Office manual for health care professionals
West Regional Section
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

<table>
<thead>
<tr>
<th>Service</th>
<th>Directory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic services in Alaska, Arizona, California, Nevada, New Mexico, Oregon, Utah and Washington</td>
<td>Visit our DocFind® online provider directory.</td>
</tr>
<tr>
<td>Dental services</td>
<td>Visit our DocFind online provider directory.</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Visit our DocFind online provider directory.</td>
</tr>
<tr>
<td>Durable medical equipment, home infusion, respiratory therapy, home health and rehab provider network</td>
<td>Visit our DocFind online provider directory.</td>
</tr>
</tbody>
</table>

**Enhanced clinical review**

California physicians affiliated with a medical group/IPA should follow the precertification process established by their medical group/IPA.

*MedSolutions Inc. dba as eviCore healthcare* 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, elective inpatient and outpatient hip and knee arthroplasties, pain management PET and nuclear cardiology.

Contact *MedSolutions dba eviCore healthcare* at:
Phone: **1-888-693-3211**  
Fax: **1-844-822-3862**

**Note:** Members participating in this program are assigned to the Enhanced Clinical Review (ECR) by their residence ZIP codes. A member requesting services outside their participating ECR network may incur out-of-pocket expenses if precertification is not obtained. Providers in adjacent networks who are not participating in the ECR program should call the member’s assigned primary care physician (PCP) prior to rendering a service.

*If there are any questions on whether a member needs a precertification authorization, the provider should contact their local ECR 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 our DocFind 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

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>California HMO only</td>
<td>PO Box 24019</td>
</tr>
<tr>
<td></td>
<td>Fresno, CA 93779-4019</td>
</tr>
<tr>
<td><strong>Colorado only</strong></td>
<td>PO Box 981107</td>
</tr>
<tr>
<td></td>
<td>El Paso, TX 79998-1107</td>
</tr>
<tr>
<td><strong>Other West region states</strong></td>
<td>PO Box 14079</td>
</tr>
<tr>
<td></td>
<td>Lexington, KY 40512-4079</td>
</tr>
<tr>
<td><strong>Appeals</strong></td>
<td>PO Box 14020</td>
</tr>
<tr>
<td></td>
<td>Lexington, KY 40512</td>
</tr>
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</table>

### Paper claims addresses (Medicare)

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona HMO</td>
<td>PO Box 981106</td>
</tr>
<tr>
<td></td>
<td>El Paso, TX 79998-1106</td>
</tr>
<tr>
<td><strong>California HMO</strong></td>
<td>PO Box 981106</td>
</tr>
<tr>
<td></td>
<td>El Paso, TX 79998-1106</td>
</tr>
<tr>
<td><strong>Medical groups and IPAs</strong></td>
<td>PO Box 981514</td>
</tr>
<tr>
<td></td>
<td>El Paso, TX 79998-1514</td>
</tr>
<tr>
<td><strong>Other paper claims</strong></td>
<td>PO Box 14079</td>
</tr>
<tr>
<td></td>
<td>Lexington, KY 40512-4079</td>
</tr>
</tbody>
</table>

### Physical, occupational and speech therapy

Visit our DocFind 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 our DocFind online provider directory.

### Sleep studies

All outpatient elective facility sleep studies (95805, 95807, 95808, 95810, 95811, 95782 and 95783) require prior authorization from [MedSolutions dba eviCore healthcare](#). Home sleep studies (95800, 95801 and 95806) do not require prior authorization.

Visit our DocFind online provider directory.

Contact [MedSolutions dba eviCore healthcare](#) at:

Phone: **1-888-693-3211**

Fax: **1-844-822-3862**
Direct-access specialties

<table>
<thead>
<tr>
<th>State</th>
<th>Specialty</th>
<th>Products</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>All*</td>
<td>Obstetrics and gynecology</td>
<td>All benefits plans</td>
<td></td>
</tr>
</tbody>
</table>

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: Alameda, Contra Costa, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Sonoma, Stanislaus and Yolo. 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 for services that do not require prior authorization:** within 48 hours of the request for appointment, except as provided in (G) to the right.
- **Urgent care appointments for services that require prior authorization:** within 96 hours of the request for appointment, except as provided in (G) to the right.
- **Non-urgent appointments for primary care:** within ten business days of the request for appointment, except as provided in (G) and (H) to the right.
- **Nonurgent appointments with specialist physicians:** within 15 business days of the request for appointment, except as provided in (G) and (H) to the right.
- **Nonurgent appointments with nonphysician mental health care providers:** within 10 business days of the request for appointment, except as provided in (G) and (H) to the right.
- **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) to the right.

(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.

(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.

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.

'California 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 — specific medical record criteria

California requires that all medical record documentation include the following information:
• Documentation indicating the patient’s preferred language.
  Documentation of offer of a qualified interpreter, and the enrollee’s refusal, if interpretation services are declined.

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 county: 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.

Texas access standards

These regulations combined with our provider access standards require that our contracted providers meet the following time frames:
• Urgent care appointments for medical conditions: within 24 hours of the request for appointment
• Urgent care for behavioral health services: within 24 hours of the request for appointment
• Routine appointments for primary care: within seven calendar days of the request for appointment
• Routine appointments for medical conditions: within three weeks of the request for appointment
• Routine appointments for behavioral health conditions: within two weeks of the request for appointment
• After-hours care: Each primary care and specialist physician must have a reliable 24-hour-a-day, 7-day-a-week answering service or machine with a beeper or paging system. A recorded message or answering service that refers members to emergency rooms is not acceptable. The same standard applies to behavioral health practitioners who are physicians with hospital admitting privileges.

Specialty provider networks*

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

Texas gynecologist as principal physician for Women’s Health Care Program

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 their 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 within 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.

**California physicians affiliated with a medical group/IPA can contact their medical group/IPA for information about Ob/Gyn and specialist as PCP.

Texas specialist as PCP**

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 they are 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.

Texas peer-to-peer process

Prior to an adverse determination being issued to a provider, a provider is given an opportunity to discuss the plan of treatment for the enrollee with a physician reviewer. This is the only opportunity to speak with the reviewing doctor to potentially alter a determination.

The issuance of an adverse determination is defined as when the adverse determination is communicated to the provider of record either verbally or in writing.

If an adverse determination has been issued verbally or in writing to a provider, the doctor may not alter or overturn the denied service. Any request for reconsideration or submission of additional clinical information received after an adverse determination has been issued verbally or in writing to a provider will be treated as an appeal request.

**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.
Texas utilization management timelines

<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>In accordance with the medical immediacy of the case (not to exceed one working day).</td>
</tr>
</tbody>
</table>

For determinations concerning acquired brain injury, a URA must provide notification of the determination through a direct telephone contact to the individual making the request not later than three business days after the date on which an individual requests utilization review or requests an extension of coverage based on medical necessity or appropriateness. This requirement does not apply to a determination made for coverage under a small employer health benefits plan.

If an appeal is denied, 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.

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

Utilization review policies

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.

Washington — use of substitute provider notification process

Background

In accordance with Washington Administrative Code (WAC) 284-170-380, Standards for Temporary Substitution of Contracted Network Providers — “Locum Tenens” Providers, 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 regulation, 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

Refer 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. A provider referral is one way members can gain access to the program. To make a referral, call the phone number on the member’s ID card. Our case management staff will call the member, explain the program to them and request their permission for enrollment.