteral nutrition
 - b. Enteral nutrition
 - c. Intravenous antibiotics
 - d. Chemotherapy
 - e. Pain management
 - f. Hormone replacement
 - g. Blood components
 - h. Prolastin
 - i. Aerosolized pentamidine
 - j. Terbutaline pump therapy
 - k. Investigational medications
3. Provider must maintain adequate inventory to meet the drug and supply needs of members.
4. If provider conducts patient satisfaction surveys, survey responses shall be made available to Aetna at the same time and with the same frequency.

D. Access and availability of services:

1. Provider must have availability of provider's registered nursing and pharmacy staff, including a pharmacist 24/7.
2. Provider must be able to initiate therapy within three hours of the referral call.

Home sleep testing additional criteria

To provide home sleep testing services, a provider must have met Aetna® credentialing and/or accreditation requirements. The home sleep test must be requested by a medical doctor and provided by one of the following two accreditation agencies: an accredited provider of the American Academy of Sleep Medicine or The Joint Commission. In addition, the provider agrees to obtain certification from CMS before serving Medicare members.

Lab, fee-for-service and capitated, provider additional criteria

If you are a **lab provider**, the following additional criteria apply:

A. Applicability

1. A laboratory must be licensed to perform laboratory services in its state(s) of practice.

B. Laboratory requirements

1. Laboratory must be accredited by the College of American Pathologists.
2. Laboratory must have a Clinical Laboratory Improvement Amendments licensure as a “highly complex” laboratory.
3. Laboratory must have an onsite pathologist or hematopathologist certified by the American Board of Pathology.
4. Laboratory must have a board-certified dermatopathologist or have a documented relationship with a board-certified dermatopathologist to send requests at no additional charge.
5. Laboratory must have a proficiency testing program for cytopathologist.
6. Laboratory must have a cytopathologist for reading thyroid aspirates or one to whom they send requests.
7. Laboratory must report to Aetna all utilization on its members, including test orders and results. This information must be sent in a form and manner dictated by Aetna.
8. Laboratory must participate in a blind proficiency program with the College of American Pathologists and American Association of Bioanalysts.
9. Laboratory must be certified to perform in-house kidney stone analysis or make arrangements to send requests to a certified stone analysis laboratory at no additional charge.

10. Laboratory must adhere to federal and state regulations regarding cytotechnologist workload limit requirements.
11. Laboratory must make best efforts to advise members up front if a laboratory test is not covered by Aetna since considered experimental or investigational.

C. Provider quality monitoring program indications

1. Laboratory must have external proficiency testing programs.
2. Laboratory must have compliance audits.

D. Access and availability of services

1. Hours of operation — Laboratory agrees to provide collection and delivery services as necessary to provide appropriate services to all offices, hospitals and ambulatory surgery centers five days a week.
2. Routine services — The results of tests that are classified by laboratory as “routine” will be reported to physicians within 24 hours of receipt of the physician’s order form. Laboratory will report Pap test results to physicians within two weeks.
3. Urgent services — Laboratory will notify physicians immediately after the performance of a test if the results are classified by lab as “immediate.” Results classified by laboratory as “urgent” will be reported to physicians no later than the morning after the test is performed.

E. Results reporting

Laboratory must provide printers and/or terminals for reporting results versus courier only.

Medical transportation provider additional criteria

If you are a **medical transportation provider**, the following additional criteria apply:

A. Applicability

1. Provider must have a current, unrestricted state and/or federal license to operate as an ambulance provider.

B. Provider standards

1. Provider must guarantee that they:
 - a. Employ full-time, state-certified emergency medical technicians (EMTs), EMT intermediates and/or paramedics providing patient care

- b. Have licensed, inspected and state-certified medical transportation vehicles
- c. Ensure drivers are appropriately licensed and insured or carry appropriate insurance
- d. Have equipment and supplies appropriate to the required treatment modalities offered by provider
- e. Are accredited by the Commission on Accreditation of Medical Transport Systems, or other criteria as outlined by Aetna® credentialing standards

C. Provider requirements and availability of services

1. Provider must have a comprehensive service protocol and must provide the following services:
 - a. Emergency medical transport
 - b. Non-emergency medical transport, for example, basic life support (BLS) transports
 - c. Transfers that entail moving a member from one facility to another and may include, but are not limited to, oxygen and vitals monitoring
2. Provider must maintain adequate inventory of medical equipment and supplies to meet the needs of members.
3. Provider must have availability of its services 24/7.



Facility

Facility core participation and additional criteria

Facility core participation criteria

These criteria shall apply to each facility applicant for the duration of the agreement and shall be enforced at the sole discretion of Aetna®. Any exceptions to the business criteria must be approved in advance by Aetna.

A. Applicability

1. If applicable, each provider must complete a facility credentialing questionnaire and must periodically supply to Aetna all requested information.
2. All providers rendering services to members at facility must be participating. Facility should notify Aetna in writing within ten days of acquiring knowledge of additions or changes in a provider's status.
3. If applicable, facility must have an agreement with a participating hospital and medical transportation provider in place for the immediate transfer of patients.

B. Facility standards

Each facility must:

1. Have a visible sign displaying the facility's name.
2. Have all areas accessible to all members, including, but not limited to, the entrance, parking and bathroom.
3. Be clean, presentable and professional and prohibit smoking.
4. Have a clean, properly equipped and accessible patient toilet and hand-washing facility.
5. Have a waiting room sufficient to accommodate members.
6. Have an established process to ensure that medication room(s) and medical records are protected from public access.
7. Have a secure and confidential filing system.
8. Have written policies protecting member confidentiality, including the maintenance of medical records and verbal and electronic submission of their information.
9. Require a medical assistant to attend sensitive (for example, gynecological or adolescent) examinations, unless the member declines the assistant's presence.
10. Produce upon request evidence of current licenses for all physicians/providers/allied health professionals practicing in the facility, including: state professional license, federal DEA certification and state-controlled drug substance registration (where applicable).
11. Keep on file and make available to Aetna any state-required practice protocols or supervising agreements for allied health professionals practicing in the facility. This includes a requirement for notifying members if an allied health professional (for example, a physician assistant, an advanced practice nurse, a nurse practitioner, a nurse midwife) may provide care.
12. Have a robust infection control and prevention program that operates in accordance with nationally recognized standards (e.g., CDC), that includes provisions to report unexpected events and to have regular staff training on appropriate hand hygiene and injection safety protocols.
13. Have appropriate equipment immediately available for the treatment of medical emergencies. And facility must have documented medical emergency procedures addressing treatment, transportation and disaster evacuation plans for members' safety. Additionally, and facility must have generators to provide power in case of a power failure.
14. Ensure infrastructure and equipment maintain current certifications, indicating proper maintenance and calibration at regularly scheduled intervals to ensure operational safety and comply with any and all applicable standards, including OSHA fire safety standards and applicable federal, state and local fire safety laws and regulations.
15. Have an advance directive policy if applicable.
16. Furnish Aetna upon request any and all studies and reports, either copies or originals as specified by Aetna, for any and all examinations being conducted by Aetna.
17. Have a mechanism in place to ensure that all contracted technical and professional services related to the services offered by facility are available.
18. Have a quality assurance program, and shall provide upon request documentation of such program (for example, development of outpatient clinical pathways, monitoring of radiologic interpretation and monitoring of acute patient transport to the hospital).
19. Have a patient safety program that promotes effective standards and protocols for avoiding medication errors and preventing falls or physical injuries.
20. Have a quality improvement program and must track outcomes or trends to be used as a tool for quality improvement.
21. Ensure that all agency staff are trained regarding the facility's applicable policies and procedures to perform the duties of their position, have received appropriate health screening as required by the department of public health and have participated in continuing education and/or in-service in accordance with state or federal standards.
22. Have emergency equipment (advanced cardiac life support [ACLS] resuscitation equipment including defibrillator and materials necessary to perform endotracheal intubation and emergency ventilation), oxygen, cardiac monitoring capability, defibrillator, nebulizer, equipment for airway maintenance and the capability to administer non-narcotic medical therapy for the treatment of headaches if facility provides inpatient, urgent care or surgical care.
23. Have one BLS-trained and one ACLS health care practitioner onsite during the hours of operation and

until any member operated on that day is discharged if facility provides emergency inpatient, urgent care or surgical care.

24. Maintain appropriate Clinical Laboratory Improvement Amendments certification for lab equipment where applicable.

C. Access and availability of services

Each facility's business must:

1. Offer inpatient hours 24/7.
2. Offer outpatient hours sufficient to meet the appointment access standards including evenings and weekends. These standards include the following:
 - a. Urgent tests should be performed the same day.
 - b. Diagnostic tests should be performed within seven business days or within a time frame agreed by a referring physician.
 - c. Screening tests should be performed within 30 business days or within a time frame agreed by a referring physician.
 - d. Treatment should be initiated within a time frame agreeable by the referring physician. Facility must return treatment reports to referring physicians in a timely fashion.
 - e. The above may be modified from time to time at the sole discretion of Aetna®.
3. Have appropriate medical staff onsite, where applicable when treating patients. "Onsite" is defined as attached to or on the grounds of the facility.
4. Arrange for physician on call, emergency services and appropriate oversight of facility operations.
5. Agree to rely on the services of a company participating physician/specialist, laboratory and/or radiologic providers, if these services cannot be performed by the facility. An exception would be if this isn't feasible in an emergency.
6. Ensure that physicians, nurse practitioners and/or physician assistants with prescriptive authority prescribe medication according to Aetna formulary, when possible.

7. For workers' compensation members/patients, provide services within a reasonable time frame or, where applicable, within the time frame required by workers' compensation law.
8. Have provisions in place to address patient overflow.

D. Subcontractors

If a facility intends to subcontract some of its services under the agreement, the facility will provide Aetna with a list of all subcontractors intended to provide services to members. In all cases, where the facility subcontracts for any services under the agreement:

1. The facility represents and warrants that subcontractor(s) will abide by the provisions set forth in the agreement.
2. Aetna reserves the right to require a designation of payment schedule from all subcontractors in a form approved by Aetna. Facility indemnifies and holds Aetna and its members harmless for payment of all compensation owed to subcontractor(s) for services provided under the agreement.
3. Aetna's prior written approval is required if the facility intends to perform covered services through employees or agents, including a subcontractor, physically located outside of the United States.

E. Copies

Unless allowed by state law or regulatory requirement, the facility agrees not to charge members for copies of medical records/reports or to require deposits for the release of these copies to members.

F. Insurance

Provider will maintain general and professional liability and other insurance according to state requirements. If there are no specific state requirements, then the amount should be what is typically maintained by providers in your state or region.

The insurance coverage will cover provider and its/their agents and employees.

Provider will give Aetna proof of insurance coverage upon request.

Provider must give company at least thirty (30) days' advance notice of any cancellation or material changes to these policies, and must post notice of malpractice insurance (existing, cancellation or exemption) in a prominent location in the office.

Diagnostic radiology facility additional criteria

If you are a **diagnostic radiology facility**, the following additional criteria apply:

A. Access and availability of services

1. A radiologist shall provide readings of all imaging studies and provide result notification to the primary care physician and/or other referring physician according to the following standards:
 - a. Urgent — within 30 minutes of the completion of the imaging study in those cases that are deemed urgent by the primary care physician and/or other referring physician
 - b. Diagnostic tests — within one business day of the completion of the imaging study
 - c. Screening tests — within seven business days of the completion of the imaging study

B. Licensure, accreditation and certification

1. Facility accreditation:

General

All independent diagnostic radiology centers that are freestanding or office based must be accredited by either the American College of Radiology (ACR) or the Intersocietal Accreditation Commission. The following imaging procedures are subject to accreditation for Medicare providers: magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computed tomography (CT), positron emission tomography (PET), nuclear medicine, nuclear cardiology and echocardiography.

Aetna® defines advanced diagnostic imaging procedures as MRI, MRA, CT, echocardiograms, nuclear cardiology and nuclear medicine imaging, such as PET and single photon emission computed tomography (SPECT). This definition excludes X-ray, ultrasound, fluoroscopy and mammography.

Mammography

Mammography facilities must be certified by the FDA, according to the requirements of the Mammography Quality Standards Act. This includes all facilities, both fixed and mobile, whether they are performing screening or diagnostic procedures. For a facility to be certified, it must have all its mammography units certified. The facility must submit a copy of its current FDA certificate to Aetna upon request.

Ultrasound

Facilities performing complete obstetrical ultrasounds must be certified by either the ACR or the American Institute of Ultrasound in Medicine. Proof of such certification must be supplied to Aetna upon request.

MRI/MRA

Facilities performing MRI and/or MRA studies must be accredited under the ACR Magnetic Resonance Accreditation Program or a comparable accreditation program as approved by Aetna. Proof of accreditation must be supplied to Aetna upon request.

2. Professional certification:

Physician

Each radiologist at the facility who provides services to members must be board-certified by either the American Board of Radiology (ABR) or the American Osteopathic Board of Radiology (AOBR).

Technologist

All technologists must be registered by the American Registry of Radiological Technicians or other appropriate registry, such as the Nuclear Medicine Technology Certification Board and licensed by the state where they work.

