Office manual for health care professionals

West Regional section

aetna™

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Welcome to your provider manual

Contacts

Chiropractic services in: **· Alaska** **· Arizona** **· California** **· Nevada** **· New Mexico** **· Oregon** **· Utah** **· Washington**	Our **provider portal**
Dental services	Our **provider portal**
Dialysis	Our **provider portal**
Durable medical equipment	Our **provider portal**
Enhanced clinical review program California physicians affiliated with a medical group or Independent Practice Association (IPA) should follow the precertification process established by their medical group or IPA.	**MedSolutions Inc. (doing business 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 certain services such as the following: • Elective outpatient stress echocardiography and diagnostic left and right heart catheterization • Elective outpatient magnetic resonance imaging (MRI)/magnetic resonance angiogram (MRA), positron emission tomography (PET) scans, and computed tomography (CT)/computed tomography angiogram (CTA) • Facility-based sleep studies • Elective inpatient and outpatient cardiac rhythm implant devices • Elective inpatient and outpatient hip and knee arthroplasties • Interventional pain management • Nuclear cardiology • Radiation therapy: complex and 3D conformal, stereotactic radiosurgery (SRS)/stereotactic body radiation therapy (SBRT), brachytherapy, hyperthermia, intensity-modulated radiation therapy (IMRT)/image-guided radiation therapy (IGRT), proton beam therapy, neutron beam therapy, and radiopharmaceuticals Contact **MedSolutions (doing business as "eviCore healthcare")** via: • Phone: **1-888-693-3211** from 7 AM to 8 PM CT, Monday through Friday • Fax: 1-844-822-3862 • Website: **eviCore.com** • Radiation therapy phone: **CareCore National (doing business as "eviCore healthcare")** at **1-888-622-7329**, 7 AM to 8 PM CT, Monday through Friday • Radiation therapy fax: 1-888-693-3210 • Radiation therapy website: **eviCore.com**, and then select the **CareCore National tab** **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.

Home health	Our **provider portal**
Home infusion	Our **provider portal**
Laboratories	The Aetna® network offers your patients access to nationally contracted, full-service laboratories. We have conveniently located patient service centers. **Quest Diagnostics®** and **LabCorp** are our national preferred laboratories. They provide tests and services to all Aetna members. To get started, visit **QuestDiagnostics.com** or **LabCorp.com**. There, you can: • Get requisitions and schedule lab appointments for your patients • Schedule specimen pickup and set up patient results delivery • Order supplies • Find a patient service center Your market may also have contracted with local laboratory providers. For a complete list of participating labs available in your area, use our **provider portal**. Health maintenance organization (HMO) members may be required to verify a participating lab with their independent practice association (IPA).
Paper claims addresses for Aetna	**California HMO only:** Aetna PO Box 24019 Fresno, CA 93779-4019 **Colorado only:** Aetna PO Box 981107 El Paso, TX 79998-1107 **All other West region states:** Aetna PO Box 14079 Lexington, KY 40512-4079 **Appeals for all West region states:** Aetna PO Box 14020 Lexington, KY 40512
Paper claims addresses for Medicare	**Arizona HMO:** Aetna PO Box 981106 El Paso, TX 79998-1106 **California HMO:** Aetna PO Box 981106 El Paso, TX 79998-1106 **Medical groups and IPAs:** Aetna PO Box 981514 El Paso, TX 79998-1514 **All other paper claims for West region states:** Aetna PO Box 14079 Lexington, KY 40512-4079
Physical, occupational, and speech therapy	• **Colorado, North Texas (Dallas/Fort Worth) and South Texas (Houston, San Antonio and Austin):** **American Therapy Administrators** at **1-888-560-6855** • **All other West region states:** our **provider portal**
Radiology	Our **provider portal**
Rehabilitation provider network	Our **provider portal**
Respiratory therapy	Our **provider portal**

Texas home health care (Aetna Medicare Advantage only)

Effective 3/1/2020, **myNEXUS** will manage the network, claims payment, precertification, and prior authorization program for home health services for Aetna Medicare Advantage members in Texas.

Important changes

- **Preapproval:** starting **March 1, 2020**, all home health-related requests for in-home skilled nursing, physical therapy, occupational therapy, speech therapy, a home health aide and medical social work listed on **Aetna.com/health-care-professionals/precertification/precertification-lists.html** before March 1, **require** advance approval from myNEXUS. This applies for services administered in a home or residence for Aetna Medicare Advantage members in Texas. myNEXUS must approve these services before they can commence.
- **Claims payment:** starting **March 1, 2020**, claims for covered home health services for claims filed with an authorization issued on or after March 1, 2020, for Texas Medicare Advantage members will be paid by myNEXUS, under the rates and terms of your myNEXUS contract.

