Office manual for health care professionals
Mid-America Regional Section
Welcome to your provider manual

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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).
Aetna Performance Network

Employers and employees look to us for options to help better control costs. That's why we created the Aetna Performance Network.

When a member needs a procedure that requires a hospital visit, research shows that most members choose the doctor before they choose the hospital. And they choose the hospital based on where their doctor has privileges. The Aetna Performance Network tightly aligns 20 specialties that drive medical procedures to top-performing hospitals.

To create the network, we performed a thoughtful analysis.

• We evaluated our participating hospitals based on certain cost and quality criteria. In some cases, we applied other business considerations.
• We looked at specialists in 20 categories that frequently use those hospitals, and specifically on their usage of tier 1 hospitals. In some markets, we also reviewed 12 out of 20 specialties on additional measures for clinical quality and cost.

Our members pay a lower percentage of their medical costs when they use Aetna Performance Network doctors and hospitals.

What specialties are evaluated for the Aetna Performance Network?

• Allergy/immunology
• Cardiology
• Cardiothoracic surgery
• Dermatology
• Endocrinology
• Gastroenterology
• General surgery
• Infectious disease
• Nephrology
• Neurology
• Neurosurgery
• Obstetrics/gynecology
• Ophthalmology
• Orthopedics
• Otolaryngology (ENT)
• Plastic surgery
• Pulmonary critical care
• Rheumatology
• Urology
• Vascular surgery

Specialties are designated based on Aexcel® network criteria in Aexcel market locations. They are further refined by their use of Aetna Performance Network hospitals.
Where is it currently available?

- Arizona
- California (Central Valley, Los Angeles, northern California, Orange County/inland, San Diego)
- Connecticut
- District of Columbia (Washington, DC)
- Florida (Brevard County, northern Florida, southern Florida — Palm Beach and Broward counties, Tampa)
- Georgia (Augusta, Savannah)
- Illinois (Chicago)
- Indiana (Indianapolis)
- Kentucky (Louisville)
- Maine
- Massachusetts
- Nevada (Las Vegas)
- New Hampshire
- New Jersey (northern, southern)
- New York (metropolitan New York City, upstate)
- North Carolina (Charlotte, Raleigh-Coastal−Greenville, Winston-Salem)
- Ohio (Cincinnati, Cleveland, Toledo)
- Oklahoma (Oklahoma City, Tulsa)
- Pennsylvania (northeast — Scranton, southeast — Philadelphia)
- South Carolina
- Tennessee (Chattanooga, Nashville)
- Texas (Austin, Houston, San Antonio)
- Virginia (Hampton Roads, Richmond, Roanoke)
- West Virginia
- Wisconsin (southeastern)

To find a doctor or hospital in the Aetna Performance Network, visit our provider search.

Savings Plus network

We created Savings Plus to help employers and employees better control costs. Savings Plus also tightly aligns specialties that drive medical procedures to top-performing hospitals.

To create the network, we performed a thoughtful analysis.

- We evaluated our participating hospitals based on certain cost and quality criteria. In some cases, we applied other business considerations.
- We looked at providers in up to 22 specialty categories who frequently use those hospitals. This included primary care in certain markets.

Our members get the highest level of benefits when they use these Savings Plus doctors and hospitals.

What specialties are evaluated for Savings Plus?

- Allergy/immunology
- Cardiology
- Cardiothoracic surgery
- Dermatology
- Endocrinology
- Gastroenterology
- General surgery
- Hematology/oncology
- Infectious disease
- Nephrology
- Neurology
- Neurosurgery
- Obstetrics/gynecology
- Ophthalmology
- Orthopedics
- Otolaryngology
- Plastic surgery
- Primary care
- Pulmonary critical care
- Rheumatology
- Urology
- Vascular surgery

Where is it currently available?

- Arizona (Maricopa, Pima, Pinal)
- Illinois (Chicago area, Lake County, northwest Indiana)
- Florida (Brevard County, Tampa)
- Ohio (Lake County area)
- Oklahoma (Oklahoma City, Tulsa)
- Texas (Austin, Houston, San Antonio)

To find a doctor or hospital in Savings Plus, visit our online provider directory. Choose the Savings Plus plan in your search selections.
## Contacts

