Topic: Appointments and Availability Standards

Bulletin Date: April 2023

Providers are contractually required to meet the Ohio Department of Medicaid (ODM) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, taking into account the urgency of and the need for the services. This includes:

- Providers are required to notify Aetna Better Health of Ohio within **3 calendars days** if they are not able to comply with appointment wait times.
- Our Provider Experience Department will routinely monitor compliance and seek Corrective Action Plans (CAP) from providers that do not meet accessibility standard.

Please review below the behavioral health related standards:

Event	Expectation
Emergency Service	24-hours; 7 days a week
Urgent Care for Behavioral Health Condition	Seen within 48-hours of request
Behavioral Health Non-Life Threatening Emergency	Within 6-hours
Behavioral Health Routine Care	Within 10 business days or 14 calendar days, whichever is earlier
CANS Ongoing Assessment	Every 90 days or when a change in the Member's condition warrants a re-assessment
ASAM Residential/Inpatient Services – 3:3.1, 3.5, 3.7	Within 48 hours of Request
ASAM Medically Managed Intensive Services-4	24 hours, 7 days/week
Psychiatric Residential Treatment Facilities	Within 48-hours

Telephone Accessibility Requirements

After Hours coverage is defined as being available or having on-call arrangements in place for medical advice, determining the need for emergency and other after-hours services including authorizing care and verifying member enrollment. Providers are expected do the following:

- It is our policy that network providers cannot use an answering service as a replacement for on-call coverage
- All providers must have a published after-hours telephone number and maintain a system that will provide access to primary care **24-hours-a-day, 7-days-a-week.**

We will routinely measure the provider's compliance with these standards.

Please make sure to update the Provider Network Management (PNM) system if a covering provider is not contracted or affiliated with OhioRISE.

- Notification must occur in advance of providing authorized services
- Failure to notify the PNM system of the covering provider's affiliation may result in claim denials and the provider may be responsible for reimbursing the covering provider.

In the event that a provider fails to meet telephone accessibility standards, a Provider Experience Representative will contact the provider to inform them of the deficiency, provide education regarding the standards, and work to correct the barrier to care.

Thank you for servicing OhioRISE members

Ohio Provider Service Team