Welcome to Aetna’s office manual for participating physicians, facilities and office staff.

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Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).
Contacts

Chiropractic services in Alaska, Arizona, California, Nevada, New Mexico, Oregon, Utah and Washington
Visit our DocFind® online provider directory.

Dental services
Visit DocFind, our online provider directory.

Dialysis
Visit DocFind, our online provider directory.

Durable medical equipment, home infusion, respiratory therapy, home health and rehab provider network
Visit DocFind, our online provider directory.

Enhanced clinical review
MedSolutions Inc. is our enhanced clinical review vendor. We’ve implemented enhanced clinical review as a comprehensive approach to both quality and utilization management for high-tech radiology services like MRI/MRA, CT/CCTA, PET and nuclear cardiology.

Contact MedSolutions at:
Phone: 1-888-693-3211
Fax: 1-888-693-3210

Note: Members participating in this program are assigned to the radiology benefits management (RBM) by their residence ZIP codes. A member requesting services outside their participating RBM network may incur out-of-pocket expenses if precertification is not obtained. Providers in adjacent networks who are not participating in the RBM program should call the member’s assigned RBM prior to rendering a service. If there are any questions on whether a member needs a precertification authorization, the provider should contact their local RBM vendor.
Laboratory

Aetna’s network offers your patients access to a nationally contracted, full-service laboratory. It has conveniently located patient service centers.

Quest Diagnostics® is our national preferred laboratory. It provides tests and services to all Aetna members.

Find a convenient location, schedule an appointment and get testing reminders by visiting Quest Diagnostics or calling 1-888-277-8772.

Your market may also have contracted with local laboratory providers.

For a complete list of participating labs available in your area, visit DocFind, our online provider directory.

Health maintenance organization (HMO) members may be required to verify a participating lab with their independent practice association (IPA).

Paper claims addresses

California HMO only
PO Box 24019
Fresno, CA 93779-4019

Colorado only
PO Box 981107
El Paso, TX 79998-1107

Other West region states
PO Box 14079
Lexington, KY 40512-4079

Appeals
PO Box 14020
Lexington, KY 40512

Paper claims addresses
(Medicare)

Arizona HMO
PO Box 981106
El Paso, TX 79998-1106

California HMO
PO Box 981106
El Paso, TX 79998-1106

Medical groups and IPAs
PO Box 981514
El Paso, TX 79998-1514

Other paper claims
PO Box 14079
Lexington, KY 40512-4079

Physical, occupational and speech therapy

Visit DocFind, our online provider directory.

Colorado, North Texas (Dallas/Fort Worth) and South Texas (Houston, San Antonio and Austin)
American Therapy Administrators
Phone: 1-888-560-6855

Radiology

Visit DocFind, our online provider directory.

Sleep studies

All outpatient elective facility sleep studies (95805, 95807, 95808, 95810 and 95811) require prior authorization from MedSolutions. Home sleep studies (95800, 95801 and 95806) do not require prior authorization from MedSolutions.

Visit DocFind, our online provider directory.

Contact MedSolutions at:
Phone: 1-888-693-3211
Fax: 1-888-693-3210
Direct-access specialties

<table>
<thead>
<tr>
<th>State</th>
<th>Specialty</th>
<th>Products</th>
<th>Comments</th>
</tr>
</thead>
</table>
| All*    | Obstetrics and gynecology      | All benefits plans | (G) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.1  
(H) Preventive care services, and periodic follow-up care, including but not limited to, standing referrals to specialists for chronic conditions; periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions; and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice, as determined by the treating licensed health care provider acting within the scope of his or her practice.1  
Note that Aetna does not delegate monitoring and assessment of these standards to any of its contracted provider groups.  
Aetna will assess its contracted provider network against these standards by conducting an annual survey to assess availability of appointments and a provider satisfaction survey to solicit concerns and perspectives with regard to the standards.  
California — Language Assistance Program  
We encourage you to use our Language Assistance Program if you need help when providing care to non-English-speaking Aetna members in your office. There is no charge for this interpretation service.  
The toll-free telephone number for an interpreter is 1-800-525-3148. This number bypasses our Provider Service Center and connects directly to qualified interpreters. |

May not apply to California medical group/IPA-affiliated physicians.  
1California Code of Regulations, Title 28 — Managed Care, Chapter 2 — Health Service Plans, Article 7 — Standards, § 1300.67.2.2 Timely Access to Non-Emergency Health Care Services.

California — the Aetna Value Network

The Aetna Value Network is a subset of our larger California HMO network. We offer it in all or portions of the following counties: Contra Costa, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara and Sonoma. Standard HMO processes remain the same for this network option. The Aetna Value Network name appears in the upper-right corner of the member’s ID card.