3. Equipment certification:

All radiology equipment must be certified by the Bureau of Radiological Health (or other appropriate state licensing board[s]) onsite and be available for inspection by Aetna representatives. When requested by Aetna, the facility agrees to an inspection by a recognized expert, mutually acceptable to the facility and company and to arbitrate when conflicts and questions about any equipment specifications and/or performance arise.

Dialysis facility additional criteria

If you are a **dialysis facility**, the following additional criteria apply:

A. Professional criteria:

1. The facility must have a medical director board-certified by the American Board of Medical Specialties or the American Osteopathic Association in internal medicine or pediatrics with subspecialty training or certificate in nephrology or board certification in nephrology.
2. On-call medical director must have privileges at a participating hospital.

Freestanding emergency room facility additional criteria (applicable to the State of Texas only)

If you are a **freestanding emergency room facility**, the following additional criteria apply:

A. Applicability

1. Facility will comply with all requirements contained in Chapter 254 of the Texas Health and Safety Code, and 25 Texas Administrative Code, Chapter 131, regarding freestanding emergency medical care facilities.
2. Facility must have a licensed physician to act as medical director. The medical director shall be responsible for:
 - a. Overseeing the clinical aspects of care
 - b. Reviewing or ensuring the review, by appropriate clinical personnel, of all abnormal laboratory and/or radiology results, and for ensuring that such results are followed up on as appropriate
 - c. Directing any follow-up communications, as appropriate, after care is rendered, back to the primary caregiver where identified
 - d. Documenting, implementing and maintaining policies and procedures to protect member confidentiality
 - e. Overseeing the quality assurance program, which includes primary verification of unencumbered state licenses of all physicians and allied health care professionals employed by the facility
 - f. Ensuring transfer protocols for patients requiring advanced care at a hospital are in place
3. Facility may employ part-time physicians, who work under the direction of the medical director, to staff the facility. However, each physician, nurse practitioner and physician assistant must have an active state professional license that is unencumbered. And each physician, nurse practitioner and physician assistant with prescriptive authority must have an unencumbered individual DEA provider number. A medical education temporary DEA will not be acceptable.
4. Facility shall guarantee that a licensed physician is onsite for all hours the facility is open. A physician must supervise nurse practitioners or physician assistants where state does not allow for independent practice by licensed nurse practitioners or physician assistants.

B. Facility/provider standards

Facility must have a gynecology table and equipment for pelvic exams for acute conditions.

C. Facility/provider access and availability of services

Hours of operation — facility shall provide emergency services in continuous operation, 24/7.

D. Facility/provider scope of services

They shall provide urgent office services, stat laboratory and plain X-ray film services, minor surgical procedures, closed treatment of fractures as is clinically prudent, injectables (as clinically indicated).

They must not provide routine/preventive care, follow-up care from a recent visit to the facility, physical therapy, elective surgical procedures, routine immunizations or flu shots, and laboratory and radiologic exams that are not associated with the treatment of an acute illness.

Instead, direct individuals to their usual source of medical care or other appropriate source of ongoing medical care for any additional care for their condition.

Seek the consent of everyone receiving care to forward a complete report of the services delivered to the individual's usual source of medical care.

Forward a complete report within 24 hours of rendering services to the ordering practitioner for each individual who received care.

MRI facility additional criteria

If you are an **MRI facility**, the following additional criteria apply:

A. Facility standards

Facility must demonstrate the ability to diminish a member's test anxiety (for example, special glasses or music to prevent member from feeling claustrophobic).

B. Access and availability of services

1. A radiologist will provide readings of all imaging studies and will notify the primary care physician or other referring physician according to the following standards:
 - a. Urgent — within 30 minutes of the completion of the imaging study in those cases that are deemed urgent by the primary care physician and/or referring physician
 - b. Diagnostic tests — within one business day of the imaging study completion
 - c. Screening tests — within seven business days of the imaging study completion

C. Licensure, accreditation and certification

1. Facility accreditation:

General

Facilities performing MRI and/or MRA studies must be accredited under the ACR Magnetic Resonance Accreditation Program or a comparable accreditation program as approved by Aetna®. The facility must provide proof of the accreditation to Aetna upon request.

Facility will submit information or verification of their accreditation status through the ACR MRI Accreditation Program. If not accredited, the facility will submit equipment information as requested by Aetna, including but not limited to the manufacturer, field strength and software versions, for all MRI/MRA equipment used. The facility must supply information or accreditation to Aetna upon request.

Facilities providing advanced imaging procedures must be accredited by either the ACR or Intersocietal Accreditation Commission for advanced imaging services. The following imaging procedures are subject to accreditation for Medicare providers:

- CT
- MRI, PET
- Nuclear medicine, nuclear cardiology and echocardiography

Aetna defines advanced diagnostic imaging procedures as MRI, MRA, CT, echocardiograms, nuclear cardiology and nuclear medicine imaging, such as PET and SPECT. This definition excludes X-ray, ultrasound, fluoroscopy and mammography.

2. Professional accreditation:

Physicians

All physicians interpreting MRI examinations and technologists must fulfill all the criteria established by the ACR as part of the ACR MRI Accreditation Program. Each radiologist who provides services to members must be board-certified by either the ABR or the AOBR.

Technologists

All technologists must be registered by the American Registry of Radiological Technicians and licensed by the state where they work.

Equipment certification

All radiology equipment must be certified by the Bureau of Radiological Health (or other appropriate state licensing board[s]) onsite and be available for inspection by Aetna representatives. At the company's request, the facility will agree to an inspection by a recognized expert. The expert will be mutually acceptable to the facility and company. The expert will also arbitrate when conflicts and questions arise about any equipment specifications and/or performance.

Nuclear cardiology/exercise echocardiogram facility additional criteria

If you are a **nuclear cardiology/exercise echocardiogram facility**, the following additional criteria apply:

A. Facility/provider requirements

1. Each cardiologist providing services to members must be board-certified by the American Board of Nuclear Medicine, the American Board of Internal Medicine, American Osteopathic Association or the ABR.
2. The cardiologists working in the facility must have documented evidence of having recognized expertise in nuclear cardiology and exercise echocardiogram.
3. The cardiologists working in the facility must be able to provide a full range of nuclear cardiology and diagnostic exercise echocardiogram services as defined by Aetna.
4. All technicians must have basic cardiac life support certification. All cardiologists must have ACLS certification.
5. All exercise echocardiogram technicians must be registered by the American Society for Echocardiography and licensed by the state (if applicable) where they work.
6. All nuclear cardiology technicians must be registered by the Nuclear Medicine Technology Certification Board for nuclear cardiology and licensed by the state (if applicable) where they work.
7. Exercise echocardiogram — The facility must have a dedicated software package and equipment for comprehensive exercise echocardiograms. Where applicable, the facility agrees to inspection by a recognized expert mutually acceptable to the facility and Aetna. The facility also agrees to arbitrate when conflicts and/or questions arise about the facility's equipment specifications and/or performance.

8. Nuclear cardiology — The facility and all its nuclear cardiology equipment must have a current license or approval from the Nuclear Regulatory Commission (and any other appropriate licensing board[s]) onsite and available at all times for inspection by company representatives. When applicable, the facility agrees to inspection by a recognized expert mutually acceptable to facility and company and to arbitrate when conflicts and questions arise about facility's equipment specifications and/or performance.

B. Access and availability of services

A cardiologist must always be available during the facility's hours of operation and onsite while members are undergoing examinations.

Physical therapy, occupational therapy, speech pathology and speech therapy facility additional criteria

If you are a **physical therapy, occupational therapy, speech pathology and speech therapy facility**, the following additional criteria apply:

A. Facility/provider standards

1. The facility must have dedicated space for physical therapy and rehabilitation services.

B. Facility/provider requirements

1. Facility must possess equipment adequate for the provision and administration of all therapy treatment according to professional standards (for example, modality treatments, resistive exercises and objective strength testing of trunk and/or lower extremities).
2. Unless state law or regulation allows for a greater ratio, the therapist to assistant staff ratio must not exceed 1:2.
3. Facility must provide an initial report and a multidisciplinary care plan to the referring provider and/or primary care physician within seven days of member starting treatment at the facility. And must continue to update those reports at appropriate intervals.

C. Access and availability of services

1. Facility will provide a minimum of 20 office hours per week.

Radiation oncology facility additional criteria

If you are a **radiation oncology facility**, the following additional criteria apply:

A. Applicability

Each radiation oncologist providing services to members must be board-certified in radiation oncology or therapeutic radiology by the ABR or board eligible.

B. Facility/provider standards

The ratio of physicians to patients treated annually must not exceed 1 to 250.

C. Facility/provider requirements

1. Facility must possess two or more megavoltage units, with at least one having electron capability. A single unit facility is acceptable if it possesses electron capability and has arrangements with another center in case of an equipment breakdown.
2. Facility must possess one simulator with fluoroscopic capability if applicable. A simulator located at a subcontracted provider need not possess fluoroscopic capability, as long as this capability is available to members at one of the facility's other locations.
3. Facility must possess a full array of encapsulated brachytherapy sources compatible with the delivery of modern intracavitary and interstitial irradiation. Or arrange for referral to appropriate facilities. (They're not required to have a full array of sources. They may have either low-dose-rate or high-dose-rate capability.)
4. Onsite computer treatment planning for photons and electron therapy must be available.
5. Facility is and will remain accredited by the American College of Radiology or the American College of Radiation Oncology or the American Society for Radiation Oncology APEX.
6. Facility must be staffed with two or more radiation oncologists, one of whom must be certified in radiation oncology by the ABR and the other must have completed a radiation oncology residency program. Facility must notify Aetna® if the board-eligible physician does not receive board certification within time frames established by the ABR.
7. Each facility must be staffed by one radiation physicist. Additional physicists should be retained for every 400 patients treated annually. All physicists must be at no less than a master's degree level and at least one physicist must be certified by the ABR (therapeutic radiological physics) or the American Association of Physics in Medicine. The consulting

physicist must be certified by the ABR (therapeutic radiological physics) or the American Association of Physics in Medicine.

8. Facility must provide one certified treatment-planning dosimetrist per 300 patients treated annually.
9. Facility must employ one full-time supervising technologist and two to three technologists per megavoltage unit for every 40 patients treated per unit per day. Or four to six technologists per megavoltage unit for every 60 patients treated per unit per day. In addition, one to two technologists per simulator are required. All technologists must be certified by the American Society of Radiologic Technologists (radiation therapy technologist) within two years of completing their formal education. At least one certified technologist must be present during all patient treatments. Subcontracted providers must have two to three technologists per megavoltage unit and need only to have one certified technologist always present.
10. Facility must employ at least one bachelor's-level nurse and one registered nurse or licensed practical nurse for every 300 patients treated annually.

D. Access and availability of services

A radiation oncologist must always be onsite when patients are being treated. Onsite means attached to or on the grounds of the radiation oncology facility.

Rehabilitation facility additional criteria

If you are a **rehabilitation facility**, the following additional criteria apply:

A. Facility standards

1. Facility must have dedicated space for physical therapy and rehabilitation services.

B. Facility requirements

1. Facility must provide an initial report and a multidisciplinary care plan to the referring provider and/or primary care physician within seven days of a member starting treatment at the facility. And must continue to update those reports at appropriate intervals.
2. Facility must possess equipment adequate for the provision and administration of therapy treatments (for example, modality treatments, resistive exercises and objective strength testing of trunk and/or lower extremities).
3. The therapist to assistant staff ratio must not exceed 1:2.

C. Access and availability of services

1. Facility will provide a minimum of 20 office hours a week.

Urgent care center facility additional criteria

If you are an **urgent care facility**, the following additional criteria apply:

A. Applicability

1. Facility must have a licensed physician to act as medical director. The medical director will be responsible for:
 - a. Overseeing the clinical aspects of care.
 - b. Reviewing or ensuring the review, by appropriate clinical personnel, of all abnormal laboratory and/or radiology results and any other diagnostic tests performed (for example, electrocardiogram [EKG]), and for ensuring that such results are followed up on as appropriate.
 - c. Directing any follow-up communications, as appropriate, after care is rendered, back to the primary caregiver where identified.
 - d. Documenting, implementing and maintaining policies and procedures to protect member confidentiality.
 - e. Overseeing the quality assurance program. This includes primary verification of current unencumbered state licenses of all physicians and allied health care professionals employed by the facility.
2. Facility may employ part-time physicians, who work under the direction of the medical director, to staff the facility. However, each physician, nurse practitioner and physician assistant must have an active state professional license that is unencumbered. And each physician, nurse practitioner and physician assistant with prescriptive authority must have an unencumbered individual DEA provider number (a medical education temporary DEA will not be acceptable).
3. Facility guarantees that a licensed physician is onsite when the facility is open. A physician must supervise nurse practitioners or physician assistants where state does not allow for independent practice by licensed nurse practitioners or physician assistants.

B. Facility/provider standards

Facility must have a gynecology table and equipment for pelvic exams for acute conditions.

C. Access and availability of services

Hours of operation — facility must provide urgent care services at least eight hours a day, Monday through Friday, with a minimum of two hours a day after 6 p.m. Facility must also provide urgent care services at least eight hours a day, Saturday and Sunday.