<table>
<thead>
<tr>
<th>Allergy extract vendor</th>
<th><strong>Nelco Lab</strong></th>
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<tbody>
<tr>
<td></td>
<td>Phone: <strong>1-800-541-0790 (TTY: 711)</strong></td>
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<tr>
<th>Complaints and appeals address</th>
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<tr>
<td>Aetna Complaints and Appeals</td>
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<tr>
<td>PO Box 14020</td>
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<tr>
<td>Lexington, KY 40512</td>
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<th>Dental</th>
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<td>Visit our provider referral directory at <a href="http://aetna.com">aetna.com</a>.</td>
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<th>Durable medical equipment</th>
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<td>Visit our provider referral directory at <a href="http://aetna.com">aetna.com</a>.</td>
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<th>Enhanced Clinical Review program</th>
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<td>Preauthorization is required for the following procedures:</td>
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<tr>
<td>• Elective outpatient magnetic resonance imaging (MRI)/magnetic resonance angiography (MRA), nuclear cardiology, positron emission tomography (PET) scans, computed tomography (CT)/computed tomography angiography (CTA)</td>
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<td>• Facility-based sleep studies</td>
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<td>• Elective outpatient stress echocardiography and diagnostic left and right heart catheterization</td>
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<td>• Elective inpatient and outpatient cardiac rhythm implant devices</td>
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<td>• Elective inpatient and outpatient hip &amp; knee arthroplasties</td>
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<td>• Pain management</td>
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<td>Preauthorization is required for all Aetna® members enrolled in our commercial and Medicare Advantage benefits plans in the following areas:</td>
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<td>• South Dakota</td>
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<td>• Wisconsin</td>
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<td>To make preauthorization requests, contact <strong>MedSolutions</strong> (does business as eviCore healthcare).</td>
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<tr>
<td>• Phone: <strong>1-888-693-3211 (TTY: 711)</strong></td>
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<td>• Fax: <strong>1-844-822-3862</strong></td>
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<td>Home health</td>
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| Physical therapy and occupational therapy (PT and OT) | American Therapy Administrators | [1-888-560-6855](tel:1-888-560-6855) (TTY: 711) | • Kansas and portions of Missouri (HMO only)  
• Oklahoma (Oklahoma City, Tulsa) |
|                                |                                |                                                 | **Rehab Provider Network (RPN)**                                        |
|                                |                                |                                                 | Phone: [1-888-256-2248](tel:1-888-256-2248) (TTY: 711) |
|                                |                                |                                                 | • Ohio only                                                              |
|                                |                                |                                                 | **All other markets**: Visit [aetna.com](http://aetna.com)                |
| Radiology                      |                                | **Visit [aetna.com](http://aetna.com)**          |                                                                         |
| Respiratory therapy            |                                | **Visit [aetna.com](http://aetna.com)**          |                                                                         |
| Speech therapy                 | American Therapy Administrators | [1-888-560-6855](tel:1-888-560-6855) (TTY: 711) | • Kansas and portions of Missouri (HMO only)  
• Oklahoma (Oklahoma City, Tulsa) |
|                                |                                |                                                 | **Rehab Provider Network (RPN)**                                        |
|                                |                                |                                                 | Phone: [1-888-256-2248](tel:1-888-256-2248) (TTY: 711) |
|                                |                                |                                                 | • Ohio only                                                              |
|                                |                                |                                                 | **All other markets**: Visit [aetna.com](http://aetna.com)                |
Illinois provider vs. member appeals

In order to file a provider appeal, you must complete our Practitioner and Provider Complaint and Appeal Request form. You must submit your appeal to us in writing with any supporting documents you wish to provide, such as medical records.

If you file an appeal for a denial of services that require prior authorization and have yet to be rendered to your patient — in other words, pre-service — that appeal will be treated as a member appeal in all instances. No member authorization form is required.

If you wish to file an appeal on behalf of your patient for a denial of services that have already been rendered — in other words, post-service — you should use our Member Complaint and Appeal form. You must clearly indicate you are acting for the member in your request, and also include a signed written authorization from the member. This is in order for it to be processed as a member appeal. Failure to provide a signed written authorization form from the member will result in processing post-service appeals as a provider appeal.

Hospitalist programs in Kansas City and St. Louis

Hospitalists can act as referring physicians for the coordination of adult medical and surgical inpatient services. They may admit members, evaluate members in the emergency room and coordinate all clinical services that members require.

They also work closely with our Case Management department to help with continuity of care on discharge or transfer to an alternate level of care.

As part of their obligation to you and our members, hospitalists will provide notification and written documentation of your patient’s status on admission, during the stay and upon discharge. They will also contact members upon discharge to check on their post-discharge progress. And they will check if the member is receiving appropriate follow-up care.