The changes only apply to some services and some members

These changes apply only to home health care services for:

- Aetna Medicare Advantage members
- Members residing in the state of Texas

The changes do not apply to other plans and members

The change does not apply to any other plans or members, including but not limited to:

- Aetna administrative services only (ASO) self-funded health maintenance organization (HMO), point-of-service (POS) and preferred provider organization (PPO) plans
- Aetna and Coventry commercial fully insured HMO, POS, and PPO plans
- Aetna Global Business® plans
- Aetna Measured Savings Program members
- Aetna Signature Administrators® plans
- Aetna Student Health℠ plans
- Cofinity® plans
- Coventry Workers' Compensation plans
- Dual-Special Needs Program (D-SNP) Medicare members
- First Health® plans
- Medicare members who reside outside of the state of Texas
- Meritain℠ Health plans
- Special Needs Program (SNP) Medicare members
    - Chronic-Special Needs Program (C-SNP) members
    - Institutional-Special Needs Program (I-SNP) members
- Traditional Choice® plans

About the new program

Go to **myNEXUScare.com/aetna** for more details.

Preapproval requests

- Go to **Portal.myNEXUScare.com** (registration is required).
- Fax the **form** to 1-866-996-0077.
- Questions? Call **myNEXUS** at **1-833-585-6262** from 8 AM to 8 PM ET, Monday through Friday.

Direct-access specialties

State	Specialty	Products
All*	Obstetrics and gynecology	All benefits plans

Medicare Dual-Eligible Special Needs plans (D-SNPs)

We offer Aetna-branded D-SNPs to Medicare beneficiaries who live within the program's service area, as long as they meet dual-eligibility requirements.

These include:

- Eligibility to enroll in a federal Medicare plan, based on age and/or disability status
- Potential eligibility for assistance from the state, based on income and assets

Note: All D-SNP members are automatically enrolled in our D-SNP care management program.

Program goals

The D-SNP care management program goes beyond traditional case and disease management programs. It provides care management, care coordination, health education and promotion, and nutrition education. Plus, the program gives useful information about coordinating community-based home services.

Our program goals are to:

- Improve member health and quality of life through early intervention, education and use of preventive services
- Increase access to care and essential services, including medical, behavioral health and social services
- Improve access to affordable care
- Integrate and coordinate care across specialties
- Encourage appropriate use of services and cost-effective approaches

Health risk assessments and individualized care plans

We offer members:

- Health risk assessments (HRAs)
- Annual reassessments
- Individualized care plans (ICPs) that document problems, goals, interventions and follow-ups

The D-SNP care management team uses HRAs to understand health challenges and develops ICPs to address them.

Providers can view and download their patients' HRAs and individualized care plans using the sites listed below.

- **AL, FL, GA, IA, KS, LA, MO, NE, NC, OH, PA, TX and WV: Aetna-PRD.AssureCare.com/provider/**
- **VA: AetnaBetterHealth.com/virginia-hmosnp/providers/portal**

Interdisciplinary care team

Members enrolled in a D-SNP are assigned an interdisciplinary care team (ICT). This helps ensure that each member's medical, functional, cognitive and psychosocial needs are considered in care planning. The team includes the member's PCP, social services specialist, pharmacist, nurse care manager, care coordinator and behavioral health specialist. The ICT supports the member's needs and is timely and cost-effective. The care manager acts as a health coach and serves as a contact between the member and the rest of their ICT.

You can reach your patient's care manager by calling one of the numbers listed below.

- **AL, FL, GA, IA, KS, LA, MO, NE, NC, OH, PA, TX and WV: 1-800-241-9379 (TTY: 711)**
- **VA: 1-855-463-0933 (TTY: 711)**

Mandatory Medicare D-SNP Model of Care training

We have developed a model of care (MOC) to make sure D-SNP members receive comprehensive care management and care coordination. The Centers for Medicare & Medicaid Services (CMS) requires us to provide MOC-compliance training to providers who care for our D-SNP members.

This training is mandatory. All network providers and their employees who serve members of Aetna Medicare D-SNPs must complete this training. CMS requires it.

Training must be done:

- When a new provider or employee is hired
- Thereafter, each calendar year

Take the **online mandatory Medicare D-SNP MOC training**.

If you need access to the site, have questions about the training or would like a printed copy of the training presentation, just contact us.