D. Scope of services

Facility will provide urgent office services, stat laboratory and plain X-ray film services, minor surgical procedures, closed treatment of fractures as is clinically prudent, injectables (as clinically indicated).

Facility agrees not to provide routine/preventive care, follow-up care from a recent visit to the facility, physical therapy, elective surgical procedures, routine immunizations or flu shots, and laboratory and radiologic exams not associated with the treatment of an acute illness.

Facility will direct individuals to whom care is delivered to their usual source of medical care or other appropriate source of ongoing medical care for further care for the condition needing treatment.

Facility will seek the consent of everyone who receives care so it can forward a complete report of the services delivered to that person's usual source of medical care.

Facility will forward a complete report within 24 hours of rendering services to the ordering practitioner for everyone who receives care.

Voluntary Interruption of Pregnancy (VIP) facility additional criteria

If you are a **VIP facility**, the following additional criteria apply:

A. Facility requirements

1. Requirements for the physician:

- a. Pre-pregnancy-termination counseling by a physician or trained counselor will be mandatory and include a full discussion of all options.
- b. Physicians may only perform terminations of pregnancy in the category of their training.
 - (1) For procedures up to 12 weeks, all gynecologists may perform them.
 - (2) For procedures between 13 and 16 weeks, special expertise is needed.
 - (3) For procedures between 17 and 24 weeks, special expertise is needed.
 - (4) There is a 16-week maximum for in-office pregnancy terminations unless a medical director makes specific exceptions on a case-by-case basis.

- c. The physician must be aware of contraindications to outpatient pregnancy terminations. The physician must personally take a history from the member before the procedure and be sure that the member is a good candidate for the procedure.
- d. The physician must be aware of the possible complications of pregnancy terminations and be prepared to deal with them.
- e. An ultrasound must be performed in all pregnancies ≥ 12 weeks amenorrhea prior to the procedure to confirm dating. An ultrasound may be done in early pregnancy to exclude ectopic pregnancy if clinically indicated.
- f. For physicians who perform terminations of pregnancy in their office, local anesthesia is recommended as the sole type of anesthesia for the member when the physician works on his or her own. If a nurse anesthetist or anesthesiologist is present, with proper monitoring instruments, it is permissible to give general anesthesia in the office.
- g. All specimens should be examined by the physician. All tissue < 7 weeks gestation must be sent to a participating laboratory for pathologic diagnosis for confirmation of intrauterine pregnancy. If the physician is certain that the products of conception have been totally removed from the uterus, and notes on the chart that the physician has physically examined the products, this is appropriate and adequate.
- h. Written follow-up instructions must be given to each patient.
- i. A post-operative follow-up visit with a gynecologist or primary care physician must be scheduled at the time of the procedure.
- j. Facility must obtain and document a signed, informed consent from the member before starting the procedure.
- k. Facility must determine patient's Hgb or hematocrit and Rh type. Members who are Rh negative must receive RhoGAM after the procedures unless they have documented Rh sensitization.
- l. Proof of pregnancy must be established by the physician by lab procedures or ultrasound before the procedure is done.
- m. Facility must require the member to have an escort when leaving the facility.

Walk-in clinic facility additional criteria

If you are a **walk-in clinic facility**, the following additional criteria apply:

A. Applicability

1. Facility must have a licensed physician to act as medical director. The medical director is responsible for:
 - a. Overseeing the clinical aspects of care.
 - b. Reviewing or ensuring the review by appropriate clinical personnel, of all abnormal laboratory and/or radiology results. And for ensuring these results are followed up on as appropriate.
 - c. Directing any follow-up communications, as appropriate, after giving care, to the primary care physician where identified.
 - d. Documenting, implementing and maintaining policies and procedures to protect member confidentiality.
 - e. Overseeing the facility's quality assurance program, which includes primary verification of current unencumbered state licenses of all physicians and allied health care professionals employed.
2. Facility must ensure that the medical director has an unrestricted DEA and nurse practitioners and physician assistants have category II pharmacy licenses.
3. Where required by state law, the facility must be entered into an appropriate supervisory or professional relationship agreement with a physician and/or have adopted practice protocols. Any state-required collaborative or consultative agreements must be filed with the appropriate state regulatory agency.
4. Facility must have established policies and procedures governing all aspects of the delivery of medical care at each location where care is delivered. Such policies and procedures will:
 - a. Be written and available at all times in each location where care is delivered
 - b. Include standards for medical record keeping and filing
 - c. Include diagnostic and treatment algorithms and guidelines applicable to the majority of conditions for which care is rendered

B. Access and availability of services

Hours of operation — the facility must provide services at least eight hours a day, Monday through Friday, with a minimum of two hours a day after 6 p.m. The facility must also provide services on Saturday and Sunday.

Office visits must not be scheduled more than one hour after initial contact with the individual seeking care.

C. Scope of services

Services shall not include follow-up care from a recent visit to the facility, physical therapy, elective surgical procedures, or laboratory and radiologic exams that aren't associated with the treatment of an acute illness.

The facility may provide urgent office services, stat laboratory, routine symptomatic/preventative services and immunizations, minor surgical procedures, closed treatment of fractures as is clinically prudent, injectables (as clinically indicated).

The facility will direct individuals getting care to their usual source of medical care or other appropriate source of ongoing medical care for any further care for the condition that was treated.

The facility will seek the consent of everyone getting care to forward a complete report of the services delivered to their usual source of medical care.

The facility will forward a complete report within 24 hours of rendering services to the ordering practitioner for everyone who receives care.



Physician, including nurse practitioner and physician assistant

Physician core participation criteria and additional criteria

Physician core criteria

These criteria, in addition to physician specific criteria, apply to each physician and the practice for the duration of the agreement. They will be enforced at the sole discretion of Aetna®. Any exceptions to the business criteria must be approved in advance by the company.

A. Applicability

1. All physicians in a group practice must satisfy these participation criteria. If not, the group cannot participate.
2. As applicable, the physician applicant must be certified either by the American Board of Medical Specialties, the American Osteopathic Association or by an Aetna-recognized certifying board, unless the applicant meets an exception under Aetna's policy. Any exceptions must be approved by the Aetna medical director or designee.
3. The physician must complete an application and periodically supply to Aetna all requested information.

B. Office standards (for physicians who maintain offices)

Each physician's medical office must:

1. Have a visible sign listing the names and titles of all physicians and allied health professionals practicing there.
2. Have all areas accessible to all members, including, but not limited to its entrance, parking lot and bathroom.
3. Be clean, presentable and professional and prohibit smoking.
4. Have a clean, properly equipped and accessible patient toilet and hand-washing facility.
5. Have a waiting room sufficient to accommodate members.
6. Have at least two examining rooms that are clean, properly equipped and private.
7. If immunization services are offered, follow the vaccine safety and refrigeration guidelines in the U.S. Centers for Disease Control (CDC) Vaccine Storage

and Handling Toolkit. Go to **[CDC.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf](https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf)** to download it.

8. Have a robust infection control and prevention program that operates in accordance with nationally recognized standards (e.g., CDC), that includes provisions to report unexpected events and to have regular staff training on appropriate hand hygiene and injection safety protocols.
9. Keep controlled substances in locked cabinets.
10. Have an office assistant in office during scheduled hours.
11. Require a medical assistant to attend specialized (for example, gynecological) examinations, unless the member declines the assistant's presence.
12. Have appropriate protocol immediately available to treat medical emergencies. And must have documented medical emergency procedures addressing treatment, transportation and disaster evacuation plans for the safety of members. Additionally, office must have generators to provide power in case of a power failure, when appropriate. For example, offices that perform procedures, store biologics or supplies of vaccines.

C. Business standards

Physician must:

1. Have a quality assurance program and provide, upon request, documentation of such program.
2. Have a secure and confidential filing system.
3. Have written policies protecting member confidentiality, including the maintenance of medical records and verbal and electronic submission of their information.
4. Have written policies addressing documentation about advance directives (whether executed or not) in member's record (except for under age 18).
5. Have an established process to ensure that medical records are protected from public access.

6. Maintain evidence of current licenses for all physicians/allied health professionals practicing in the office, including state professional license, federal DEA certification and state controlled drug substance registration (where applicable).
7. Keep on file and make available to Aetna® any state-required practice protocols or supervising agreements for allied health professionals practicing in the office. This includes a requirement to notify members if an allied health professional (for example, a physician assistant, an advanced practice nurse, a nurse practitioner, a nurse midwife) may provide care.
8. Designate by age, according to Aetna guidelines, members for whom physician will provide care.

D. Access and availability of services

Each physician's medical office must meet the following criteria:

1. Office must offer a reliable way for members and other health care professionals to be reached 24/7.
2. Office must have a process in place for responding to a member within 30 minutes after notification of an urgent call.
3. Office must ensure that they provide coverage for members 24/7, or else arrange for coverage with another Aetna participating physician.
 - a. For outpatient services, a covering physician's office must be geographically accessible and consistent with local community patterns of care for the area to help ensure that a member does not have to travel more than 30 minutes from the member's regular physician's office to get help from the covering physician.
4. For workers' compensation members/patients, provide services within a reasonable time frame or, where applicable, within the time frame required by workers' compensation law.
5. If applicable, physician must inform member and follow program guidelines in the Beginning Right® maternity program or other company-designated maternity program if the member has the benefit.
6. Each physician must have admitting privileges at a participating hospital or coverage must be arranged with a participating physician who has privileges at a participating hospital.
7. To use participating providers as required in the agreement.

E. Subcontractors

To the extent the physician/physician group intends to subcontract some of its services under the agreement, the physician/physician group will provide Aetna with a list of all subcontractors intended to provide physician services to members. In all circumstances, where physician/physician group subcontracts for any services under the agreement:

1. Physician/physician group represents and warrants that subcontractor(s) will abide by the provisions set forth in the agreement.
2. Company reserves the right to require a designation of payment schedule from all subcontractors in a form approved by Aetna. Physician/physician group will indemnify and hold the company and its members harmless for payment of all compensation owed subcontractor for services provided under the agreement.
3. Aetna's prior written approval is required if the physician/physician group intends to perform covered services through employees or agents, including a subcontractor, physically located outside of the United States of America.

F. Copies

Unless allowed by state law or regulatory requirement, the physician/physician group agrees not to charge members for copies of medical records/reports or to require deposits for the release of these copies to members.

G. Insurance

Provider will maintain general and professional liability and other insurance according to state requirements. If there are no specific state requirements, then the amount should be what is typically maintained by providers in your state or region.

The insurance coverage will cover provider and its/their agents and employees.

Provider will give Aetna proof of insurance coverage upon request.

Provider must give company at least thirty (30) days' advance notice of any cancellation or material changes to these policies, and must post notice of malpractice insurance (existing, cancellation or exemption) in a prominent location in the office.

H. Professional competence and conduct criteria

1. Physician must not have an unsatisfactory professional liability claims history, including, but not limited to, lawsuits, arbitration, mediation, settlements or judgments. And must not have

engaged in any unprofessional conduct, unacceptable business practices or any other act or omission and must not have a history of involuntary termination (or voluntary termination during or in anticipation of an investigation or dismissal) of employment or any other sort of engagement as a health care professional, of reduction or restriction of duties or privileges, or of a contract to provide health care services, which, in the view of the committee and/or applicable peer review committee, may raise concerns about possible future substandard professional performance, competence or conduct.

2. In the case of an encumbered license, the applicant demonstrates to the applicable peer review committee's satisfaction that encumbered license does not raise concern about possible future substandard professional performance, competence or conduct.

I. References

1. Physician must supply professional references as requested by the applicable Aetna® peer review committee.
2. The applicable Aetna peer review committee will have the right to act on any reference or information received from a physician's colleagues. Physician waives any and all rights to bring any legal action relating to such information or the collection or use thereof against Aetna; any affiliates or related companies or any director, officer, employee or agent thereof; or any person or entity providing a reference or information at the request of the applicable company peer review committee.

Nurse practitioner serving as a primary care physician additional criteria

If you are a **nurse practitioner serving as a primary care physician and available for member selection, also known as primary care nurse practitioner**, the following additional criteria apply:

A. Applicability

1. A primary care nurse practitioner must:
 - a. Be a registered nurse
 - b. Have a minimum of a master's degree in nursing
 - c. Have received post-graduate or graduate education designed to prepare the provider in the primary care specialty area to which the provider is applying

- d. Be board-certified by an agency recognized by the state in which they practice or by an Aetna-approved accrediting agency and state approved to practice in the role of primary care as an advanced practice registered nurse

If required by the state, the primary care nurse practitioner must have a supervising/collaborating/consulting physician agreement. This agreement must be with an Aetna participating primary care physician who is board-certified and agrees to maintain the supervising/collaborating/consulting physician agreement, or a replacement thereof, during the entire term of the agreement. Upon Aetna's request, the primary care nurse practitioner must be able to submit supporting documentation from a participating network physician demonstrating the supervisory/collaborative/consultative agreement in any aspects of primary care nurse practitioner practice. The documentation must address, but is not limited to:

- a. A supervisory/collaborative/consultative agreement for any state-required prescription supervision
 - b. A supervisory/collaborative/consultative agreement for any state-required collaboration on practice
 - c. A supervisory/collaborative/consultative agreement, as applicable, for provision of hospital admitting backup
 - d. Agreement to hold member harmless for any physician collaboration fees and services
 - e. Agreement to be available 24/7
 - f. Physical proximity and availability by electronic means between the nurse practitioner's office and supervising/collaborating/consulting physician's office as required by state
3. Primary care nurse practitioner must notify Aetna immediately upon termination of a supervisory/collaborative/consultative arrangement by either party.
 4. Primary care nurse practitioner must notify Aetna within ten business days of a known change in a supervisory/collaborative/consultative arrangement by either party.