The use of any participating hospitalist physician’s services is strictly voluntary. In any case where a member objects to the hospitalist attending to his or her care, the PCP will be informed so that they can reassume direction of the patient’s care.

Radiology accreditation requirements

Aetna has radiology accreditation requirements for our commercial and Medicare Advantage business.

To be eligible for reimbursement for the technical part of advanced diagnostic imaging procedures, the following types of providers must be accredited by the American College of Radiology (ACR) and/or the Intersocietal Accreditation Commission (IAC):

- Freestanding imaging centers
- Independent diagnostic testing facilities
- Nonphysician practitioners
- Office-based imaging facilities
- Physicians
- Suppliers of advanced diagnostic imaging procedures

This accreditation requirement applies to the technical part of advanced diagnostic imaging procedures. For these purposes, advanced diagnostic imaging procedures exclude X-ray, ultrasound, fluoroscopy and mammography.

Included are:
- MRI
- MRA
- CT
- Echocardiograms
- Nuclear medicine imaging, such as PET
- Single photon emission computed tomography (SPECT)

Note:
- This requirement will not apply to patients who are in the hospital or in hospital emergency departments.
- This policy will not apply to hospitals, unless they own one of the above listed providers.
- The accreditation process can take 9 to 12 months.
PCP initial lab designation and change request forms

Refer to the forms library for the Initial Lab Designation and Change Request Forms for Oklahoma. Log in to our provider website. Once there, go to Plan Central > Aetna Health Plan > Aetna Support Center > Forms Library > Lab Selection Forms.

Note: Providers not accredited by the ACR or IAC by January 1, 2012, will not be eligible for payment for advanced diagnostic imaging services.

Specialist as Principal Physician Direct Access (SPPDA) program in Oklahoma

The voluntary SPPDA program provides eligible members suffering from serious or complex medical conditions with direct access to covered specialty care.

Program details
HMO-based members with serious or complex medical conditions who require ongoing specialty care are eligible to join in the program. “Serious or complex medical conditions” are medical conditions or diseases that are:

- Life-threatening
- Degenerative
- Disabling

Examples include: acquired immune deficiency syndrome (AIDS), cancer, chronic and persistent asthma, diabetes with target organ involvement, emphysema and organ failure that may require transplant.

To help promote continuity of care for members participating in the SPPDA program, these members’ PCPs will continue to play an active role in coordinating their care. PCPs will:

- Help, where appropriate, in drafting any necessary treatment plans
- Treat problems unrelated to those that caused the member to enroll in the program
- Receive periodic updates concerning the care their patients have received through the program

The SPPDA program is in addition to existing programs by which eligible members may directly access covered obstetric/gynecologic, mental health, substance abuse, or routine vision services or treatment. The program is not available to members suffering from conditions that are not serious or complex. Members with such conditions may, however, request limited standing referrals from their PCPs.

The member must meet specific medical criteria for chronicity and severity of a chronic condition as defined below.

- The PCP must have seen the patient within three months prior to requesting the direct access authorization.
- The primary diagnosis is based on a chronic disease.
- There may or may not be a secondary diagnosis (comorbidity).
- The patient has evidence of severe disease or progression despite treatment.

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

Aetna has a utilization review and patient management program for determining what health care services are covered and payable under the health plan and the extent of such coverage and payments. The program helps members:

- Receive appropriate health care
- Maximize use of covered health care services

On our website, you can find more information on our utilization review policies, including precertification, concurrent review and discharge planning, and retrospective review.

Aetna does not reward physicians or other individuals who conduct utilization reviews for issuing denials of coverage or for creating barriers to care or service. Financial incentives for utilization management decision makers do not encourage denials of coverage or service. Rather, we encourage the delivery of appropriate health care services. In addition, we train utilization review staff to focus on the risks of underutilization and overutilization of services. Aetna does not encourage utilization-related decisions that result in underutilization.

Provider vs. member appeals

Reconsideration of adverse determination (peer-to-peer review timelines in Missouri only)

Providers may request reconsideration (peer-to-peer review) of an adverse determination of a request for authorization. This does not include reconsideration of appeals. See the timelines for submitting peer-to-peer review requests to the right.

Timeline to request peer-to-peer review

Within 14 calendar days of the denial letter date.

Time frame to expect a response to request

Within one business day of the request.

Note: If the provider is not available for the peer-to-peer review within the one-business-day time frame, we will accommodate the provider’s schedule to allow for a review of the request.