- **AL, FL, GA, IA, KS, LA, MO, NE, NC, OH, PA, TX and WV: 1-833-570-6670 (TTY: 711)**
- **VA: 1-855-463-0933 (TTY: 711)**

*May not apply to California medical group or IPA-affiliated physicians.

Healthcare Effectiveness Data and Information Set measures

To support Healthcare Effectiveness Data and Information Set (HEDIS®*) initiatives, be sure to submit encounter data for the Care for Older Adults (COA) measure. That way, the supporting documentation for all D-SNP members ages 65 and above is in the member's chart.

Requirements

- Advance Care Planning (CPTII: 1157F, 1158F)
- Functional Status Assessment (CPTII: 1170F)
- Medication Review (CPTII: 1159F and 1160F must both be submitted on the same claim and on the same day
- Pain Screening (CPTII: 1125F, 1126F)

D-SNP payments and billing

Medical Savings Program levels	Cost sharing and Medicaid benefits
Qualified Medicare Beneficiary (QMB)	Medicare Parts A&B are cost-sharing protected
Qualified Medicare Beneficiary Plus (QMB+)	• Medicare Parts A&B are cost-sharing protected • Full Medicaid benefits
Specified Low-Income Medicare Beneficiary (SLMB)	No cost-sharing protection
Specified Low-Income Medicare Beneficiary Plus (SLMB+)	• Medicare Parts A&B may, or may not, be cost-sharing protected (dependent on state policy) • Full Medicaid benefits
Qualifying Individual (QI)	No cost-sharing protection
Qualified Disabled Working Individual (QDWI)	No cost-sharing protection
Full Benefit Dual-Eligible (FBDE)	• Medicare Parts A&B may, or may not, be cost-sharing protected (dependent on state policy) • Full Medicaid benefits

Providers may not bill cost-sharing-protected members for either the balance of the Medicare rate or the provider's charges for Medicare Parts A&B services. Cost-sharing-protected members are protected from liability for Medicare Part A&B charges, even when the amounts that the provider receives from Medicare and Medicaid are less than the Medicare rate or less than the provider's customary charges.

In addition, federal law prohibits Medicare Providers from billing individuals who have QMB or QMB+ status. All Medicare providers and suppliers, not only those that accept Medicaid, must not charge individuals enrolled in the QMB or QMB+ program for Medicare Parts A&B cost-sharing. Further, QM and QMB+ members cannot elect to pay Medicare cost-sharing rates. Providers that bill QMB or QMB+ members for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions.

NOTE: If a member is cost-sharing protected, the provider shall bill any cost-sharing obligations to the state Medicaid agency, the member's Medicaid managed care organization, or Aetna. Go to **Aetna.com/healthcare-professionals/assets/documents/2020-dnsp-cost-share-grid.pdf** to find state-specific information on which organization to bill for cost sharing.

California — the Aetna Value Network℠ option

The Aetna Value Network is a subset of our larger California HMO network.

The 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.

We offer this network option in all or portions of the counties listed below.

- 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
- Yolo

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

California — access standards

These regulations require that each health plan's contracted provider network has adequate capacity and availability of licensed health care providers. Each network must 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) on this page[1]
- **Urgent care appointments for services that require prior authorization:** within 96 hours of the request for appointment, except as provided in (G) on this page[1]
- **Nonurgent appointments for primary care:** within ten business days of the request for appointment, except as provided in (G) and (H) on this page[1]
- **Nonurgent appointments with specialist physicians:** within 15 business days of the request for appointment, except as provided in (G) and (H) on this page[1]
- **Nonurgent appointments with nonphysician mental health care providers:** within 10 business days of the request for appointment, except as provided in (G) and (H) on this page[1]
- **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) on this page[1]

(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: We do not delegate monitoring and assessment of these standards to any of its contracted provider groups.

We will assess our 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.

Continued on next page

[1]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 — 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 phone number for an interpreter is **1-800-525-3148**. This number bypasses our Provider Contact Center and connects directly to qualified interpreters.

California — maternal behavioral health screening

Screening tools

The final determination for a referral to treatment resources belongs to the screening or treating professional. Practitioners serving Aetna members can, however, use the following screening tools as aides in the decision-making process:

- **Prenatal**

  The Pfizer, Inc. website, "PHQScreeners.com" provides the **Patient Health Questionnaire-9 (PHQ-9)**.