B. Access and availability of services

1. Each primary care nurse practitioner's medical office must, throughout the term of participation with Aetna, have at least one primary care nurse practitioner for

every 3,000 active patients. This means those patients seen within the past two years.

2. Each primary care nurse practitioner's medical office must have a minimum of 20 regularly scheduled office hours to treat patients over at least four days a week (whether members or other patients). With respect to Missouri, exceptions to these standards will be allowed if primary care physician's medical office is in an underserved area.
3. If a primary care nurse practitioner has more than one office participating with Aetna®, then the primary care nurse practitioner must have a minimum of 20 regularly scheduled office hours to treat patients in each location over at least four days a week. With respect to Missouri, exceptions to these standards will be allowed if primary care provider's medical office is in an underserved area.
4. Each primary care nurse practitioner must schedule appointments with members within the following time frames:
 - a. Emergency care: must be seen immediately (or referred to emergency room, as appropriate)
 - b. Urgent complaint: same day or within 24 hours
 - c. Symptomatic/nonurgent acute complaint (for example, sore throat): within three days
 - d. Routine care: within seven days
 - e. Preventive routine care: within four weeks
 - f. Follow-up visit: within two weeks

C. Office procedures

Primary care nurse practitioner must provide or use the following in the office:

1. Primary care nurse practitioner performs EKGs (except for pediatric age limit — newborn through age 17).
2. Primary care nurse practitioner performs pelvic exams for acute conditions in all offices caring for women who are members and older than 17.
3. Primary care nurse practitioner administers routine immunizations.
4. For hematocrits and hemoglobin (peds only), "finger sticks" are performed within office.

Nurse practitioner serving as a specialist, also known as specialist nurse provider, additional criteria

If you are a **nurse practitioner serving as a specialist, also known as specialist nurse provider**, the following additional criteria apply:

A. Applicability

1. A specialist nurse practitioner must:
 - a. Be a registered nurse
 - b. Have a minimum of a master's degree in nursing
 - c. Have received post-graduate or graduate education designed to prepare the provider in the primary care specialty area to which the provider is applying
 - d. Be board-certified by an agency as recognized by the state in which they practice or by an Aetna-approved accrediting agency and state approved to practice in the role of an advanced practice registered nurse
2. If required by the state, the specialist nurse practitioner must have a supervising/collaborating/consulting physician agreement. This agreement must be with an Aetna participating physician who is board-certified and agrees to maintain the supervising/collaborating/consulting physician agreement, or a replacement thereof, during the entire term of the agreement. Upon Aetna's request, specialist nurse practitioner must be able to submit supporting documentation from a participating network physician demonstrating the supervisory/collaborative/consultative agreement in any aspects of specialist nurse practitioner practice. The documentation must address but is not limited to:
 - a. A supervisory/collaborative/consultative agreement for any state-required prescription supervision
 - b. A supervisory/collaborative/consultative agreement for any state-required collaboration on practice
 - c. A supervisory/collaborative/consultative agreement, as applicable, for provision of hospital admitting backup
 - d. Agreement to hold member harmless for any physician/practitioner collaboration fees and services
 - e. Agreement to be available 24/7

- f. Physical proximity and availability by electronic means between the specialist nurse practitioner's office and supervising/collaborating/consulting physician's office as required by state
- 3. Specialist nurse practitioner must notify Aetna® immediately upon termination of a supervisory/collaborative/consultative arrangement by either party.
- 4. Specialist nurse practitioner must notify Aetna within ten business days of a known change in a supervisory/collaborative/consultative arrangement by either party.

B. Access and availability of services

- 1. Specialist nurse practitioner will be available at least an average of 20 hours a week for scheduling office appointments.

Physician assistant additional criteria

If you are a **physician assistant serving as a primary care physician**, the following additional criteria apply:

A. Applicability

- 1. A physician assistant must:
 - a. Be a registered physician assistant
 - b. Have a bachelor's or master's degree designed to prepare the provider in the primary care specialty area to which the provider is applying
 - c. Have a certificate of completion following training
 - d. Be board-certified by a certifying agency recognized by the state in which they practice or by Aetna
 - e. Be approved by the state to practice as a primary care physician
- 2. If required by the state, the physician assistant must have a supervising/collaborating/consulting physician agreement. This agreement must be with an Aetna participating primary care physician who is board-certified and agrees to maintain the supervising/collaborating/consulting physician agreement, or a replacement thereof, during the entire term of the agreement. Upon Aetna's request, the physician assistant must be able to submit supporting documentation from a participating network physician demonstrating the supervisory/collaborative/consultative agreement in any aspects of physician assistant practice. The documentation must address

but is not limited to:

- a. A supervisory/collaborative/consultative agreement for any state-required prescription supervision
- b. A supervisory/collaborative/consultative agreement for any state-required collaboration on practice
- c. A supervisory/collaborative/consultative agreement, as applicable, for provision of hospital admitting backup
- d. Agreement to hold member harmless for any physician collaboration fees and services
- e. Agreement to be available 24/7
- f. Physical proximity and availability by electronic means between the physician assistant's office and supervising/collaborating/consulting physician's office as required by state

- 3. Physician assistant must notify Aetna immediately upon termination of a supervisory/collaborative/consultative arrangement by either party.
- 4. Physician assistant must notify Aetna within ten business days of a known change in a supervisory/collaborative/consultative arrangement by either party.

B. Access and availability of services

- 1. Each physician assistant medical office must, throughout the term of participation with Aetna, have at least one physician for every 3,000 active patients. This means those patients seen within the past two years.
- 2. Each physician assistant's medical office must have a minimum of 20 regularly scheduled office hours to treat patients (whether members or other patients) over at least four days a week. With respect to Missouri, exceptions to these standards will be allowed if primary care provider's medical office is in an underserved area.
- 3. If a physician assistant has more than one office participating with Aetna, then the physician assistant must have a minimum of 20 regularly scheduled office hours over at least four days a week to treat patients in each location. With respect to Missouri, exceptions to these standards will be allowed if primary care provider's medical office is in an underserved area.

4. Each physician assistant must schedule appointments with members within the following time frames:
 - a. Emergency care: must be seen immediately (or referred to emergency room, as appropriate)
 - b. Urgent complaint: same day or within 24 hours
 - c. Symptomatic/nonurgent acute complaint (for example, sore throat): within three days
 - d. Routine care: within seven days
 - e. Preventive routine care: within four weeks
 - f. Follow-up visit: within two weeks

C. Office procedures

Physician assistant must provide or use the following in the office:

1. Physician assistant performs EKGs (except for pediatric age limit — newborn through age 17).
2. Physician assistant performs pelvic exams for acute conditions in all offices caring for women who are members and older than 17.
3. Physician assistant administers age-appropriate routine immunizations.
4. For hematocrits and hemoglobin (peds only), “finger sticks” are performed within office.

Primary care provider additional criteria

If you are a physician serving as a primary care physician, the following additional criteria apply:

A. Access and availability of services

1. Each primary care physician medical office must, throughout the term of participation with the company, have at least one primary care physician for every 3,000 active patients. This means those patients seen within the past two years.
2. Each primary care physician medical office must have a minimum of 20 regularly scheduled office hours over at least four days a week to treat patients (whether members or other patients).
3. If primary care physician has more than one office participating with Aetna®, then the primary care physician must have a minimum of 20 regularly scheduled office hours over at least four days a week to treat patients in each location.
4. Each primary care physician must schedule appointments with members within the following time frames:

- a. Emergency care: must be seen immediately (or referred to emergency room, as appropriate)
- b. Urgent complaint: same day or within 24 hours
- c. Symptomatic/nonurgent acute complaint: within three days (for example, sore throat)
- d. Regular and routine care: within seven days
- e. Preventive routine care: within eight weeks or as required by applicable state law
- f. Follow-up visit: within two weeks

B. Office procedures

Physician must provide or use the following in the office:

1. Primary care physician performs EKGs (except for pediatric age limit — newborn through age 17).
2. Primary care physician performs pelvic exams for acute conditions in all offices caring for women who are members and older than 17.
3. Primary care physician administers age-appropriate routine immunizations.
4. Pediatric hematocrit and hemoglobin “finger sticks” are performed within office.

Specialist (physician) provider additional criteria

If you are a **specialist (physician)**, the following additional criteria apply:

A. Access and availability of services

1. Specialist physician will be available at least an average of eight hours a week for scheduling office appointments.
2. Accreditation as an office-based surgical facility is not sufficient for separate payment of facility fees or related surgical charges.
3. When applicable, specialist physician will provide readings of all imaging studies and notify the primary care physician or other referring physician according to the following standards:
 - a. Urgent: within 30 minutes of completing the imaging study in cases deemed urgent by the primary care physician and/or referring physician
 - b. Diagnostic tests: within one business day of completing the imaging study

Missouri physician serving as a primary care physician (provider) additional criteria

If you are a **Missouri physician serving as a primary care physician**, the following additional criteria apply:

A. Access and availability of services

1. Each primary care physician medical office must, throughout the term of participation with the company, have at least one primary care physician for every 3,000 active patients. This means patients seen within the past two years.
 2. Each primary care physician medical office must have a minimum of 20 regularly scheduled office hours to treat patients (whether members or other patients) over at least four days a week. Exceptions to these standards will be allowed if primary care physician's medical office is in an underserved area.
 3. If primary care physician has more than one office location participating with the company, then the primary care physician must have a minimum of 20 regularly scheduled office hours over at least four days a week to treat patients in each location. Exceptions to these standards may be allowed if the primary care physician's medical office is in an underserved area.
 4. Each primary care physician must schedule appointments with members within the following time frames:
 - a. Emergency care: must be seen immediately (or referred to emergency room, as appropriate)
 - b. Urgent complaint: same day or within 24 hours
 - c. Symptomatic/nonurgent acute complaint: within three days (for example, sore throat)
 - d. Regular and routine care: within seven days
 - e. Preventive routine care: within 30 days
 - f. Follow-up visit: within two weeks
- b. Have a bachelor's or master's degree designed to prepare the provider in the primary care specialty area to which the provider is applying
 - c. Have a certificate of completion following training
 - d. Be board certified by a certifying agency recognized by the state in which they practice or by Aetna®
 - e. Be approved by the state to practice as a primary care physician
2. If required by the state, the physician assistant must have a supervising/collaborating/consulting physician agreement. This agreement must be with an Aetna participating primary care physician who is board certified and agrees to maintain the supervising/collaborating/consulting physician agreement, or a replacement thereof, during the entire term of the agreement. Upon the company's request, physician assistant must be able to submit supporting documentation from a participating network physician demonstrating the supervisory/collaborative/consultative agreement in any aspects of physician assistant practice.
 3. The documentation must address, but is not limited to:
 - a. A supervisory/collaborative/consultative agreement for any state-required prescription supervision
 - b. A supervisory/collaborative/consultative agreement for any state-required collaboration on practice
 - c. A supervisory/collaborative/consultative agreement, as applicable, for provision of hospital admitting backup
 - d. An agreement to hold member harmless for any physician collaboration fees and services
 - e. An agreement to be available 24/7
 - f. Proximity and availability by electronic means between the physician assistant and supervising/collaborating/consulting physician's office as required by state
 3. Physician assistant must notify the company immediately upon termination of a supervisory/collaborative/consultative arrangement by either party.
 4. Physician assistant must notify the company within ten business days of a known change in a supervisory/collaborative/consultative arrangement by either party.

Missouri physician assistant serving as a primary care physician (provider) additional criteria

If you are a **Missouri physician assistant serving as a primary care physician (provider)**, the following additional criteria apply:

A. Applicability

1. A physician assistant must:
 - a. Be a registered physician assistant

B. Access and availability of services

1. Each physician assistant medical office must, throughout the term of participation with the company, have at least one physician for every 3,000 active patients. Active means patients seen within the past two years.
2. Each physician assistant's medical office must have a minimum of 20 regularly scheduled office hours to treat patients (whether members or others) over at least four days a week. Exceptions to these standards will be allowed if the primary care provider's medical office is in an underserved area.
3. If a physician assistant has more than one office participating with the company, then the physician assistant must have a minimum of 20 regularly scheduled office hours over at least four days a week to treat patients in each location. Exceptions to these standards will be allowed if the primary care provider's medical office is in an underserved area.
4. Each physician assistant must schedule appointments with members within the following time frames:
 - a. Emergency care: must be seen immediately (or referred to emergency room, as appropriate)
 - b. Urgent complaint: same day or within 24 hours
 - c. Symptomatic/nonurgent acute complaint (for example, sore throat): within three days
 - d. Routine care: within seven days
 - e. Preventive routine care: within 30 days
 - f. Follow-up visit: within two weeks

C. Office procedures

Physician assistant must provide or use the following in the office:

1. Physician assistant performs EKGs (except for pediatric age limit — newborn through age 17).
2. Physician assistant performs pelvic exams for acute conditions in all offices caring for women who are members and older than 17.
3. Physician assistant administers age-appropriate routine immunizations.
4. For hematocrits and hemoglobin (peds only), "finger sticks" are performed within office.