Case management referrals

Referring patients to our complex case management program

Patients with complex cases often need extra help understanding their health care choices and benefits. They may also need support navigating the community services and resources available to them.

Our complex case management program is a collaborative process that involves the member, their provider and Aetna. It aims to produce better health outcomes while efficiently managing health care costs.

Members can gain access to the program through a provider referral. To make a referral, just call the number on the member’s ID card. Our case management staff will call the member, explain the program to them and then ask them to join.
Missouri and Illinois

Specialty networks and narrow networks

St. Louis Metro area: Carelink St. Louis
Carelink St. Louis is a patient centric model of care powered by a high-performance network (HPN). It’s available to members located in the following Missouri and Illinois counties.

Missouri counties
• Franklin
• Jefferson
• St. Charles
• St. Louis City
• St. Louis County

Illinois counties
• Madison
• Monroe
• St. Clair

The network is the result of an enhanced relationship between Aetna and Mercy, SSM Health, St. Elizabeth’s in Belleville, IL and Saint Anthony’s Health Center in Alton, IL. The network that supports Carelink is made up of the systems and their affiliated providers named above and therefore, by the nature of the HPN concept, will not support inclusion of all Aetna contracted providers.

Carelink – St John’s criteria
• Members must choose a PCP.
• Members need a referral from their PCP to see a specialist referral.
• Prior authorization rules apply.

Central Illinois Region: Carelink – St John’s Hospital, Springfield, IL
Carelink St John’s is a patient centric model of care powered by a high-performance network (HPN). It is available to members located in the Macon, Mason, Sangamon and Shelby counties in Illinois. The network is the result of an enhanced relationship between Aetna and Hospital Sisters Health System, St John’s Hospital.

Carelink criteria for Missouri residents
• Members are encouraged to choose a PCP.
• HPN members who live in Missouri do not need a specialist referral.
• Carelink Specialist claims will NOT deny without a referral from their PCP.
• Prior authorization rules apply.

Carelink criteria for Illinois residents
• Members must choose a PCP.
• Members need a referral from their PCP to see a specialist referral.
• Prior authorization rules apply.

Lab services
Carelink members may use Quest, Mercy or SSM affiliated providers for lab services.

Note: Participating providers shall not provide less than Medically Necessary services to our members and shall not induce any other provider to provide less than Medically Necessary services. For all PPO plans, our members must be allowed to receive services from a nonparticipating provider and utilize their Out-of-Network benefit without interference by a participating provider, if they so choose. In no instance does Aetna encourage or induce participating providers to provide less than Medically Necessary services to our members. Failure to direct medically appropriate care upon request by a Missouri member and failure to provide services to a Missouri member, due to the absence of a referral, violate the provisions of your contract and could result in financial penalties and/or termination of the contract. Provider acknowledges that solely Aetna shall determine the amount of any financial penalty imposed.
Members accessing the MO/IL Coventry networks (administered on Aetna networks)

Aetna continues to operate dual networks in Illinois and Missouri. Members may present ID Cards containing both Aetna and Coventry logos (see the example ID card below).

Keep the following in mind.

• Your current Coventry participation agreement may still be in effect and the terms of that agreement would apply for such members with dual-logo ID cards.
• Claims will be processed based on Aetna policies.
• You can help your patients save on health care costs when you direct them to in-network providers. These providers may vary depending on which network the member uses. You can find a list of in-network providers at aetna.com or by contacting our Provider Service Center at 1-888-632-3862 (TTY: 711).

Provider manuals
To find more provider manuals and other resources, you can visit: aetna.com/health-care-professionals/provider-education-manuals.html.

Reimbursements for providers with multiple contracts
For providers participating in multiple health systems and contracted for Aetna members sold with a Coventry network, all items listed below apply.

1. If a member’s product requires PCP selection (HMO/POS/MC), the provider will be reimbursed according to the contract with the oldest PHO contract affiliation.
2. If the member’s product does not require PCP selection (PPO/OAMC), the provider will be reimbursed according to the Aetna Maximum Allowable Fee Schedule (AMFS).
3. If the member’s product is attached to a value based contract (HPN, ACP), the provider will be reimbursed based on value-based contract terms.

Recovery time frames
The contract in which the member claim is processed under will determine the time frames. If the contract is silent, standard payor policy applies. If you find an overpayment, you can contact our Provider Service Center at 1-888-632-3862 (TTY: 711), and request an adjustment be made to future payments. Or you can send a check along with a copy of the remittance advice to the address provided.