California — Access Standards

These regulations require that each health plan’s contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following time frames:

• **Urgent care appointments**: same day or within 24 hours of the request for appointment  
• **Nonurgent appointments for primary care**: within seven calendar days of the request for appointment  
• **Nonurgent appointments with specialist physicians**: within 15 business days of the request for appointment, except as provided in (G) and (H) below1  
• **Nonurgent appointments with nonphysician mental health care providers**: within 10 business days of the request for appointment, except as provided in (G) and (H) below1  
• **Nonurgent appointments for ancillary services for the diagnosis or treatment of injury, illness or other health conditions**: within 15 business days of the request for appointment, except as provided in (G) and (H) below1  

California — Language Assistance Program

We encourage you to use our Language Assistance Program if you need help when providing care to non-English-speaking Aetna members in your office. There is no charge for this interpretation service.  
The toll-free telephone number for an interpreter is 1-800-525-3148. This number bypasses our Provider Service Center and connects directly to qualified interpreters.
California — specific medical record criteria

California requires that all medical record documentation include the following information:

• Documentation indicating the patient’s preferred language (California only). Documentation of offer of a qualified interpreter, and the enrollee’s refusal, if interpretation services are declined (California only).

Nevada — the Aetna Value Network

The Aetna Value Network is a subset of our larger Nevada HMO network. We offer it in all or portions of the following counties: Clark. Standard HMO processes remain the same for this network option. The Aetna Value Network name appears in the upper-right corner of the member’s ID card.

Specialty provider networks*

Aetna Specialty Pharmacy™ medicine and support services
Phone: 1-866-782-2779
Fax: 1-866-329-2779

Gynecologist as principal physician for Women’s Health Care Program (Texas only)

The direct-access program allows female members to visit any participating gynecologist for women’s health-related care without a referral. We’re expanding the program to allow the gynecologist to issue referrals for women’s health and non-women’s health conditions detected during a visit. In this instance, the gynecologist can refer the member to the appropriate specialist and continue overseeing the member for that condition. Or the gynecologist can request that the member’s primary care physician (PCP) follow up and provide oversight.

In addition, in keeping with Aetna’s expanded laboratory and radiology policy, the gynecologist can order any necessary laboratory or radiological testing without a referral. (This excludes pregnant women who are participating in our Beginning Right® maternity program.) The member should be referred to the appropriate capitated or contracted labs, if applicable.

How to bill

The gynecologist or PCP who performs the annual gynecologic primary and preventive visits should bill using the evaluation and management (E&M) codes for preventive visits (99384-7 and 99394-7). All other visits to the gynecologist should be coded using standard E&M codes. The gynecologist will collect the standard specialist copayment. When a woman uses both a gynecologist and a PCP for her care, the physicians should work together to coordinate her care. They should use their standard processes to communicate the treatment plans, services rendered and summaries of visits. Parts of the Aetna gynecologist as principal physician for Women’s Health Care Program allow:

• The gynecologist to act as the principal physician for all of women’s health care. It empowers the woman to choose either her gynecologist or her PCP to care for her needs at that particular time in her life based on the expertise of the physician she chooses.

*California physicians affiliated with a medical group/IPA should follow the precertification and ordering process for specialty medications established by their medical group/IPA.
• The woman to be evaluated by her gynecologist without a referral from the PCP.
• The gynecologist to perform and be paid for diagnostic testing that can be done in his or her office. This includes studies on the “Automatic List” as well as screening and diagnostic mammography, pelvic ultrasounds, urodynamic testing and bone density testing.
• The gynecologist to refer the member for all laboratory and radiological studies needed without requiring a referral from her PCP. All laboratory or radiological testing should continue to be performed at the capitated facility linked to the woman’s PCP, or if there is no capitated network, at any participating laboratory or radiology facility in the relevant network.
• The gynecologist to refer members to any participating specialist or PCP in our network (except in IPA networks) for evaluation and treatment of any condition detected during a gynecological visit. Follow-up care by a specialist physician can be coordinated through either the PCP or the gynecologist.
• The gynecologist to precertify an admission when the patient needs to be admitted to a short procedure unit or hospital for surgery and the gynecologist is the admitting physician. This precertification process will automatically generate the referral for the procedure to ensure payment without the need for the member to get a referral from a PCP. Precertification for the site of therapeutic abortions may be dependent on regional facilities and the participation of doctors who perform these procedures in their office or in cost-effective facilities.