Missouri nurse practitioner serving as a primary care physician (provider)

If you are a **Missouri nurse practitioner serving as a primary care physician (provider) and available for member selection, also known as primary care nurse practitioner**, the following additional criteria apply:

A. Applicability

1. A primary care nurse practitioner must:
 - a. Be a registered nurse
 - b. Have a minimum of a master's degree in nursing
 - c. Have received post-graduate or graduate education designed to prepare the provider in the primary care specialty area to which the provider is applying
 - d. Be board-certified by an agency recognized by the state in which they practice or by an Aetna®-approved accrediting agency and state approved to practice in the role of primary care as an advanced practice registered nurse

If required by the state, the primary care nurse practitioner must have a supervising/collaborating/consulting physician agreement. This agreement must be with an Aetna participating primary care physician who is board-certified and agrees to maintain the supervising/collaborating/consulting physician agreement, or a replacement thereof, during the entire term of the agreement. At the company's request, the primary care nurse practitioner must be able to submit supporting documentation from a participating network physician demonstrating the agreement in any aspects of primary care nurse practitioner practice. The documentation must address, but is not limited to:

- a. A supervisory/collaborative/consultative agreement for any state-required prescription supervision
- b. A supervisory/collaborative/consultative agreement for any state-required collaboration on practice
- c. A supervisory/collaborative/consultative agreement, as applicable, for provision of hospital admitting backup
- d. Agreement to hold member harmless for any physician collaboration fees and services
- e. Agreement to be available 24/7

f. Proximity and availability by electronic means between the nurse practitioner's office and supervising/collaborating/consulting physician's office as required by state

3. Primary care nurse practitioner must notify the company immediately upon termination of a supervisory/collaborative/consultative arrangement by either party.
4. Primary care nurse practitioner must notify the company within ten business days of a known change in a supervisory/collaborative/consultative arrangement by either party.

B. Access and availability of services

1. Each primary care nurse practitioner's medical office must, throughout the term of participation with the company, have at least one primary care nurse practitioner for every 3,000 active patients. This means patients seen within the past two years.
2. Each primary care nurse practitioner's medical office must have a minimum of 20 regularly scheduled office hours to treat patients (whether members or other patients) over at least four days a week. Exceptions to these standards will be allowed if primary care physician's medical office is in an underserved area.
3. If a primary care nurse practitioner has more than one office participating with the company, then the primary care nurse practitioner must have a minimum of 20 regularly scheduled office hours over at least four days a week to treat patients in each location. Exceptions to these standards will be allowed if primary care provider's medical office is in an underserved area.
4. Each primary care nurse practitioner must schedule appointments with members within the following time frames:
 - a. Emergency care: must be seen immediately (or referred to emergency room, as appropriate)
 - b. Urgent complaint: same day or within 24 hours
 - c. Symptomatic/nonurgent acute complaint (for example, sore throat): within three days
 - d. Routine care: within seven days
 - e. Preventive routine care: within 30 days
 - f. Follow-up visit: within two weeks

C. Office procedures

Primary care nurse practitioner must provide or use the following in the office:

1. Primary care nurse practitioner performs EKGs (except for pediatric age limit — newborn through age 17).
2. Primary care nurse practitioner performs pelvic exams for acute conditions in all offices caring for women who are members and older than 17.
3. Primary care nurse practitioner administers age-appropriate routine immunizations.
4. For hematocrits and hemoglobin (peds only), "finger sticks" are performed within office.

Missouri obstetrician/gynecologist additional criteria

If you are a **Missouri obstetrician/gynecologist**, the following additional criteria apply:

A. Access and availability of services

1. Specialist physician will be available at least an average of eight hours a week for office appointments.
2. Accreditation as an office-based surgical facility is not sufficient for separate payment of facility fees or related surgical charges.
3. When applicable, specialty physician will provide readings of all imaging studies and will notify the primary care physician or other referring physician of the results according to the following standards:
 - a. Urgent: within 30 minutes of completing the imaging study in those cases that are deemed urgent by the primary care physician and/or referring physician
 - b. Diagnostic tests: within one business day of the completion of the imaging study
4. Each obstetrician/gynecologist specialist physician must schedule appointments with members within the following time frames:
 - a. Appointments must be scheduled within one week for members in the first or second trimester of pregnancy
 - b. Appointments must be scheduled within three days for members in the third trimester
 - c. Emergency obstetrical care is subject to the same standards as emergency care



Other provider

Provider core participation criteria and additional criteria

Provider core criteria

These criteria, in addition to provider-specific criteria, apply to each provider and the group for the duration of the agreement and will be enforced at the sole discretion of Aetna®. Any exceptions to the business criteria must be approved in advance by Aetna.

A. Applicability

1. Provider must complete an application and shall periodically supply information to Aetna as requested.
2. If provider is part of a group practice, all providers in the group must satisfy these participation criteria. If not, the group cannot participate.

B. Office standards (apply to providers that maintain offices)

Each provider's office must:

1. Have a visible sign and title listing the names of all providers practicing in the office.
2. Have all areas accessible to all members, including, but not limited to, its entrance, parking lot and bathroom.
3. Be clean, presentable and professional and prohibit smoking.
4. Have a clean, properly equipped and accessible patient toilet and hand-washing facility.
5. Have a waiting room sufficient to accommodate members.
6. Have at least two examining rooms that are clean, properly equipped and private.
7. If immunization services are offered, follow the vaccine safety and refrigeration guidelines in the U.S. Centers for Disease Control (CDC) Vaccine Storage and Handling Toolkit. Go to **[CDC.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf](https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf)** to download it.
8. Have a robust infection control and prevention program that operates in accordance with nationally recognized standards (e.g., CDC), that includes provisions to report unexpected events and to have regular staff training on appropriate hand hygiene and injection safety protocols.
9. Keep controlled substances in locked cabinets.
10. Have a quality assurance program and provide, upon request, documentation of such program.
11. Have a secure and confidential filing system.
12. Have written policies protecting member confidentiality, including the maintenance of medical records and verbal and electronic submission of their information.
13. Have written policies addressing documentation about advance directives (whether executed or not) in member's record (except for under age 18).
14. Have an established process to ensure that medical records are protected from public access.
15. Have an office assistant in office during scheduled hours.
16. Require a medical assistant to attend sensitive (for example, gynecological) examinations, unless the member declines the assistant's presence.
17. Comply with current Aetna® policies and all applicable legal requirements regarding use of allied health professionals.
18. Maintain evidence of current licenses for all providers practicing in the office, including: state professional license, federal DEA certification and state controlled drug substance registration (where applicable).
19. Keep on file and make available to Aetna any state-required practice protocols or supervising agreements for allied health professionals practicing in the office.
20. Designate by age, according to company guidelines, those members for whom provider will provide care.
21. Have appropriate protocol immediately available for the treatment of medical emergencies and have documented medical emergencies procedures addressing treatment, transportation and disaster evacuation plans to provide for members' safety. Additionally, the office must have generators to provide power in case of a power failure, when appropriate. For example, the generator requirement applies to offices that perform procedures, store biologics or supplies of vaccines.

C. Access and availability of services

1. Provider's office must offer a reliable mechanism for members and other health care professionals to reach the office 24/7.
2. Except for exclusively hospital-based providers, provider's office must ensure that 24/7 coverage for members is rendered by provider or arranged with another company participating provider.
 - a. For outpatient services, a covering provider's office must be geographically accessible and consistent with local community patterns of care for the area to help ensure that a member doesn't have to travel more than 30 minutes from the member's regular provider's office to access the covering provider's services.
3. For workers' compensation members/patients, provider will provide services within a reasonable time frame or, where applicable, within the time frame required by workers' compensation law.

D. Subcontractors

To the extent the provider/provider group intends to subcontract some of its services under the agreement, provider/provider group will provide Aetna with a list of all subcontractors intended to be used to provide services to members. In all circumstances, where provider/provider group subcontracts for any services under the agreement:

1. Provider/provider group represents and warrants that subcontractor(s) will abide by the provisions set forth in the agreement.
2. Company reserves the right to require a designation of payment schedule from all subcontractors in a form approved by the company. Provider/provider group will indemnify and hold company and its members harmless for payment of all compensation owed subcontractor for services provided under the agreement.
3. Company's prior written approval is required if the provider/provider group intends to perform covered services through employees or agents, including a subcontractor, located outside of the United States of America.

E. Copies

Unless allowed by state law or regulatory requirement, provider/provider group agrees not to charge members for copies of medical records/reports or to require deposits for the release of these copies to members.

F. Insurance

Provider will maintain general and professional liability and other insurance according to state requirements. If there are no specific state requirements, then the amount should be what is typically maintained by providers in your state or region.

The insurance coverage will cover provider and its/their agents and employees.

Provider will give Aetna® proof of insurance coverage upon request.

Provider must give company at least thirty (30) days' advance notice of any cancellation or material changes to these policies, and must post notice of malpractice insurance (existing, cancellation or exemption) in a prominent location in the office.

G. Professional competence and conduct criteria

1. Provider must not have an unsatisfactory professional liability claims history including, but not limited to, lawsuits, arbitration, mediation, settlements or judgments. And provider must not have

engaged in any unprofessional conduct, unacceptable business practices or any other act or omission, and must not have a history of involuntary termination (or voluntary termination during or in anticipation of an investigation or dismissal) of employment or any other sort of engagement as a health care professional, of reduction or restriction of duties or privileges, or of a contract to provide health care services that, in the view of the applicable peer review committee, may raise concerns about possible future substandard professional performance, competence or conduct.

2. In the case of an encumbered license, the applicant demonstrates to the applicable peer review committee's satisfaction that encumbered license does not raise concern about possible future substandard professional performance, competence or conduct.

H. References

1. Provider must supply professional references as specified in the application or as requested by the applicable company peer review committee.
2. The applicable company peer review committee will have the right to act on any information received from provider's colleagues or other medical professionals. Provider waives any and all rights to bring any legal action relating to such information or the collection or use thereof against Aetna; any affiliates or related company or any director, officer, employee or agent thereof; or any person or entity providing a reference or information at the request of the applicable company peer review committee.

Applied behavior analyst (ABA) services provider additional criteria

If you are an **ABA services physician**, the following additional criteria apply:

1. Services must be provided directly or supervised by individuals licensed by the state or certified by the Behavior Analyst Certification Board as board-certified behavior analysts (BCBAs). Supervised individuals would include a board-certified assistant behavior analyst (BCaBA) or a paraprofessional.
2. Though not licensed or certified at a professional level, paraprofessionals come from various occupational fields, such as education or health care (but may include other fields such as engineering and law), and are trained to assist other professionals.

3. There must be supervision of the unlicensed or noncertified paraprofessionals.
4. Policies and procedures for the supervision of paraprofessionals must be documented. A minimum of one hour of face-to-face supervision is required of the unlicensed or noncertified paraprofessional by a BCBA or licensed psychologist (or behavioral health professional) for each 10 hours of applied behavior analysis by the supervised provider. In addition, the supervisor must be onsite with the child at least one hour a month, face to face, to provide direct supervision of the paraprofessional.
5. All BCBAs and BCaBAs must maintain certification and follow recertification requirements as outlined by the Behavior Analyst Certifying Board (that is, supervision requirements for BCaBAs). In addition, BCBAs must meet the current Aetna® credentialing and recertification standards.
6. BCBAs and BCaBAs must meet the attached behavioral health provider criteria for all provisions that apply to the BCBA and BCaBA.
7. All BCBAs, BCaBAs and paraprofessionals must meet state requirements. If state requirements are not defined, all BCBAs, BCaBAs and paraprofessionals must meet Aetna standards.

Certified registered nurse anesthetist (CRNA) provider additional criteria

If you are a **CRNA provider**, the following additional criteria apply:

A. Applicability

1. A CRNA must:
 - a. Be a registered nurse
 - b. Complete an advance formal training program in his or her level of nursing specialty in which he or she is practicing within the scope of the licensure/certification/registration
 - c. Be state approved to practice as a CRNA
2. Where required by state law, CRNA will have entered into an appropriate supervising/collaborating/consulting physician agreement with a physician trained in anesthesiology and will have adopted practice protocols. A CRNA must meet all state requirements applicable to their licensure. Any state-required supervisory/collaborative/consultative agreements must be filed with the appropriate state

regulatory agency. Supervising/collaborating/consulting anesthesiologist (or physician in markets where there are no anesthesiologists available for contracting) must be a participant in Aetna's network or, if not participating, must be providing services at a participating facility.

