Aetna Better Health® of Oklahoma continuity of care plan update — July 2024

Dear Health Care Providers,

As a part of our ongoing commitment to support our health care partners and ensure the highest quality of care for our members, Aetna Better Health implemented a temporary waiver of prior authorization (PA) denials for health care facilities.

This initiative, which went into effect in early April, has been instrumental in facilitating smoother and more efficient access to necessary medical services. **As this waiver period comes to an end July 1, we are dedicated to ensuring a seamless transition and continued excellence in member care.**

On the following pages, you will find our comprehensive prior authorization process as well as resources and tools. Thank you for maintaining continuity of care for our members during and beyond this transition period.

Submit PA requests online here:
Apps.Availity.com/availity/web/public.elegant.login

Forms can be found here:
AetnaBetterHealth.com/oklahoma/providers/materials-forms.html

Upcoming office hours**:**
Tuesday, July 2 from 11 AM to noon
Tuesday, July 30 from 11 AM to noon

Teams login information:
Meeting ID - 253 222 155 812
Passcode - BDuodq

Let's talk.

Our Provider Experience team is ready to assist with any PA support you may need today.

1-844-365-4385

To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the Provider Secure Web Portal or call us.

Documentation requirements for authorization request:

- Member information
- Diagnosis code(s)
- Treatment or procedure code(s)
- Anticipated start and end dates of service(s)
- All supporting clinical documentation to support medical necessity

Include:

- Office/ department contact name
- Telephone
- Fax number

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Aetna Better Health® of Oklahoma

Prior authorizations

Primary care providers (PCP) or treating providers are responsible for initiating and coordinating a members request for authorization. However, specialists, PCPs and other providers may need to contact the Prior Authorization Department directly to obtain or confirm a prior authorization.

The requesting provider is responsible for complying with Aetna Better Health of Oklahoma's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health of Oklahoma will not prohibit or otherwise restrict providers, acting within the lawful scope of their practice, from advising, or advocating on behalf of, an individual who is a patient and member of Aetna Better Health of Oklahoma about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Services Requiring Prior Authorization

Our Secure Web Portal located on our website, lists the services that require prior authorization, consistent with Aetna Better Health of Oklahoma's policies and governing regulations. The list is updated at least annually and updated periodically as appropriate. In addition to the list, you will find a link that will allow you to access ProPAT, which is an easy tool in which you enter codes to see if a Prior Authorization is needed or not. For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website. Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment. All out of network services must be authorized. All services provided by out-of-state providers/ practitioners greater than 50 miles from the state border require prior authorization.

Exceptions to Prior Authorizations

- Access to family planning services
- Well-woman services by an in-network provider
- Minor Consent Services
- Basic Prenatal Care
- Preventive Services
- STD and HIV testing and services
- Behavioral Health Crisis services
- Medication Assisted Treatment (MAT)
- Programs for Assertive Community Treatment (PACTs)
- Behavioral Health Urgent Services

Emergency Services

Aetna Better Health of Oklahoma covers emergency services without requiring prior authorization for members, whether the emergency services are provided by a contracted or non-contracted provider. Aetna Better Health of Oklahoma will not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms. Aetna Better Health of Oklahoma will cover emergency services provided outside of the contracting area except in the following circumstances:

- When care is required because of circumstances that could reasonably have been foreseen prior to the members departure from the contracting area
- When routine delivery, at term, if member is outside the contracting area against medical advice, unless the member is outside of the contracting area due to circumstances beyond her control. Unexpected hospitalizations due to complications of pregnancy are covered.

Aetna Better Health of Oklahoma will abide by the determination of the physician regarding whether a member is sufficiently stabilized for discharge or transfer to another facility.

Payment will not be withheld from providers in or out of network. However, notification is encouraged for appropriate coordination of care and discharge planning. The notification will be documented by the Prior Authorization Department or concurrent review clinician. Additionally, emergency medical services include at least a 72-hour supply of medically necessary discharge drugs when needed.

Post-stabilization Services

Aetna Better Health of Oklahoma will cover post-stabilization services under the following circumstances without prior authorization, whether or not the services are provided by an Aetna Better Health of Oklahoma network provider:

- When Aetna Better Health of Oklahoma authorized the services
- The provider requested prior approval for the post-stabilization services, but Aetna Better Health of Oklahoma did not respond within one (1) hour of the request
- The provider could not reach Aetna Better Health of Oklahoma to request prior approval for the services
- The Aetna Better Health of Oklahoma representative and the treating provider could not reach an agreement concerning the member's care, and an Aetna Better Health of Oklahoma medical director was not available for consultation
    - Note: In such cases, the treating provider will be allowed an opportunity to consult with an Aetna Better Health of Oklahoma medical director; therefore, the treating provider may continue with the member's care until a medical director is reached or any of the following criteria are met
        - An Aetna Better Health of Oklahoma provider with privileges at the treating hospital assumes responsibility for the member's care
        - An Aetna Better Health of Oklahoma provider assumes responsibility for the member's care through transfer
        - Aetna Better Health of Oklahoma and the treating provider reach an agreement concerning the member's care
        - The member is discharged

Provider Requirements

Generally, a member's PCP, or treating provider is responsible for initiating and coordinating a request for authorization. However, specialists and other providers may need to contact the Prior Authorization Department directly to obtain or confirm a prior authorization.