Note: Depending on a member’s plan, referrals to out-of-network providers may not be covered or may result in substantial out-of-pocket costs to the member. Certain providers may be affiliated with an IPA, physician medical group, integrated delivery system or other provider group. Members who select these providers will generally be referred to specialists and hospitals affiliated with or otherwise affiliated with those groups.

Women’s health: variations from the national program for the State of Texas

For information on our Aetna Women’s Health℠ programs, refer to the Women’s Health Programs & Policies manual. Or, visit our secure provider website. Once logged in, go to “Clinical Resources” > “Main Page” > “Women’s Health Programs & Policies.”

Note (Texas only): Obstetrical ultrasounds performed in the office do not require an authorization and are paid on a fee-for-service basis. Austin, Corpus Christi and San Antonio markets do not participate in the non-stress test enhancement program and are paid on a fee-for-service basis.

NOTICE: The term “precertification,” used here and throughout the office manual, means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets our clinical criteria for coverage. It does not mean precertification as defined by Texas law, as a reliable representation of payment of care or services to fully insured HMO and preferred provider organization members.

Specialist as PCP (Texas only)**

A full-risk HMO member may apply to the health plan to use a non-primary care specialist as a PCP.

The written request must include:
• Certification by the non-PCP specialist of the medical need for the member to use the non-PCP specialist as a PCP
• A statement signed by the non-PCP specialist that he or she is willing to accept responsibility for the coordination of all of the member’s health care needs
• The signature of the member

The non-PCP specialist must meet the health plan’s requirements for PCP participation, including credentialing. The contractual obligations of the non-PCP specialist must be consistent with the contractual obligations of the health plan’s PCPs.

For help, call Patient Management at the number on the member’s ID card.

**California physicians affiliated with a medical group/IPA can contact their medical group/IPA for information about Ob/Gyn and specialist as PCP.
Utilization management timelines (Texas only)

<table>
<thead>
<tr>
<th>Type of decision</th>
<th>Aetna will issue response within:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval notice</td>
<td>Two working days</td>
</tr>
<tr>
<td>Adverse determinations notice</td>
<td>One working day (written notice within three working days)</td>
</tr>
<tr>
<td>Post-stabilization care, emergency treatment or life-threatening conditions</td>
<td>Within the time appropriate to the circumstances, but not exceeding one hour</td>
</tr>
<tr>
<td>Appeal of adverse determination</td>
<td>As soon as practical, but no later than 30 days after the date the appeal is received</td>
</tr>
<tr>
<td>Expedited appeal (for example, life-threatening conditions, continued stays for hospitalized patients)</td>
<td>One working day or in accordance with the medical immediacy of the case</td>
</tr>
</tbody>
</table>

Health care providers may request a review by a provider in the same or similar specialty — one who typically manages the condition. They can do this by submitting a written request for review of the appeal within 10 working days of receiving the adverse determination.

For more information on precertification and utilization management review, see the Patient Management and Acute Care section.

Washington — use of substitute provider notification process

Background

In accordance with Washington Administrative Code (WAC) 284-43-260 – 262, Standards for Temporary Substitution of Contracted Network Providers: “Locum Tenums,” Aetna permits the following categories of contracted network providers in Washington state to arrange for temporary substitution by a substitute provider: doctor of medicine, doctor of osteopathic medicine, doctor of dental surgery, doctor of chiropractic, podiatric physician and surgeon, doctor of optometry, doctor of naturopathic medicine and advanced registered nurse practitioners for 90 days every calendar year.

Per the above WAC, at the time of substitution, the substitute provider:

• Must have a current Washington license and be legally authorized to practice in this state
• Must provide services under the same scope of practice as the contracted network provider
• Must not be suspended or excluded from any state or federal health care program
• Must have professional liability insurance coverage
• Must have a current drug enforcement certificate, if applicable

Workflow

• Providers must notify their Aetna network account manager of their intent to use substitute providers at least 10 business days prior to the beginning of the substitution period using the Intent to Use a Substitute Provider Form.
• An Aetna medical director will review the Intent to Use a Substitute Provider Form submission and provide acceptance or rejection of the proposal and return it to the provider.
• After the plan has been accepted, any changes to the plan must be submitted at least 10 business days in advance of the intended change, marking the change(s) on the originally submitted form.
• A medical director will review the planned change and will accept or reject the plan and return the form to the provider.

To obtain a copy of the Intent to Use a Substitute Provider Form, log in to our secure provider website. Then go to “Plan Central” > “Aetna Health Plan” > “Aetna Support Center” > “Forms Library.”

Contact information:
Seattle Network Management
Phone: 1-800-720-4009
Fax: 860-262-9619

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