3. CRNA must have an unrestricted right to prescribe medications to the fullest extent permitted under state law.

Genetic counselor provider additional criteria

If you are a **genetic counselor**, the following additional criteria apply:

A. Applicability

1. Genetic counselor must be certified by the American Board of Genetic Counseling.

B. Access and availability of services

1. Genetic counselor will be available at least an average of eight hours a week for scheduling appointments.

Lactation consultant provider additional criteria

If you are a **lactation consultant**, the following additional criteria apply:

A. Applicability

1. Lactation consultant must be certified by and maintain certification as an International Board Certified Lactation Consultant.

B. Office standards (applies specifically to lactation consultants that maintain offices)

1. Lactation consultant must have at least one examining room that is clean, properly equipped and private.

C. Provider requirements

1. Provider must educate patients in self-care techniques and home care management, including, but not limited to, providing written member education materials.
2. Upon request by Aetna if provider conducts patient satisfaction surveys, responses must be made available to Aetna at the same time and with the same frequency.
3. Provider must have written policies/processes documenting infectious disease control and disinfection of and proper care and storage of breast pumps and supplies.
4. Provider must have written policies documenting the protocols for notifying and/or consulting with the

members' physician(s) (pediatrician and/or obstetrician and/or nurse midwife) for medical problems that require intervention. (Examples include: infant failure to thrive, maternal mastitis, maternal and/or infant thrush, neonatal jaundice.)

5. Provider must have written documentation of all member encounters, plans of care and communications with all physician/clinician providers.

D. Access and availability of services:

1. Provider will be available at least an average of eight hours a week for scheduling appointments.
2. Provider must be able to initiate a therapy within three hours of the referral call for urgent services and within 24 hours of the referral call for routine services.

E. The following provider core participation criteria office standards will not apply to lactation consultants:

1. Provider must have at least two examining rooms that are clean, properly equipped and private.
2. If immunization services are offered, follow the vaccine safety and refrigeration guidelines in the U.S. Centers for Disease Control (CDC) Vaccine Storage and Handling Toolkit. Go to **[CDC.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf](https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf)** to download it.
3. Provider must have an office assistant in office during scheduled hours.
4. Provider is required to have a medical assistant to attend sensitive (for example, gynecological) examinations, unless the member declines the assistant's presence.

Nurse midwife provider additional criteria

If you are a **nurse midwife**, the following additional criteria apply:

A. Applicability

1. A nurse midwife must:
 - a. Be a registered nurse
 - b. Have a minimum of a master's degree in nursing
 - c. Have received post-graduate or graduate education designed to prepare the provider in the midwifery specialty to which the provider is applying
 - d. Be board-certified by an agency as recognized by the state in which they practice or by an

Aetna®-approved accrediting agency and state approved to practice in the role of midwifery

2. If required by the state, the nurse midwife must have a supervising/collaborating/consulting physician agreement. This agreement must be with an Aetna participating physician who is board-certified and specializes in obstetrical care and agrees to maintain the supervising/collaborating/consulting physician agreement, or a replacement thereof, during the entire term of the agreement. Upon a request from Aetna, a nurse midwife must be able to submit supporting documentation from a participating network physician demonstrating the supervisory/collaborative/consultative agreement in any aspects of nurse midwife practice. The documentation must address but is not limited to:
 - a. A supervisory/collaborative/consultative agreement for any state-required prescription supervision
 - b. A supervisory/collaborative/consultative agreement for any state-required collaboration on practice
 - c. A supervisory/collaborative/consultative agreement, as applicable, for provision of hospital admitting backup
 - d. Agreement to hold member harmless for any physician/practitioner collaboration fees and services
 - e. Agreement to be available 24/7
 - f. Physical proximity and availability by electronic means between the nurse midwife's office and supervising/collaborating/consulting physician's office as required by state
3. Nurse midwife must notify Aetna immediately upon termination of a supervisory/collaborative/consultative arrangement by either party.
4. Nurse midwife must notify Aetna within ten business days of a known change in a supervisory/collaborative/consultative arrangement by either party.
5. Nurse midwife must enroll member and follow program guidelines in Aetna's designated maternity program if the member has the benefit.

B. Access and availability of services

1. Nurse midwife will be available at least an average of eight hours a week for scheduling office appointments.
2. If within nurse midwife's scope of license, nurse midwife must have admitting privileges at a

participating hospital or coverage must be arranged with a participating provider who has privileges at a participating hospital.

Podiatry provider additional criteria

If you are a **podiatry physician**, the following additional criteria apply:

A. Applicability

Provider must be certified by an Aetna®-recognized board unless the applicant meets an exception under Aetna's policy. Any exceptions must be approved by the Aetna medical director or designee.

B. Provider standards

Provider must have the capability to take X-rays or arrange for X-ray service with a participating provider.

C. Access and availability of services

1. Provider will have a minimum of 20 office hours per week.
2. If within provider's scope of license, provider must have admitting privileges at a participating hospital or coverage must be arranged with a participating provider who has privileges at a participating hospital.

Acupuncture for Medicare member for chronic lower-back pain core participation criteria

A. Applicability

1. These criteria apply to each participating provider for the duration of the agreement and shall be enforced at the sole discretion of Aetna®.
2. Each participating provider and each provider applicant must have documentation to prove that they meet all of the stated criteria in this document.

B. General

1. Each facility must have all of the appropriate federal- and state-mandated regulatory licenses and certifications, including — without limitation — a certificate of operation or a certificate of occupancy.
2. As applicable, each participating physician and each physician who is an applicant must meet state licensure requirements in order to provide acupuncture services.
3. As applicable for the provision of the Medicare benefit for chronic lower-back pain, a nurse practitioner may only furnish acupuncture if the nurse practitioner meets all of these criteria:
 - a. Fulfill all applicable state requirements
 - b. Have a master's- or doctoral-level degree in acupuncture or oriental medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM)

- c. Possess a current unrestricted license to practice acupuncture in a state, territory or commonwealth (Puerto Rico, for example) of the United States or the District of Columbia

4. As applicable for the provision of the Medicare benefit for chronic lower-back pain, a physician assistant may only furnish acupuncture if the physician assistant meets all of these criteria:
 - a. Fulfill all applicable state requirements
 - b. Have a master's- or doctoral-level degree in acupuncture or oriental medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM)
 - c. Possess a current unrestricted license to practice acupuncture in a state, territory or commonwealth (Puerto Rico, for example) of the United States or the District of Columbia
5. As applicable for the provision of the Medicare benefit for chronic lower-back pain, a clinical nurse specialist may only furnish acupuncture if the clinical nurse specialist meets all of these criteria:
 - a. Fulfill all applicable state requirements
 - b. Have a master's- or doctoral-level degree in acupuncture or oriental medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM)
 - c. Possess a current unrestricted license to practice acupuncture in a state, territory or commonwealth (Puerto Rico, for example) of the United States or the District of Columbia
6. As applicable for the provision of the Medicare benefit for chronic lower-back pain, an auxiliary provider (any professional who is not previously listed) may only furnish acupuncture if auxiliary provider meets all of these criteria:
 - a. Fulfill all applicable state requirements
 - b. Have a master's- or doctoral-level degree in acupuncture or oriental medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM)
 - c. Possess a current unrestricted license to practice acupuncture in a state, territory or commonwealth (Puerto Rico, for example) of the United States or the District of Columbia
 - d. Must be under the appropriate level of supervision of a physician, physician's assistant, nurse practitioner, or clinical nurse specialist.



Behavioral health services

Behavioral health facility core participation criteria and additional criteria

Behavioral health facility core criteria

A. Applicability

1. These criteria apply to each facility applicant for participation and each facility participating in plans, and will be enforced at the sole discretion of Aetna®.
2. Each applicant for participation as a facility must have documentation that it has met the criteria stated below.
3. Each participating facility must continue to meet the following criteria for the duration of the agreement.

B. General

1. Facility must have the appropriate license(s) and certification(s) mandated by governmental regulatory agencies, including, without limitation, certificate of operation or certificate of occupancy.
2. Facility must have documented emergency procedures, including procedures addressing treatment, provision of transportation and disaster evacuation plans to provide for members' safety.
3. Facility must have an arrangement with a participating hospital in place for the immediate transfer of patients.
4. All providers at facility providing services to members must be credentialed according to company standards. Facility will notify company in writing within ten business days if it acquires new providers. Or if there are any changes in the status of providers who provide services.

C. Facility standards

1. Facility must:
 - a. Be clean, presentable, professional and prohibit smoking.
 - b. Ensure that all areas are accessible to all members including, but not limited to, its entrance, parking lot and bathroom.
 - c. Have, without limitation, appropriate equipment immediately available for the treatment of medical emergencies. Additionally, if facility provides inpatient and/or residential treatment services, facility must have generators to provide power in case of a power failure. All facilities must comply with all local, state and federal safety regulations.
 - d. Have a waiting room able to accommodate at least five patients and when applicable have a sufficient number of changing rooms to allow for patient privacy.
 - e. Complete a location schedule, attached, identifying the address(es) and physical location(s) of the facility.
 - f. Ensure infrastructure and equipment maintain current certifications, indicating proper maintenance and calibration at regularly scheduled intervals to ensure operational safety and comply with any and all applicable standards, including OSHA fire safety standards and applicable federal, state and local fire safety laws and regulations.
 - g. Have a visible sign listing the name of the entity.
 - h. Have a clean, properly equipped and accessible patient restroom and hand-washing facility.
 - i. Have an established process to ensure that medication room(s) and medical records are protected from public access.
 - j. Have a secure and confidential filing system.
 - k. Have written policies protecting member confidentiality, including the maintenance of medical records, and maintain verbal and verbal and electronic submission of their information.
 - l. Require a medical assistant to attend sensitive examinations, unless the member declines the assistant's presence.
 - m. Produce upon request evidence of current licenses for all providers practicing in the facility, including state professional license, federal DEA certification and state controlled drug substance registration (where applicable).
 - n. Keep on file and make available to Aetna® any state-required practice protocols or supervising agreements for allied health professional practicing in the facility, including a requirement for notifying members if an allied health professional (for example, a physician assistant, an advanced practice nurse, a nurse practitioner, a nurse midwife) may provide care.
 - o. Have an advance directive policy, if applicable.
 - p. Furnish Aetna, upon request, any and all studies and reports, either copies or originals as specified, for any and all examinations being conducted by Aetna.
 - q. Have a mechanism in place to ensure that all contracted technical and professional services related to the services offered by the facility are available, if applicable.
 - r. Have a quality assurance program and provide upon request documentation of such program.
 - s. Have a quality improvement program and track outcomes or trends to be used as a tool for quality improvement.

- t. Ensure that all staff are trained regarding the facility's applicable policies and procedures to perform the duties of their position; received appropriate health screening in compliance with all applicable local, state and federal regulations related to health screenings; and have participated in continuing education and/or in-service in accordance with state or federal standards.
 - u. Maintain appropriate Clinical Laboratory Improvement Amendments certification for lab equipment where applicable.
2. Any exceptions to the above must be approved in advance by Aetna®.

D. Facility requirements

1. Mental health inpatient must be under the care of an attending psychiatrist. For inpatient mental health care, there will be a minimum of five face-to-face sessions per week with a psychiatrist. Psychiatric care must be documented in the treatment record. In addition, a psychiatrist must be available as medically necessary 24/7.
 2. Mental health residential services must be under the care of an attending psychiatrist with documented treatment as medically necessary. Mental health residential care members must be treated by a psychiatrist at least once a week. A licensed behavioral health professional must be on duty 24/7.
 3. Inpatient services in a substance abuse facility must be under the care of an appropriately trained MD/DO and with availability 24/7. Psychiatric care must be available with documentation of treatment as medically necessary.
 4. Substance abuse residential services must be under the care of an appropriately trained MD/DO with documented treatment as medically necessary. A licensed behavioral health professional or an appropriately state-certified professional (for example, a certified addiction counselor or a certified alcohol and drug abuse counselor) must be on duty during day and evening for therapeutic services. For detoxification, a licensed nurse must be on duty 24/7. Care must be provided under the direct supervision of a physician. Direct supervision by the physician includes availability by telephone 24/7 and the ability to provide onsite services or the provision for direct services by an appropriately trained physician. Psychiatric care must be available with documentation of treatment as medically necessary.
5. Members in mental health partial hospitalization must be seen and treated by a psychiatrist (with care documented) twice weekly or more often as medically necessary. Mental health partial hospitalization clinical programming is provided at least four hours a day and at least three times weekly or more often as medically necessary. All daily clinical programming must meet the minimum standard for duration and have a similar intensity of service regardless of the day of the week the care is provided.
 6. Substance abuse partial hospitalization patients must be under the care of an appropriately trained MD/DO. Substance abuse partial hospitalization clinical programming is provided at least four hours a day and at least three times weekly with psychiatric care available as medically necessary. All daily clinical programming must meet the minimum standard for duration and have a similar intensity of service regardless of the day of the week the care is provided.
 7. Members in mental health intensive outpatient program must be seen and treated by a psychiatrist (with care documented) as medically necessary. Mental health intensive outpatient clinical programming is provided at least two hours a day and at least three times weekly or more often as medically necessary. All daily clinical programming must meet the minimum standard for duration and have a similar intensity of service regardless of the day of the week the care is provided.
 8. Substance abuse intensive outpatient patients must be under the care of an appropriately trained MD/DO. Substance abuse intensive outpatient clinical programming is provided at least two hours a day and at least three times weekly with psychiatric care available as medically necessary. All daily clinical programming must meet the minimum standard for duration and have a similar intensity of service regardless of the day of the week the care is provided.
 9. Ambulatory detoxification services in an appropriately licensed facility must be under the care of an appropriately trained MD/DO. Psychiatric care must be available with documentation of treatment as medically necessary. Facility will arrange for physician on call, emergency services and appropriate oversight of facility program.
 10. Family outreach must occur within 72 hours of admission, and care must be available as clinically indicated.

