

SERVICES NOT COVERED BY AETNA BETTER HEALTH OF NEW YORK OR MEDICAID

You must pay for services that are not covered by Aetna Better Health of New York or by Medicaid if your provider tells you in advance that these services are not covered, AND you agree to pay for them are:

Examples of services not covered by Aetna Better Health of New York or Medicaid:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Services of a Provider that is not part of the plan (unless Aetna Better Health of New York sends you to that provider)

If you have any questions, call Member Services at **1-855-456-9126**.

SERVICE AUTHORIZATIONS, ACTIONS AND ACTION APPEALS

When you ask for approval of a treatment or service, it is called a **service authorization request**. To submit a service authorization request, you must

Service authorization steps

Following are the steps for pre-approval:

- Your provider gives Aetna Better Health information about the services he or she thinks you need.
- Aetna Better Health reviews the information.
- If the request cannot be approved, a different Aetna Better Health provider will review the information.
- Aetna Better Health will let you know when we make a decision. We will send you and your provider a letter to tell you about our decision. You and your provider will get a letter when a service is approved or denied.
- If the request is denied, the letter will say why.
- If a service is denied, you or your provider can file an appeal.

We will authorize services in a certain amount and for a specific period. This is called an **authorization period**.

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Prior Authorization

Some covered services require prior authorization (approval in advance) from our Prior Authorization staff before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- Medical / Adult Day Health Care
- Attendant Care
- Audiology and Hearing Aids
- Dentistry
- Dietary Supplements and Nutritional Counseling
- Durable Medical Equipment includes Medical/Surgical Supplies, Prosthetics, Orthotics and Orthopedic footwear, Canes, Hospital Bed, Wheelchairs, Oxygen and Walkers
- Home Care- Skilled/Licensed Nursing (RN or LPN) Physical Therapy, Occupational Therapy, Speech Pathology, Medical Social Services
- Home Care- Non-licensed Home Health Aides (HHA)
- Home Delivered or Congregate Meals
- Medical Supplies
- Non-Emergency Transportation
- Nursing Home Care
- Personal Care-includes housekeeping, meal prep, bathing, toileting
- Personal Emergency Response System (PERS)
- Podiatry
- Prosthetics and Orthotics
- Respiratory Therapy- medical equipment, supplies, respiratory therapy, and oxygen
- Social and Environmental Supports
- Social Day Care
- Speech Therapy
- Vision
- Telehealth
- Consumer Directed Personal Assistance Services (CDPAS)

Concurrent Review

You can also ask your Care Manager to get more of a service than you are getting now. This is called **concurrent review**.

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Retrospective Review

Sometimes we will do a review on the care you are getting to see if you still need the care. We may also review other treatments and services you already got. This is called **retrospective review**. We will tell you if we do these reviews.

What happens after we get your service authorization request?

The plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or **fast track** process. You or your doctor can ask for a *fast-track* review if it is believed that a delay will cause serious harm to your health. If your request for a *fast-track* review is denied, we will tell you and your request will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than indicated below.

Timeframes for prior authorization requests

- **Standard review:** We will make a decision about your request within 3 workdays of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14 day if we need more information.
- **Fast track review:** We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests

- **Standard review:** We will make a decision within 1 workday of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.

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- **Fast track review:** We will make a decision within 1 workday of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 workday if we need more information.

If we need more information to make either a standard or fast track decision about your service request, the timeframes above can be extended up to 14 days. We will:

- Write and tell you what information is needed. If your request is in a *fast track* review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Decide as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling **1-855-456-9126** or writing.

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling **1-866-712-7197**.

If our answer is YES to part or all of what you asked for, we will authorize the service or give you the item that you asked for.

If our answer is NO to part or all of what you asked for, we will send you a written notice that explains why we said no. See ***How do I File an Appeal of an Action?*** which explains how to make an appeal if you do not agree with our decision.

What is an Action?

When Aetna Better Health of New York denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends, or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required timeframes, those are considered plan "actions. An action is subject to appeal. (See *How do I File an Appeal of an Action?* below for more information.)

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Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend, or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take.
- Cite the reasons for the action including the clinical rationale, if any.
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process).
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal.
- Describe the availability of the clinical review criteria relied upon in making the decision, if the involved issues of medical necessity or whether the treatment or service in question was experimental or investigational; **and**
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

The notice will also tell you about your right to an appeal and a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing.
- It will say that that you must file an appeal before asking for a Fair Hearing; **and**
- It will explain how to ask for an appeal.

