Aetna Better Health® of Kansas
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Aetna Better Health® of Kansas

Appointment Availability Standards/ Telephone Accessibility Standards

This bulletin serves as a reminder to providers of the appointment availability standards for eligible members. This is in accordance with minimum appointment availability standards based on the acuity and severity of the presenting condition in conjunction with the member's past and current medical history. You are contractually required to meet the timely access to care and services below, considering the urgency of and the need for the services. In addition, we also have provided information as to the expectations concerning Telephone accessibility standards for afterhours calls from members.

The following grid considers the timeframes from KDHE and National Committee for Quality Assurance (NCQA) regulations.

Provider Type	Emergency Services	Urgent Care	Preventative & Routine Care	Wait Time in Office Standard	After-Hours
PCP	Same Day and or refer to emergency room as necessary	Within 48 hours	Within 3 weeks	No more than 45 minutes	An after-hours phone call from an appropriate practitioner within an hour of the member contacting the organization.
Specialty Referral (Includes high-volume specialty care)	Same Day	Within 48 hours of referral	Within 30 calendar days	No more than 45 minutes	

Provider Type	Emergency Services	Non-Life-Threatening Urgent Care	Urgent – no immediate danger	Pregnant Women with Substance Abuse	Non-Pregnant with Injection Substance Abuse
Members Presenting for SUD Services	Immediately	Assessment within 24 hours; services rendered within 24 hours of assessment	Assessment within 14 calendar days	Treatment within 24 hours of assessment. ; When it is not possible to admit the Member within this timeframe interim services shall be made available within forty-eight (48) hours of initial contact to include prenatal care."	Assessment and admission to treatment no later than 14 calendar days of making request for Assessment. . If no program has the capacity to admit the Member within the required timeframe, interim services shall be made available to the Member no later than forty-eight (48) hours after such request. Admission to treatment must not exceed 120 calendar days of the request for assessment."

Members Presenting for Mental Health Services

- **Members Discharged from Inpatient Care**
  Providers must encourage member attendance and follow-up appointments after discharge within 1-10 days. The timeframe begins the day the member is discharged.

- **Members not Admitted for Inpatient Care for Mental Health Services**
  Providers must follow up with any member, seen for or provided with any emergency service and not admitted for inpatient care and treatment, to determine the need for any further services or referral to any services, within seventy-two (72) hours of crisis resolution.

Provider Type	Emergency Services	Non-Life Threatening (Urgent Care)	Urgent (no immediate danger)_	Preventative & Routine	After Hours	Wait Time in Office Standards
Members Presenting for Mental Health Services	Immediately	Assessment within 6 hours	Members with non-urgent needs shall be assessed within fourteen (14) business days of the date the services are requested	New Patient initial Visit within 10 business days of request for services	24 hours per day/ 7 days per week	NCQA: No more than 45 minutes

- Non-life-threatening urgent: There is no immediate danger to self or others and/or if the situation is not addressed within 6 hours, it may escalate resulting in a risk to self or others:
  - Extreme anxiety
  - Parent child issues
  - Passive suicidal ideation
  - Excess drug or alcohol usage
- Urgent – no immediate danger: There is no immediate danger to self or others and/or if the situation is not addressed within 14 business days, it may escalate resulting in a risk to self or others:
  - Follow-up to a crisis stabilization
  - Escalating depression
  - Escalating anxiety
  - Escalating drug/alcohol usage
  - Escalating behavioral issues in children

Telephone Accessibility Standards

You are responsible for after-hours coverage either by being available or having on-call arrangements in place with other qualified, participating Aetna Better Health providers for the purpose of rendering medical advice and determining the need for emergency or other after-hours services including authorizing care and verifying member enrollment with us.

It is our policy that providers cannot substitute an answering service as a replacement for establishing appropriate on-call coverage. On-call coverage

response for routine, urgent, or emergent health care issues is held to the same accessibility standards regardless if after hours coverage is managed by the PCP, current service provider, or the on-call provider.

A published after-hours telephone number must be available to members to enable access to care 24 hours per day, 7 days per week. In addition, we encourage you to offer open access scheduling, expanded hours, and alternative options for communication (e.g., scheduling appointments via the web, communication via e-mail) between members, their PCPs, and practice staff. We routinely measure your compliance with these standards as follows:

- Our medical and provider management teams will evaluate emergency room data to determine if there is a pattern where a PCP failed to comply with after-hours access or if a member may need service coordination intervention.
- Our compliance and provider management teams will evaluate member, caregiver, and provider grievances regarding after hour access to care on a monthly basis to determine if a PCP is failing to comply.

In addition, you must comply with telephone protocols for all of the following situations:

- Answering member telephone inquiries in a timely manner
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a member
- Identifying and rescheduling broken and no-show appointments
- Identifying special member needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs
  Triage for medical and dental conditions and special behavioral needs for noncompliant individuals

We consider a telephone response acceptable/unacceptable based on the following criteria:

Acceptable – An active provider response, such as:

- Telephone is answered by provider, office staff, answering service, or voice mail
- The answering service either:
  - Connects the caller directly to the provider
  - Contacts the provider on behalf of the caller and the provider returns the call
  - Provides a telephone number where the provider/covering provider can be reached

- The provider's answering machine message provides a telephone number to contact the provider/covering provider

Unacceptable:

- The answering service:
  - Leaves a message for the provider on the PCP/covering provider's answering machine
  - Responds in an unprofessional manner
- The provider's answering machine message:
  - Instructs the caller to go to the emergency room for care, regardless of the exigencies of the situation, without enabling the caller to speak with the provider for non-emergent situations
  - Instructs the caller to leave a message for the provider
- No answer
- Listed number is no longer in service
- Provider is no longer participating in the Aetna Better Health network
- On hold for longer than five minutes
- Telephone lines are persistently busy despite multiple attempts to contact the provider

Hours of operation must be convenient to, and do not discriminate against, members. This includes offering hours of operation that are no less than those for non-members, commercially insured, or public fee-for-service individuals.

Questions?

If you have general questions about this communication, please contact our Provider Experience Department:
By Phone: **1-855-221-5656**
By Email: **providerexperience_ks@aetna.com**