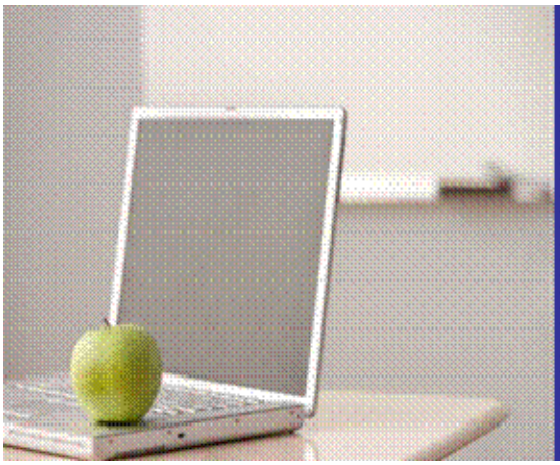

Patient Referrals

Guidelines for submitting referrals for your patients

Electronic referrals -- No longer accepting procedure codes for services that require precertification
We will return these requests as "Not certified - Requires medical review," and ask you to resubmit the code(s) using the precertification process. In some instances, we will grant a "modified" response where Consult Treat (C&T) code 99499 replaces the rejected procedure code.

Refer to the Aetna Participating Provider Precertification List for procedures that require precertification.

Our referral system recognizes when a specialty capitation arrangement may apply. As appropriate, we will substitute the "Referred to" provider with a provider who is aligned to the capitation arrangement of the requesting provider. In these situations, we will issue a "Modified" response.

Referral submissions -- when to use exact procedure code or C&T
As a reminder, Aetna's guidelines for patient referrals allow us to authorize:

- Exact procedure code referrals -- submitted with code(s) other than 99499. Primary care physicians (PCPs) should use these referrals when a member needs care for a specific health reason.
  * Beginning September 1, 2010, we will only reimburse for the procedure code(s) that match the code(s) on the referral.

- C&T referrals -- submitted with code 99499. In most areas, C&T referrals do not need to include the specialists' procedures. We will pay specialists for performing associated covered services in an office setting, in accordance with current claims processing guidelines.

Referrals submitted without a procedure code will default to a C&T referral (99499). Authorized procedures are subject to the number of visits on the referral.

Aetna's referral policy within our Health Care Professional Toolkit
More information about our referral policy lives within our secure provider website via NaviNet® -- and for your reference, is copied on the following page:

Aetna®

Referral Policies

In benefits plans that require the issuance of referrals for specialist care, the primary care physician is responsible for coordinating his/her patients' health care. If it is necessary for the patient to see a specialist, other than for direct-access services or emergency care, the primary care physician must request a referral prior to the patient's visit to the specialist. The referral must be for covered benefits under the plan.

Please submit an inquiry through the Eligibility transaction or call the number on your patient's member ID card to confirm covered benefits.

If your patient visits a specialist without a referral, depending on his/her plan type, the patient may be responsible for payment for all services rendered or for paying a deductible and coinsurance. The patient should not return to the primary care physician to request a referral after the service is rendered; primary care physicians should not issue retroactive referrals.

In Aetna products that do not require the issuance of a referral, a patient may self-refer to either participating or nonparticipating physicians/health care professionals. The patient is responsible for paying any applicable copayment, deductible and/or coinsurance for self-referred benefits. See the Patient Management and Acute Care section for rules regarding preauthorization for certain services.

In Aetna Open Access plans, referrals also are not necessary. A patient may self-refer to any participating physician/health care professional.

In addition to the requirement that primary care physicians review every referral issued by their practice, we recommend that the initial consultative referral be authorized for one visit, except when the patient is known to have a predicted need for more visits, or when the patient is involved in an ongoing process of care. This encourages communication from the specialist to the primary care physician.

Following an initial consultation, additional referrals from the primary care physician are required in the following instances:

- If the specialist wishes to provide additional services not originally requested on the referral.
- If the specialist refers his/her patient to a second specialist.
- If the specialty visits will exceed the number of visits initially authorized by the primary care physician.
- If the specialty visits require an extension beyond the Referral Thru Date.

Our standard Participating Specialist Physician Agreement requires that specialists communicate with the referring physician in a timely fashion. After receiving the consultation report from the specialist, the primary care physician can consider the appropriate course of treatment (for example, referrals for additional services and/or follow-up care, if needed).

Referrals may be authorized for consultation and treatment (C&T) using CPT code 99499. In most areas, C&T referrals do not need to specify the procedures to be performed by the specialist. Specialists will be reimbursed for any associated covered procedure performed in an office setting, in accordance with current claims processing guidelines.

Please note: referrals do not permit specialists to refer members to another specialist for care. If this is necessary, patients must get a referral from their primary care physician to see another specialist. This referral is not a guarantee of payment. Payment is subject to eligibility on date of service, plan benefits, limitations and exclusions, pre-existing condition limitations, and patient liability under the plan.