Prenatal scoring using the PHQ-9

Score	Action
1 to 4	Take no immediate action.
5 to 14	Refer the member to a behavioral health counselor via the Member Services number on their member ID card. Instruct the member to ask for Behavioral Health (BH) Customer Service.
15 or higher	Immediately call BH Condition Management Services at **1-800-424-4660 (TTY: 711)**.

- **Postnatal**

  The American Academy of Pediatrics website provides the **Edinburgh Postnatal Depression Scale**.

Postnatal scoring using the Edinburgh Scale

Score	Action
1 to 6	Take no immediate action.
7 to 13	Refer the member to a behavioral health counselor via the Member Services number on their member ID card. Instruct the member to ask for Behavioral Health (BH) Customer Service. (BH Customer Service can make referrals to BH providers.)
14 or higher	Immediately call BH Condition Management Services at **1-800-424-4660 (TTY: 711)**.
Question #10 (self-harm): 1 or higher	Immediately call BH Condition Management Services at **1-800-424-4660 (TTY: 711)**.

Screening services are reimbursable

The screening services described in this section are reimbursable. Submit your claim with the following billing combination: CPT codes 96127 or G0444 (brief emotional/ behavioral assessment) in conjunction with diagnosis code Z13.31 (screening for depression).

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 an offer of a qualified interpreter, and the enrollee's refusal, if interpretation services are declined

Nevada — the Aetna Value Network℠ option

The Aetna Value Network is a subset of our larger Nevada HMO network. The 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.

We offer this network option in all or portions of Clark county.

Texas — access standards

The 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 7 calendar days of the request for appointment
- **Routine appointments for medical conditions:** within 3 weeks of the request for appointment
- **Routine appointments for behavioral health conditions:** within 2 weeks of the request for appointment
- **After-hours care:** Each primary care and specialist physician must have a reliable answering service or machine with a beeper or paging system 24 hours a day, 7 days a week. 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*

- Website: Aetna Specialty Pharmacy® medicine and **support services**
- Phone: **1-866-782-2779 (TTY: 711)**
- Fax: 1-866-329-2779

Texas — gynecologists as principal physicians for the Women's Health Care Program

This 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 nonwomen'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 Aetna 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 following:

- The gynecologist can 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.
- The woman can be evaluated by her gynecologist without a referral from the PCP.

*California physicians affiliated with a medical group or Independent Practice Association (IPA) should follow the precertification and ordering process for specialty medications established by their medical group or IPA.

- The gynecologist can 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 can 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 can 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 can 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.

Note (Texas only): Obstetric 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 nonstress test enhancement program and are paid on a fee-for-service basis.

Note: 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 — specialists as PCPs*

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

The written request must include:

- Certification by the nonPCP specialist of the medical need for the member to use the nonPCP specialist as a PCP
- A statement signed by the nonPCP specialist saying 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 nonPCP specialist must meet the health plan's requirements for PCP participation, including credentialing. The contractual obligations of the nonPCP 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.

Note: The issuance of an adverse determination is defined as when an 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.

*California physicians affiliated with a medical group or Independent Practice Association (IPA) can contact their medical group or IPA for information about obstetrics-gynecology (ob-gyn) and specialists as PCPs.

Texas — utilization management timelines

Type of decision	Aetna will issue response within
Approval notice	2 working days
Adverse determinations notice	1 working day (written notice within 3 working days)
Post-stabilization care, emergency treatment or life-threatening conditions	Within the time appropriate to the circumstances but not to exceed 1 hour
Appeal of adverse determination	As soon as practical but no later than 30 days after the date the appeal is received
Expedited appeal (for example, life-threatening conditions, continued stays for hospitalized patients)	In accordance with the medical immediacy of the case but not to exceed 1 working day

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. This must not be 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.

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.

Utilization review policies

We do 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. We do not encourage utilization-related decisions that result in underutilization.

Washington — use of the 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, we permit 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
- 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
- Provide services under the same scope of practice as the contracted network provider
- Not be suspended or excluded from any state or federal health care program
- Have professional liability insurance coverage
- 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 each Intent to Use a Substitute Provider form submission, accept or reject it, and then return the submission to the provider.
- If a provider wants to propose a change to an accepted submission, mark the changes on the original accepted form and then submit it at least 10 business days in advance of the proposed change
- A medical director will review the marked-up form, accept it or reject it, and then return the submission to the provider.

To get a copy of the Intent to Use a Substitute Provider form, go to **Aetna.com > Forms Library**.

Contact information:
Seattle Network Management

- Phone: **1-800-720-4009**
- Fax: 860-262-9619

Case management referrals

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 us. 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.

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