The requesting provider is responsible for complying with Aetna Better Health of Oklahoma's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims.

A prior authorization request must include the following:

- Current, applicable codes may include:
  - Current Procedural Terminology (CPT)
  - International Classification of Diseases, 10th Edition (ICD-10)
  - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth, sex, and identification number of the member
- Primary care provider or treating provider
- Name, address, phone and fax number and signature, if applicable, of the referring or provider
- Name, address, phone, and fax number of the consulting provider
- Problem/diagnosis, including the ICD-10 code
- Reason for the referral
- Presentation of supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request

All clinical information must be submitted with the original request.

How to request Prior Authorizations

A prior authorization request may be submitted by:

- Submitting the request through the 24/7 Secure Provider Web Portal located on the Aetna Better Health of Oklahoma's website at **AetnaBetterHealth.com/oklahoma/index.html**
- Fax the request form to the appropriate fax number below. Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing.
  - Prior Authorization **833-923-0831**
  - Concurrent Review **833-923-0780**
  - Behavioral Health **833-923-0829**
- Through our toll-free number at **1-844-365-4385**.

To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the Provider Secure Web Portal linked above or call us at **1-844-365-4385**. The portal will allow you to check status, view history, and email a Care Manager for further clarification if needed.

Medical Necessity Criteria

To support prior authorization decisions, Aetna Better Health uses nationally recognized, and community developed, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Prior authorization staff members that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to Aetna Better Health policies and procedures.

Clinical medical necessity determinations are based only on the appropriateness of care and service and the existence of coverage. Aetna Better Health does not specifically reward practitioners or other individuals for issuing denials of coverage or care; or provide financial incentives of any kind to individuals to encourage decisions that result in underutilization.

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health uses the following medical review criteria. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria. The criteria are consistently applied, consider the needs of the members, and allow for consultations with requesting providers when appropriate. Providers may obtain a copy of the utilization criteria upon request by contacting an Aetna Better Health Provider Experience representative. These are to be consulted in the order listed:

- Criteria required by applicable State or federal regulatory agency
- Aetna Medicaid Pharmacy guidelines
- Applicable MCG Guidelines as the primary decision support for most medical diagnoses and conditions
- American Society of Addiction Medicine Criteria (ASAM) – substance use disorder services
- Aetna Clinical Policy Bulletins (CPBs)
- Aetna Policy Council Review

If MCG states “current role remains uncertain” for the requested service, the next criteria in the hierarchy, Aetna Better Health of Oklahoma CPBs, should be consulted and utilized. Medical and behavioral health management criteria and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

MCG formerly (Milliman Care Guidelines)

Aetna Better Health of Oklahoma uses MCG guidelines to verify consistency in hospital–based utilization practices. The guidelines span the continuum of member care and describe best practices for treating common conditions. MCG guidelines are updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific case is available for review upon request.

American Society of Addiction Medicine (ASAM)

Aetna Better Health of Oklahoma uses ASAM criteria for authorizing Substance Use Disorder (SUD) services. ASAM is a nationally recognized, evidence-based criteria which are applied based on the needs of the individual member. A copy of individual guidelines pertaining to a specific case is available for review upon request.

Timeliness of Decisions and Notifications to Providers, and Members

Aetna Better Health makes prior authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by the Oklahoma Health Care Authority (OHCA), Aetna Better Health adheres to the following decision/ notification time standards. For standard requests, notice will be provided as expeditiously as the member's health condition requires, but in a time frame not to exceed 72 hours following receipt of the request for service, in accordance with Oklahoma Statute Title 56 § 4002.6.

For urgent requests, notice will be provided as expeditiously as the member's health condition requires, but in a time frame not to exceed 24 hours following receipt of request, in accordance with Oklahoma Statute Title 56 § 4002.6. Aetna Better Health ensures the availability of appropriate staff twenty-four (24) Hours, seven (7) Days per week to respond to authorization requests within the established time frames for urgent requests. Departments that handle pre-prior authorizations must meet the timeliness standards appropriate to the services required.