11. Attending psychiatrist, physician or primary therapist must contact member's primary care physician with member's consent within 48 hours of admission and at discharge as medically necessary. All contacts must be documented in the medical record.
12. Primary therapist must personally contact a member's outpatient provider within 24 hours or first business day of admission with member's consent. Outpatient provider will be made aware of clinical treatment plan, as appropriate. All contacts must be documented in the treatment record. All contacts must be documented in the medical record.
13. For child and adolescent admissions, as appropriate and as permitted by state regulations, primary therapist shall obtain parental (or custodial) consent to contact key participants to complete a diagnostic evaluation. Consistent with good clinical practice, key participants including but not limited to school-based personnel and primary care providers shall be contacted within 72 hours of admission for completion of the diagnostic evaluation. All contacts must be documented in the medical record.
14. For all members, discharge planning will begin at the point of admission with the expectation that a first appointment with a behavioral health provider will be scheduled prior to discharge and will occur within seven days of discharge from an inpatient setting.
6. Facility physicians, nurse practitioners and/or physician assistants with prescriptive authority will, when possible, prescribe medication in accordance with the Aetna® formulary.
7. Facility must have provisions in place to address patient overflow.
8. For workers' compensation members/patients, facility will provide services within a reasonable time frame or, where applicable, within the time frame required by workers' compensation law.
9. Facility will provide immediate notice to Aetna of any circumstance that limits facility's ability to provide the facility services.

F. Subcontractors

To the extent the facility intends to subcontract some of its services under the agreement, facility will provide Aetna with a list of all subcontractors intended to be used to provide services to members. In all circumstances, where the facility subcontracts for any services under the agreement:

1. Facility assumes full and complete responsibility for compensating subcontractor.
2. Facility represents and warrants that subcontractor(s) will abide by the provisions set forth in the agreement.
3. Aetna reserves the right to require a designation of payment schedule from all subcontractors in a form approved by Aetna. Facility indemnifies and holds Aetna and its members harmless for payment of all compensation owed subcontractor(s) for services provided under the agreement.
4. Aetna's prior written approval is required, if the facility intends to perform covered services through employees or agents, including a subcontractor, physically located outside the United States of America.
5. Delegation must meet Aetna's standards and requires preapproval, and the appropriate the agreements must be in place before any functions can be delegated.

G. Copies

Unless permitted by law, the facility agrees not to charge members for copies of medical records/reports or to require deposits for the release of these copies to members.

H. Insurance

Provider will maintain general and professional liability and other insurance according to state requirements. If there

E. Access and availability of services

1. Hours of operation — inpatient facility hours of operations are 24/7.
2. Facility must initiate treatment within a time frame agreeable by the referring clinician, if applicable. Facility must return treatment reports to referring clinician, if applicable, as soon as possible.
3. Where applicable to facility, appropriate clinical staff shall be onsite at all times when patients are being treated. "Onsite" is defined as attached to or on the grounds of the facility.
4. Facility shall arrange for physician on call, emergency services and appropriate oversight of facility operations.
5. If the facility requires the services of a physician/specialist or if specific laboratory, radiologic services and/or other ancillary services cannot be performed by the facility, the facility will rely on the services of a company participating physician/specialist, laboratory and/or radiologic provider, unless not feasible in an emergency situation.

are no specific state requirements, then the amount should be what is typically maintained by providers in your state or region.

The insurance coverage will cover provider and its/their agents and employees.

Provider will give Aetna proof of insurance coverage upon request.

Provider must give company at least thirty (30) days' advance notice of any cancellation or material changes to these policies, and must post notice of malpractice insurance (existing, cancellation or exemption) in a prominent location in the office.

I. Philosophy

1. Facility must support the philosophy and concept of managed care and Aetna®. Facility shall not differentiate or discriminate in the treatment of or in the access to treatment of patients, on the basis of their status as members or other grounds identified in the agreement.
2. Facility has the right and is encouraged to discuss with its patients pertinent details regarding the diagnosis of the patient's condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment and any reasonable alternatives to such recommended treatment.
3. Facility's obligations under the agreement not to disclose proprietary information do not apply to any disclosures to a patient determined by the facility to be necessary or appropriate for the diagnosis and care of a patient, except to the extent such disclosure would otherwise violate the facility's legal or ethical obligations.
4. Facility is encouraged to discuss Aetna's provider reimbursement methodology with facility patients who are members, subject only to the facility's general contractual and ethical obligations not to make false or misleading statements. Accordingly, proprietary information does not include descriptions of how facility is reimbursed, although such proprietary information does include the specific rates paid by Aetna due to their competitively sensitive nature.

J. Professional competence and conduct

1. Facility will immediately notify Aetna of any adverse action relating to the facility's, or any of the facility's participating providers', where applicable: (i) hospital staff privileges; (ii) DEA or state narcotics numbers; (iii) participation in Medicare, Medicaid or other governmental programs; or (iv) state licensure, certification, accreditation or other authorization required by law or the agreement to provide the facility services. Facility shall inform the applicable company peer review committee in writing of any previous adverse actions with respect to any of the above. For the purpose of this section, "adverse action" includes, but is not limited to, any of the following or their substantial equivalents (regardless of any subsequent action or expungement of the record): denial; exclusion; fine; monitoring; probation; suspension; letter of concern, guidance, censure or reprimand; debarment; expiration without renewal; subjected to disciplinary action or other similar action or limitation; restriction; counseling; medical or psychological evaluation; loss, in whole or in part; staff privileges reduced, withheld, suspended, voluntarily surrendered, resigned, revoked or subject to any special provisions; termination or refused participation; revocation; administrative letter; nonrenewal; voluntary or involuntary surrender of licensure or status to avoid, or in anticipation of, any of the adverse actions listed regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry; and initiation of investigations, inquiries or other proceedings that could lead to any of the actions listed, regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry. Any such adverse actions may be grounds for action, including, without limitation, denial or termination of facility or other sanctions imposed pursuant to Aetna's credentialing/quality improvement programs.

Behavioral health provider core participation criteria and additional criteria

Behavioral health provider core criteria

A. Applicability

1. These criteria apply to each provider applicant for participation and each provider participating in plans, and will be enforced at the sole discretion of Aetna®. Any exceptions to the business criteria must be approved in advance by Aetna.
2. Each applicant for participation as a provider must have documentation that the criteria stated below have been met.
3. Each participating provider must continue to meet the following criteria for the duration of participation in the Aetna plans.

B. General

1. Each applicant must fully complete the provider application form, and each applicant and participating provider must periodically supply to Aetna all requested information, including forms and applicable confidential information.
2. If the provider is part of a group practice, all participating providers in the group must meet these participation criteria and must agree to participate in all plans covered under the group agreement.
3. Where required by state law, provider will have entered into an appropriate supervisory or professional relationship agreement with a physician and/or have adopted practice protocols. Any state-required collaborative or consultative agreements must be filed with the appropriate state regulatory agency.
4. If providers practicing within a specialty have prescription authority under applicable state law, provider must have an unrestricted right to prescribe medications to the fullest extent permitted under state law within that specialty.

C. Office standards

Each provider's office must:

1. Have a visible sign listing the names of all providers and/or the group name.
2. Have a clean, properly equipped and accessible patient restroom.
3. Have a waiting room sufficient to accommodate members.
4. Use proper storage mechanisms and disposal if injectables and/or medications are housed in the office.
5. Secure controlled substances.
6. Have a secure and confidential filing system.
7. Have written policies protecting member confidentiality, including the maintenance of medical records and verbal and electronic submission of their information.
8. Have an established process to ensure that medical records are protected from public access.
9. Have written policies addressing documentation about advance directives (whether executed or not) in member's record (except for members under age 18), if applicable.
10. Have written policies addressing office antidiscrimination guidelines.
11. Comply with the Aetna's current policies and all applicable legal requirements regarding use of allied health professionals.
12. Keep on file and make available to Aetna any state required practice protocols or supervising agreements for allied health professionals practicing in the office.
13. Have appropriate protocol(s) immediately available for the treatment of medical emergencies and have documented medical emergency procedures addressing treatment, transportation and disaster evacuation plans to provide for the members' safety.
14. Maintain evidence of current licensure for all providers practicing in the office, including state professional licensure, DEA certification and state controlled drug substance registration (where applicable).
15. Be clean, presentable, professional and prohibit smoking. The office must meet all applicable city ordinances.
16. Be accessible to all members, including, but not limited to, its entrance, parking lot and bathroom.

D. Availability of services and coverage

1. Availability of services

- a. Hours of operation — provider will provide office hours to members and Aetna®.
- b. For workers' compensation members/patients, provider will provide services within a reasonable time frame or, where applicable, within the time frame required by workers' compensation law.

2. Coverage

- a. Provider must offer a reliable mechanism for members and other health care professionals to reach the office 24/7. Provider must meet all state and accreditation organization (NCQA or other applicable agency) standards.

- b. Except for exclusively hospital-based providers, provider will ensure that 24/7 coverage for members is rendered by provider or arranged with another company participating provider.

For outpatient services, a covering provider's office must be geographically accessible and consistent with local community patterns of care. This helps ensure that a member doesn't have to travel more than 30 minutes to access the covering provider's services.

- c. If within a provider's scope of license, provider must have admitting privileges at a participating hospital or must have an arrangement with a participating physician who has privileges at a participating hospital.

E. Copies

1. Provider agrees not to charge or will require only a reasonable rate to cover copying or other costs for member acquisition of medical records or reports. Further, provider agrees not to require deposits for the release of these copies to members.

F. Insurance

Provider will maintain general and professional liability and other insurance according to state requirements. If there are no specific state requirements, then the amount should be what is typically maintained by providers in your state or region.

The insurance coverage will cover provider and its/their agents and employees.

Provider will give Aetna proof of insurance coverage upon request.

Provider must give company at least thirty (30) days' advance notice of any cancellation or material changes to these policies, and must post notice of malpractice insurance (existing, cancellation or exemption) in a prominent location in the office.

G. Professional competence and conduct criteria

1. Provider must not have an unsatisfactory professional liability claims history, including, but not limited to, lawsuits, arbitration, mediation, settlements or judgments and must not have engaged in any unprofessional conduct, unacceptable business practices or any other act or omission and must not have a history of involuntary termination (or voluntary termination during or in anticipation of an investigation or dismissal) of employment or any other sort of engagement as a health care professional, of reduction or restriction of duties or privileges, or of a contract to provide health care services that, in the view of Aetna and/or applicable peer review committee, may raise concerns about possible future substandard professional performance, competence or conduct.
2. In the case of an encumbered license, the applicant demonstrates to the applicable peer review committee's satisfaction that the encumbered license does not raise concern about possible future substandard professional performance, competence or conduct.

H. References

1. Provider must supply professional references as specified in the application or as requested by the applicable company peer review committee.
2. The applicable company peer review committee has the right to act on any information received from the provider's colleagues or other medical professionals. Provider waives any and all rights to bring any legal action relating to such information or the collection or use thereof against Aetna; any affiliates or related company or any director, officer, employee or agent thereof; or any person or entity providing a reference or information at the request of the applicable company peer review committee.

Behavioral health physician core participation criteria and additional criteria

Behavioral health physician core criteria

A. Applicability

1. These criteria apply to each applicant for participation and each physician participating in plans and will be enforced at the sole discretion of Aetna®. Any exceptions to the business criteria must be approved in advance by Aetna.
2. Each applicant for participation as a physician must have documentation that the criteria stated below have been met.
3. Each participating physician must continue to meet the following criteria for the duration of participation in Aetna plans.

B. General

1. The applicant must be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association, unless the applicant meets an exception under Aetna's policy. All exceptions must be approved by an Aetna medical director or designee.
2. If the physician is part of a group practice, all participating physicians in the group must meet these participation criteria and must agree to participate in all plans covered under the group agreement.
3. The physician must complete an application and will supply all requested information to Aetna.

