Aetna

Optum has contracted with Aetna Better Health to provide NP model of care during a nursing facility event and has assumed responsibility for obtaining service authorizations for Part A Skilled Services. Facility representatives should contact Optum NP/RN when an authorization is needed.

Member type	Aetna - Dual Medicare/Medicaid
NOMNC Fax	NOMNC Letter -- SNF needs to fax to Health Plan 855-734-9389
Authorization #	#855-364-0974; Select option #2; then option #4
Authorization Fax#	#855-734-9389
Claims #	#855-364-0974; Select option #2; then option #3
Scenarios	
PART A AUTHORIZATION	Optum NP will submit clinical information to Health Plan for authorization purposes. The Health Plan will fax the uthorization numbers back to the facility representative designated by the Optum NP. NOMNCS are administered by the facility representative as they do for traditional Medicare.
CURRENT RESIDENT Enrolled in MyCare while in the facilty - prior authorization. Skilling without 3 day hospital stay.	Three Day qualifying stay has been waived. Optum NP will submit clinical information to Health Plan for any new skilled services and/or skilled services after hospitalization. The Health Plan will fax the Authorization numbers to the facility representative designated by Optum NP.
NEW TO FACILITY FROM HOSP OR COMMUNITY New Fully Integrated Dual Member being admitted to your facility for the first time from the hospital or community:	Optum NP to obtain facility admission authorization. Plan CM and UM staff will work with the inpatient discharge planner to identify a network facility for safe discharge. The Plan CM and Optum NP/RN will collaborate with each other to support the member's transition from the hospitalization. A custodial admission to the nursing facility does not require authorization if the memer is not receiving non-skilled services. Plan CM will notify plan UM staff of all long-term or custodial admissions.
CURRENT MEMBER READMIT TO FACILITY Current Fully Integrated member is being readmitted to facility following a hospitalization	The nursing facility will notify Optum NP/RN of the member's readmission. Optum NP will submit clinical information to Health Plan UM staff to determine skilled benefit. Aetna will fax the authorization of any new services to the nursing facility representative designated by Optum NP/RN. If the member is returning to their previous custodial level of care, and no new services are being provided, no authorizaotin is required.
SHORT TERM COMMUNITY MEMBER FROM HOSP TO FACILITY If the member is new to the facility short term care or transitional care needed. (Member discharged from the hospital as skilled; Medicare benefits). How does the provider get a prior authorization number to put on the claim for reimbursement?	N/A-This population is not managed by Optum.
CONTINUATION OF SKILLED TIME How does the provider communicate a need for continued skilled care?	Facility to communicate through collaboration with Optum NP/RN. Optum NP/RN will communicate additional needs to Health Plan. Extension of skilled benefit will be determined by Medicare guidelines. The authorizatoin determination will be provided by the plan and will be faxed to the facility representative identified by Optum NP/RN.
AFTER HOURS/HOLIDAY AUTHORIZATIONS How can authorizations be obtained after hours, holidays and weekends? Part A and B	Please provide the member will all medically necessary serivces. Notify Optum NP/RN of the need for service authorization. Optum will notify the Health Plan who will fax the authorizatoin number to the nursing facility representative desinaged by Optum within the nexte business day. Part B authorizations are processed directly by the Health Plan. Please call or fax the Aetna Better Health Prior Authorization team (contact information above) while providing all medically necessary services.
RETROACTIVE AUTHORIZATIONS Are retroactive authorization requests for Part A skilled?	When patient condition changes and Optum is not notified, retroactive authorization may be considered based on Medicare criteria. Notify Optum NP of the event.
BED HOLD AUTHORIZATION Is an authorization required for Bed Hold days when member is admitted to hospital or on LOA?	Contact the Health Plan Prior Authorization team using the contact information listed above to obtain an authorizatoin.

HOSPITAL ADMIT AUTHORIZATION When members are admitted to the hospital from the facility, is the facility responsible for obtaining an authorization for the hospitalization?	The hospital is responsible for notifying the Health Plan of the admission and for obtaining an authorization.
911 ADMISSION What are the requirements for an emergency "911" admission?	The hospital is responbsible for notification of an admission. The nursing facility should follow their standard emergency protocols.
PART B AUTHORIZATION	Part B is the responsibility of Health Plan. The NP will write the order, the facility representative to contact Health Plan for authorization number.
THERAPY LOG	The nursing facility is to contact Optum NP/RN to obtain authorization for therapy services. The health plan will fax the authorization numer to the nursing facility representative designated on the request.
PHYSICIAN APPOINTMENTS When members are sent out for physician appointments or other services, is the facility responsible for obtaining authorization for those services?	An authorization is not required for wellness or follow up visits after a medical event. Outpatient and out-of-network authorizations are the responsibility of the treating provider. A transportation authorization may be necessary according to plan benefits (See Transportation section below). Please review the transporation benefit with the Aetna Better Health Care Manager for your facility.
DME / OUTPATIENT SERVICES AUTHORIZATION Will the facility be required to obtain authorization for services such as DME, Outpatient Services when provided and billed by the facility for skilled and/or LTC?	The serice provider is responsible for obtaining the service authorizatoin.
Behavioral Health Managing Provider	The serice provider is responsible for obtaining the service authorization through Aetna.
When the Plan is the secondary payer, will the facility receive a paid claim EOP for the Medicaid portion of the benefit even if there is a $0 payment? This is needed for Medicare cost reporting.	Facility needs to call Health Plan Provider Relations/Claims number above for information
EXPEDITE	Facility is responsible for expedition of authorizations through the health plan. If unsuccessful, contact Optum NP/RN or Provider Relations Advocate for help in communication. Facility needs to call Health Plan for information.
APPEAL PROCESS	If the nursing facility would like to discuss a service denial, within 24 hours of denial receipt, contact the Health Plan Prior Authorizatoin team (see contact information above). If after 24 hours of denial receipt, : standard Medicare Appeal process is followed
TRANSPORTATION	Emergency transportation is covered for all members under the health plan WAIVER MEMBERS: Medical and non-medical covered; members may be ambulatory NON-WAIVER MEMBERS: Med transportation ONLY covered for ambulette and non-emergency ambulance; Ambulatory members only over 30 miles and medically necessary; ambulatory members must arrange own transportation under 30 miles. NOTE: arranged via Logisticare & Medically neccessary: non-emergency transportation, greater than 30 miles to be seen by provider/practitioner

For Transportation Contact Logisticare:
Members Questions: 855-364-0974
Reservations: 866-799-4395
Ride Assistance: 866-799-4405
Facilities Contact for Standing Orders: 866-910-7680
Facility Fax Contact: 866-910-7681

Emergency Transportation is covered for all members under the health plan and is billed directly to the health plan.

Waiver Members:

- Medical and non-medical transportation is covered – Arranged via Logisticare with no mileage restriction
- Members may be ambulatory

Non-waiver Members:

- Medical transportation **ONLY -** is covered for ambulette (non-ambulatory, wheelchair bound) and non-emergency Ambulance (i.e. Stretcher, ALS/BLS) transportation - Arranged via Logisticare with no mileage restriction
- Ambulatory members are covered **ONLY** if transport is over 30 miles and is medically necessary** – Arranged via Logisticare
- Ambulatory members must arrange own transportation for under 30 miles this includes community and skilled nursing members. They do not need to contact Logisticare for these arrangements.

**Medically Necessary: non-emergency transportation, greater than 30 miles, to be seen by a provider/practitioner