If we are reducing, suspending, or terminating an authorized service the notice will also tell you about your rights to have your services continued while your appeal is decided. To have your services continued you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days

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of the date on the notice. If we are reducing, suspending, or terminating and authorized service and you want your services to continue while your appeal is decided, you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I Contact my Plan to file an Appeal?

We can be reached by calling **1-855-456-9126** or writing to PO Box 81040, 5801 Postal Road, Cleveland, OH 44181. The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a notice telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a restriction, reduction, suspension, or termination of services you are currently authorized to receive, you must request a plan appeal to continue to receive these services while your appeal is decided. We must continue your service if you ask for a plan appeal no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later. To find out how to ask for a plan appeal, and to ask for aid to continue, see “**How do I File an Appeal of an Action?**” above.

Although you may request a continuation of services, if the plan appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your case was being reviewed.

How Long Will It Take the Plan to Decide My Appeal of an Action?

Unless your appeal is fast tracked, we will review your appeal of the action taken by us as a standard appeal. We will send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. We will also send you your records that are part of the appeal review.

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We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend, or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases, you may request a “*fast track*” appeal. (See “**Fast Track Appeal Process**” section below.)

Fast Track Appeal Process

We will always expedite our review if the appeal is about your request for more of a service you are already receiving. If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for a *fast-tracked* review of your appeal. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for a *fast-track* appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for a *fast-track* appeal within 2 days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Note: You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice. If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an “external appeal” of our decision.

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State Fair Hearings

If we deny your plan appeal or fail to provide a Final Adverse Determination notice within the timeframes under **“How Long Will It Take the Plan to Decide My Appeal of an Action?”** above, you may request a Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a Fair Hearing within 120 calendar days of the date we sent you the Final Adverse Determination notice. If we are reducing, suspending, or terminating an authorized service and you want to make sure that your services continue pending the Fair Hearing, you must make your Fair Hearing request within 10 days of the date on the Final Adverse Determination notice.

Your benefits will continue until you withdraw the Fair Hearing or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance (OTDA):

Online Request Form: [Request Hearing | Fair Hearings | OTDA \(ny.gov\)](#)

Mail a Printable Request Form:

NYS Office of Temporary and Disability Assistance Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

Fax a Printable Request Form: **518-473-6735**

Request by Telephone:

Standard Fair Hearing line – **1-800-342-3334**

Emergency Fair Hearing line – **1-800-205-0110**

TTY line – **711** (request that the operator call **1-877-502-6155**)

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Request in Person:

New York City

14 Boerum Place, 1st Floor Brooklyn, New York 11201

Albany

40 North Pearl Street, 15th Floor Albany, New York 12243

For more information on how to request a Fair Hearing, please visit:

<http://otda.ny.gov/hearings/request/>

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called a fast-track external appeal. The external appeal reviewer will decide a fast-track appeal in 72 hours or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the “one that counts.”

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COMPLAINTS AND COMPLAINT APPEALS

Aetna Better Health of New York will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by Aetna Better Health of New York staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint, please call: (855) 456-9126 or write to: PO Box 81040 5801 Postal Road Cleveland, OH 44181. When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Complaint?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you, didn't show up, or you do not like the quality of care or services you have received from us, you can file a complaint with us.

The Complaint Process

You may file a complaint orally or in writing with us. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information, but the process must be completed within 7 days of the receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

Our answer will describe what we found when we reviewed your complaint and our decision about your complaint.

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How do I Appeal a Complaint Decision?

If you are not satisfied with the decision, we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal orally or in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement within 15 business days telling you the name, address, and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial compliant decision. For standard complaint appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the *fast-track* complaint appeal process. For *fast-track* complaint appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and *fast track* complaint appeals, we will provide you with written notice of our decision of your complaint appeal. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

Participant Ombudsman

The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. You can get free independent advice about your coverage, complaints, and appeal options. They can help you manage the appeal process. They can also provide support before you enroll in a MLTC plan like Aetna Better Health of New York. This support includes unbiased health plan choice counseling and general plan related information. Contact ICAN to learn more about their services:

- Phone: **1-844-614-8800** (TTY Relay Service: **711**)
- Web: www.icannys.org | Email: ican@cssny.org

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