C. Office standards

Each physician's office must:

1. Have a visible sign listing the names of all physicians practicing and/or the group name.
2. Have a mechanism for notifying members if an allied health professional (that is, doctoral- and/or master's-level psychologist, master's-level clinical social worker, master's-level clinical nurse specialist or psychiatric nurse practitioner, or other behavioral health care specialists who are licensed, certified or registered by the state in which they practice) may provide care.
3. Be clean and presentable, have a professional appearance and prohibit smoking. The office must meet all applicable city ordinances.
4. Be accessible to all members, including, but not limited to, the entrance, parking lot and restroom.
5. Have a clean, properly equipped and accessible patient restroom.
6. Have a waiting room sufficient to accommodate members.
7. Use proper storage and disposal mechanisms if injectables and/or medications are housed in the office.
8. Secure controlled substances.
9. Have a secure and confidential filing system.
10. Have written policies protecting member confidentiality, including the maintenance of medical records and verbal and electronic submission of their information.
11. Have an established process to ensure that medical records are protected from public access.
12. Have written policies addressing advance directives (whether executed or not) in member's medical record (except for members under age 18), if applicable.
13. Have written policies addressing office antidiscrimination guidelines.
14. Have evidence of current licensure for all physicians/allied health professionals practicing in the office, including state professional licensure, DEA certification and state controlled drug substance registration (where applicable).
15. Keep on file and make available to Aetna any state-required practice protocols or supervising agreements for allied health professionals practicing in the office.
16. Have appropriate protocols immediately available for the treatment of medical emergencies and have documented medical emergency procedures addressing treatment, transportation and disaster evacuation plans to provide for members' safety.

D. Availability of services and coverage

1. Availability of services
 - a. Hours of operation — provider will provide office hours to members and Aetna®.
 - b. For workers' compensation members/patients, physician will provide services within a reasonable time frame or, where applicable, within the time frame required by workers' compensation law.
2. Coverage

Each physician's medical office must:

- a. Offer a reliable way for members to reach a health care professional 24/7. Physician must meet all state and accreditation organization standards (NCQA or other applicable agency).
- b. Respond to a member within 30 minutes after notification of an urgent call.
- c. Ensure that 24/7 coverage for members is rendered by a physician or arranged with another company participating physician.

For outpatient services, a covering physician's office must be geographically accessible and consistent with local community patterns of care. This helps ensure that a member doesn't have to travel more than 30 minutes to access the covering physician's services.

- d. Have admitting privileges at a participating hospital or coverage must be arranged with a participating physician who has privileges at a participating hospital.
- e. Agree to use company participating providers as required in the physician agreement.

E. Copies

1. Physician agrees not to charge or will require only a reasonable rate to cover copying or other costs for member to obtain medical records or reports. Further, physician agrees not to require deposits for the release of these copies to members.

F. Insurance

Provider will maintain general and professional liability and other insurance according to state requirements. If there are no specific state requirements, then the amount should be what is typically maintained by providers in your state or region.

The insurance coverage will cover provider and its/their agents and employees.

Provider will give Aetna proof of insurance coverage upon request.

Provider must give company at least thirty (30) days' advance notice of any cancellation or material changes to these policies, and must post notice of malpractice insurance (existing, cancellation or exemption) in a prominent location in the office.

G. Office records

1. A physician must demonstrate that his or her medical records are legible, reproducible and otherwise meet Aetna's standards for confidentiality and medical record keeping practices, and that clinical documentation demonstrates comprehensive care. Members' medical records will include reports from referred and/or referring providers, discharge summaries, records of emergency care received and such other information as Aetna may require from time to time.
2. Each member encounter must be documented in writing and signed or initialed by the physician or as required by state law.

H. Professional competence and conduct criteria

1. Physician must not have an unsatisfactory professional liability claims history including, but not limited to, lawsuits, arbitration, mediation, settlements or judgments and must not have engaged in any unprofessional conduct, unacceptable business practices or any other act or omission and must not have a history of involuntary termination (or voluntary termination during or in anticipation of an investigation or dismissal) of employment or any other sort of engagement as a health care professional, of reduction or restriction of duties or privileges, or of a contract to provide health care services that, in the view of Aetna and/or applicable peer review committee, may raise concerns about possible future substandard professional performance, competence or conduct.
2. In the case of an encumbered license, the applicant demonstrates to the applicable peer review committee's satisfaction that the encumbered license does not raise concern about possible future substandard professional performance, competence or conduct.

I. References

1. Physician must supply professional references as requested by the applicable Aetna peer review committee.

2. The applicable Aetna peer review committee has the right to act on any reference or information received from the physician's colleagues. Physician waives any and all rights to bring any legal action relating to such information or the collection or use thereof against the company; any affiliates or related companies or any director, officer, employee or agent thereof; or any person or entity providing a reference or information at the request of the applicable company peer review committee.

Pervasive developmental disorder or autism provider additional criteria (applicable to California only)

A. Applicability

1. These criteria shall apply to each applicant for participation and each participating provider in the state of California that provides behavioral health treatment, as defined below, and shall be enforced at the sole discretion of Aetna®.
2. "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:
 - a. The treatment is prescribed by a licensed physician and surgeon, or is developed by a licensed psychologist.
 - b. The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
 1. A qualified autism service provider
 2. A qualified autism service professional supervised and employed by the qualified autism service provider
 3. A qualified autism service paraprofessional supervised and employed by a qualified autism service provider
 - c. The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan will be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and will be consistent with Section 4686.2 of the California Welfare and

Institutions Code, pursuant to which the qualified autism service provider does all of the following:

1. Describes the patient's behavioral health impairments to be treated
 2. Designs an intervention plan that includes the service type, number of hours and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported
 3. Provides intervention plans that use evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism
 4. Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate
- d. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan will be made available to the health care service plan upon request.
3. "Pervasive developmental disorder or autism" will have the same meaning and interpretation as used in Section 1374.72 of the California Health and Safety Code.

B. Professional criteria

1. All participating providers must meet the current company credentialing and recredentialing standards.
2. A "qualified autism service provider" must be either of the following:
 - a. A person, entity or group that is certified by a national entity, such as the Behavior Analyst Certification Board; that is accredited by the National Commission for Certifying Agencies; and who designs, supervises or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity or group that is nationally certified
 - b. A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist or audiologist, pursuant to Division 2

(commencing with Section 500) of the Business and Professions Code, who designs, supervises or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

3. A “qualified autism service professional” must be an individual who meets all of the following criteria:
 - a. Provides behavioral health treatment
 - b. Is employed and supervised by a qualified autism service provider
 - c. Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider
 - d. Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant or behavior management program as defined in Section 54342 of Title 17 of the California Code of Regulations

e. Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code

4. A “qualified autism service paraprofessional” must be an unlicensed and uncertified individual who meets all of the following criteria:
 - a. Is employed and supervised by a qualified autism service provider
 - b. Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider
 - c. Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code
 - d. Has adequate education, training and experience, as certified by a qualified autism service provider

Telehealth criteria

If you are a hybrid provider or virtual only provider (as defined below), these additional telehealth criteria apply to you. All requirements of Company’s core and other additional participation criteria that pertain to your services/specialty continue to apply to you, unless a specific exception is noted in these telehealth criteria.

Definitions

Consultation: Any encounter during which a provider renders telehealth services.

Hybrid providers: Qualified health care providers that provide both in-person and telehealth services.

Telehealth: The delivery of health care services via synchronous or asynchronous communications such as video, telephone, chat, or other communications networks or devices that do not involve in-person patient contact.

Virtual only providers: Qualified health care providers that provide health care services only through telehealth.

All hybrid providers and virtual only providers are subject to the following:

A. Services

All telehealth services must be provided in accordance with applicable law and Company policies. For example, the telehealth communication method (e.g., video vs. audio) and the type of telehealth service provided (e.g., mental health counseling vs. family planning) must be in compliance with applicable state and federal law (e.g., certain states prohibit asynchronous or audio-only telehealth and certain states may prohibit particular services being provided via telehealth).

Of the telehealth methods and services permitted by law, Company determines, in its sole discretion, which methods and services may be provided via telehealth under the provider’s agreement with Company.

Only the CPT®/HCPCS codes located in the Telemedicine and Direct Patient Contact Payment Policy, as updated by Company from time to time, will be considered covered services under the provider's agreement with Company. No other codes for telehealth services will be payable or eligible for reimbursement. Plan exclusions may also apply.

B. Licensure in member states and as required by law

Providers must satisfy all applicable license, registration, and certification requirements noted in the participation criteria for all states in which members to whom they are providing telehealth services are located. As required by applicable law, providers must also hold licenses, registrations, and certifications in the state(s) in which they are physically located.

C. Telehealth consultation requirements

1. During each consultation:
 - a. The patient must be present and participating throughout the consultation (for audiovisual or telephonic consultations).
 - b. Each person participating in the consultation in each location must be introduced.
 - c. The consultation must meet all established criteria for billing face-to-face visits, such as patient history, risk factors, reporting, exam, diagnosis, supervision of patient care, and treatment recommendation.
 - d. Physicians are responsible for supervising the safety and quality of telehealth services provided to patients by non-physician providers within their practice.
2. Environment and equipment
 - a. In addition to other office standards that apply, the consultation must take place in a professional environment that follows confidentiality and privacy regulations.
 - b. Background noise must be kept to a minimum to prevent distractions.
 - c. People must not enter the room during the consultation unless they are required for the consultation and introduced to all on the call.

D. Post-telehealth consultation requirements

1. Mute the audio and disconnect the video/phone call.
2. Follow up on any patient questions or concerns that were not addressed during the consultation.
3. As applicable, coordinate the communication of the patient's treatment/management plan and follow-up needs to the appropriate primary care physician.
4. Ensure timely referral to an in-person appropriate care setting (e.g., in-person office visit) for services requiring in-person care (e.g., physical examination, laboratory testing, or radiologic imaging).
5. Maintain all information from the consultation as part of the patient's medical record.
6. Ensure all documentation is available to Company upon request and as otherwise required by the provider's agreement with Company. Company may conduct reviews and audits of telehealth services provided to members. Failure to produce the requested information, including the medical record, may result in a denial of the service.

E. Telehealth security and confidentiality requirements

Providers must consider the security, patient confidentiality and privacy needs that arise from using telehealth. Providers who offer telehealth must use a secure, electronic communication channel. In addition to any other security and confidentiality criteria required by law and Company policies, the electronic channel must have:

1. Secure cameras and software that comply with Health Insurance Portability and Accountability Act (HIPAA) requirements.
2. A mechanism to authenticate the identity of the member and their identification number.
3. The patient's informed consent to participate in the consultation, including appropriate expectations, disclaimers and service terms, and any fees that may be imposed.
4. Structured symptom assessment and risk reduction features (e.g., patients are directed to contact the practice and/or emergency room if certain symptoms are reported).
5. No inclusion of third-party advertising or use of the patient's information for marketing.

6. Payment Card Industry Data Security Standard (PCI-DSS) compliance.
7. Provider compliance with all applicable local, state, and federal privacy and security regulations related to performing telehealth services.

F. Accessibility requirements

Telehealth must be accessible to all members, including those with disabilities. Accessibility standards for members with disabilities include that:

Any information and communication technology utilized must conform to the accessibility standards of Web Content Accessibility Guidelines 2.1 A/AA or latest version, **available here**, as well as with any additional applicable federal and state disability laws.

Virtual only providers are additionally subject to the following:

While virtual providers must otherwise meet all the above telehealth criteria, as well as all other participation criteria applicable to their services/specialty, virtual providers are not required to maintain a physical office or to treat members in person.

A. Referral plan

Virtual only providers must:

Have a referral plan in place, acceptable to Company, to refer members to participating qualified health care providers for all in-person services required under the participation criteria and for any other needed preventive, acute, chronic, or emergent in-person services (e.g., physical examination, laboratory testing, or radiologic imaging). All referrals should be: (1) timely; (2) to an appropriate care setting; (3) to a participating provider that is geographically accessible to the member (not more than 30 minutes away from the member, or such longer timeframe determined by Company for members in rural areas); and (4) to a provider who will engage in bi-directional communication with the virtual only provider on the member's health, as appropriate, for treatment purposes. Company is entitled to review provider's referral plan at any time.

B. Primary care services

Virtual only providers providing primary care services or related services are not serving as primary care providers/physicians (PCPs), may not represent themselves to members as their PCPs, and are not available for member PCP selection, unless explicitly specified otherwise in writing by Company. We encourage providers to recommend that their patients seek age-appropriate in-person preventive care, in accordance with evidence-based guidelines.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location. Not all services are covered. Exclusions, limitations and conditions of coverage may apply. Plans may be subject to medical underwriting or other restrictions. Rates and benefits vary by location. Plans not available in all states. Providers are independent contractors and not agents of Aetna®. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Aexcel designation is only a guide to choosing a physician. Members should confer with their existing physicians before making a decision. Designations have the risk of error and should not be the sole bases for selecting a doctor. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Aetna receives rebates from drug manufacturers that may be taken into account in determining the Aetna preferred drug list. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Pharmacy participation is subject to change. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy providing prescription services by mail. This pharmacy is a for-profit entity. Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. This pharmacy is a for-profit entity. Medications on the precertification, step therapy and quantity limits lists are subject to change. Aetna's Preferred Drug List is subject to change.

Information is believed to be accurate as of the production date; however, it is subject to change. Visit **Aetna.com** or **AetnaMedicare.com** for more information about Aetna® plans.

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