Decision/Notification Requirements

Decision	Notification Timeframe	Extension
Urgent pre-service decision (approvals and denials)*	Within 24 hours of the initial request	Up to 48 hours if member requests** Up to 48 hours if health plan requests and State approves**
Non-urgent preservice decision (approvals and denials)	Within 72 hours of the initial request	Up to 14 days if member requests** Up to 14 days if health plan requests and State approves**
Urgent concurrent request (approvals and denials)	Within 24 hours of the initial request	Up to 48 hours if member requests** Up to 48 hours if health plan requests and State approves**

*Note: Includes DME requests within 5 days of discharge from acute.
*Note: Includes member transfer from acute to post-acute level of care (LTAC, SNF, Rehab)

Prior Authorization Period of Validation

Prior authorization numbers are valid for the date of service authorized. The member must be enrolled and eligible on each date of service.

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, Aetna Better Health will assign a prior authorization number, which refers to and documents the approval. Aetna Better Health sends written documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request.

Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health makes such decisions on a case-by-case basis in consultation with the Aetna Better Health medical director.

Out-of-State Providers

Members may travel to a border state (Arkansas, Colorado, Kansas, Missouri, New Mexico or Texas) within fifty (50) miles of the Oklahoma State border to receive covered services. Reimbursement for covered services in another state is available to the extent that reimbursement for covered services are furnished within Oklahoma boundaries. The services rendered must be provided by a provider who is contracted with Aetna Better Health.

On occasion, a member may need services that are out of state and greater than the fifty (50) miles from the Oklahoma State border due to unavailability of the in-State service. All requests for a service by a provider out of state greater than the fifty (50) mile Oklahoma border require prior authorization review. These are reviewed on a case-by-case basis and require detailed verification of unavailability within Oklahoma.

American Indian/Alaska Native (AI/AN)

AI/AN members can access out-of-network Indian Health Care Providers (IHCP) for services that are covered benefits.

Notice of Action (NOA) Requirements

To deny, reduce, suspend, or terminate a prior authorization request, limits, or to authorize a service in the amount duration or scope that is less than requested or denies payment, in whole or part for a service, an NOA must be completed.

The notice will include:

- The action that Aetna Better Health has or intends to take
- The specific reason for the action, customized to the member circumstances, and in easily understandable language to the member
- A reference to the benefit provision, guideline, or protocol or other similar criterion on which the denial decision was based
- The name and contact information for the physician or dentist that reviewed and denied the service
- Notification that, upon request, the provider or member, if applicable, may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based
- Notification that the provider has the opportunity to discuss medical and behavioral healthcare UM denial decisions with a physician or other appropriate reviewer
- A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal
- An explanation of the appeals process, including the right to member representation (with the member's permission) and the timeframes for deciding appeals
- A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures
- The member or provider (with written permission of the member) right to request a Medicaid State Fair Hearing and instructions about how to request a Medicaid State Fair Hearing
- A description of the expedited appeals processes for urgent preservice or urgent concurrent denials

- The circumstances under which expedited resolution is available and how to request it
- The member's right to request continued benefits pending the resolution of the appeal or pending a Medicaid Fair Hearing, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these benefits
- Translation service information
- The procedures for exercising the member's rights

Continuation of Benefits

Aetna Better Health will continue member's benefits during the appeal process if:

- The member or the provider files the appeal timely
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider (i.e., a network provider)
- The original period covered by the original authorization has not expired, unless inadequate notice was given to allow a member a timely appeal

Aetna Better Health will continue the member's benefits until one of the following occurs:

- The member withdraws the appeal
- A State fair hearing office issues a hearing decision adverse to the member
- The time period or service limits of a previously authorized service has been met

Prior Authorization and Coordination of Benefits

Aetna Better Health will coordinate benefits with other Providers, any Subcontractors and OHCA's contractors. If other insurance is the primary payer before Aetna Better Health, prior authorization of a service is not required, unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow our prior authorization rules.

Self-Referrals

Aetna Better Health does not require referrals from Primary Care Providers (PCP) or treating providers. Members may self-refer and access some services without an authorization from their PCP. These services include vision care, family planning, minor consent services, and women's health care services. The member must obtain these self-referred services from the Aetna Better Health provider network, except in the case of family planning.

Members may access family planning services from any qualified provider. Members also have direct access to Women's Health Care Provider (WHCP) services. Members have the right to select their own women's health care provider, including nurse midwives participating in the Aetna Better Health network, and can obtain maternity and gynecological care without prior approval from a PCP.

Referrals

Aetna Better Health® members are not required to obtain a written referral from their PCP to obtain services from a participating provider.

Members can self-refer to a provider for services. However, members should be informed that there are possible consequences, including but not limited to, experiencing a delay in accessing the services needed during this process.

Members can self-refer for the following services:

- Behavioral health services, including SUD treatment
- Vision services
- Emergency services
- Family planning services
- Prenatal care
- Department of health providers, including mobile clinics
- Services provided by IHCPs to AI/AN members

Authorization Denials

If you receive an authorization denial you may request a peer-to-peer review. To request a peer-to-peer review you will call **1-833-459-1998**.