Behavioral Health Provider Manual

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Aetna®

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Introduction

Welcome to the Aetna Behavioral Health network! We are pleased to serve as a major contributor in the behavioral health care field.

Our behavioral health programs focus on the increasing role of mental health on a person's overall well-being.

We look forward to working with you and will provide you with tools to help you provide high-quality service to Aetna‡ members.

Our guiding principles

Our behavioral health programs support our belief in the following:

- Enhancing our members' — your patients' — experience.
- Adhering to the importance of the "mind-body" principle and connection.
- Providing a treatment approach that is evidence based, goal directed and consistent with accepted standards of care, all Aetna Clinical Policy Bulletins, and Aetna Clinical Practice Guidelines.
- Providing treatment that is medically necessary according to the following definition: "Medically necessary services are those health care services that a practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; (c) not primarily for the convenience of the patient, physician or other health care provider; and (d) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors."
- Educating members about the risks and benefits of available treatment options.
- Developing a strong relationship with you, informing you about available resources, and concentrating on the importance of continuity of care among all behavioral health professionals, for the benefit of your patients and you.
- Integrating behavioral health care across our product spectrum.

What you'll find in this manual

We developed this manual with you in mind — giving you what you need to work with us and ease your administrative burdens.

This manual contains information about:

- Network participation
- Specialty programs
- Outpatient Care Management Program
- Credentialing/recredentialing
- Site visits and monitoring
- Contact information/how to reach us
- Clinical Practice Guidelines
- Authorization and referral processes
- Member and provider denials and appeals
- Case management
- Quality programs
- Working with Aetna electronically and much more!

Resources and staff

Our medical directors and staff are always available to speak with you, and we are committed to providing you with the tools, education and resources needed to easily work with us.

Aetna Behavioral Health medical directors make all final coverage* denial determinations involving clinical issues. If a treating provider does not agree with a decision regarding coverage or would like to discuss an individual member's case, Aetna Behavioral Health medical directors are available 24 hours a day, 7 days a week, to discuss specific concerns and provide additional information. If you have questions about coverage decisions for one of your Aetna Behavioral Health patients, please call **1-888-632-3862**.

Aetna Behavioral Health utilization management (UM) staff are available at least eight hours per day for UM issues.

*For these purposes, "coverage" means either the determination of (i) whether or not the particular service or treatment is a covered benefit under the terms of the particular member's benefits plan, or (ii) where a physician or health care professional is required to comply with Aetna's patient management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement.

How to find this manual online

We update this manual as needed to ensure you have the most up-to-date, accurate information. If you are not currently viewing this document online, you can find it by logging in to our secure provider website via NaviNet® at **www.aetna.com**, selecting "Health Care Professionals," then "Medical Professionals Log In" under "Secure Site Log In." Already registered? Go to **https://connect.navinet.net**. Once on our provider website, select "Aetna Support Center," "Doing Business with Aetna," then "Aetna Benefit Products" and "Aetna Behavioral Health and Employee Assistance Program."

If you would like a hard copy of this manual or any information contained in this manual, and do not have Internet access, please call our Provider Service Center at 1-800-624-0756 (for HMO-based and Medicare Advantage plans) or 1-888-MD AETNA (1-888-632-3862) (for all other plans).

Network Participation

Aetna's Behavioral Health Specialty Programs

Our Behavioral Health Specialty Programs, including case management and disease management, help our members achieve optimal wellness by supporting their medical and psychological needs. Patients who complete these programs have been shown to have significant symptom relief and improvement in overall health.

Our specialty programs range from Medical Psychiatric Case Management to Alcohol, Depression and Anxiety Disorder Disease Management programs. We've created a handy one-page summary detailing our Behavioral Health Specialty Programs to help you and your patients learn more and benefit from these programs.

To view or print a PDF:

- Visit **www.aetna.com** and log in to our secure provider website.
- Select "Aetna Support Center" then "Clinical Resources" from the Aetna Plan Central home page.
- Choose "Clinical Resources for Physicians and Their Patients."
- Scroll to "Behavioral Health."
- Click on the "Aetna's Behavioral Health Specialty Programs Flyer" link.

Or, if you would like a paper copy of the flyer, please call our Provider Service Center.

We thank you for considering these exciting programs as additional care options for your eligible Aetna patients.

Aetna's Behavioral Health Outpatient Care Management Program

The purpose of Aetna's Outpatient Care Management Program is to support physicians and health care professionals, and improve outcomes for patients with particularly complex behavioral health conditions. Patients selected for participation are identified through a screening process involving evaluation of behavioral, medical and pharmacy data. Using American Psychiatric Association (APA) Practice Guidelines and the latest evidence-based approaches, Aetna's multi-disciplinary team of health care professionals work with you to enhance patient outcomes. This team includes psychiatrists, clinical psychologists, social workers and a registered nurse.

Online Behavioral Health Assessment

Some of your patients may be concerned about anxiety, depression or other issues but are unsure about whether they need professional help or resources. Aetna Behavioral Health offers an interactive, online Behavioral Health Assessment (BHA) to support members and providers in the treatment of behavioral health issues. We invite your patients to participate in completing this online assessment. Members can access the BHA through the Aetna Navigator® member website through **www.aetna.com**, or by going directly to **www.aetnabhra.com**.

Using the BHA, patients are able to get information and identify emotional or mental health issues they are experiencing. Patients may give their providers on-line access to these assessment results. Providers can then use this information to develop a treatment plan and monitor a patient's progress.

This information may also help to determine a patient's appropriateness for one of Aetna's disease management programs (Medical Psychiatric Case Management, Depression Disease Management, Eating Disorders Case Management, Intensive Case Management, Bipolar Disease Case Management, Alcohol Disease Management and Anxiety Disease Management). These programs:

- Provide information to your patients about their mental health issues.
- Support your patients in making appointments and following your treatment plan.
- Help your patients locate additional resources in the community.
- Help your patients make optimal use of their benefits package.

All of these activities are conducted in accordance with applicable state and federal laws.

Again, welcome to the network! We look forward to working with you and hope you find this manual to be a valuable tool for your practice.

This *Behavioral Health Provider Manual*, the EAP Manual and other related communications are posted on our secure provider website via NaviNet at www.aetna.com.

We have developed a spectrum of behavioral health services for our members and, in doing so, we contract with licensed psychiatrists, psychologists, social workers and other master's-prepared clinicians. Among these practitioners, numerous clinical and cultural specialties are represented to serve individual member and geographic needs.

Our goal is to create a collaborative relationship with the behavioral health care professional community. We believe that the key to quality care and member satisfaction is through a very informed, high-quality network. To accomplish this, we credential clinicians who are independently licensed and well trained in their particular area of expertise.

Credentialing/recredentialing of individual behavioral health care professionals

A behavioral health care professional must be credentialed by Aetna before joining the behavioral health network. Thereafter, we require that health care professionals be credentialed every two to three years, depending on state requirements. We participate in the Council for Affordable Quality Healthcare (CAQH) initiative to simplify the credentialing process by eliminating extensive paperwork. CAQH's Univeral Credentialing DataSource is an innovative, Web-based tool for physicians and other health care professionals. Our credentialing program is a systematic process of assessing, reassessing and validating the qualifications and practice history of a health care professional against defined participation criteria.

The minimum criteria to become a credentialed Aetna behavioral health care professional are as follows:

1. Graduation from an accredited professional school applicable to the applicant's degree, discipline and licensure.
2. For physicians, completion of residency training in psychiatry and board certification, unless the physician meets the conditions delineated in Aetna's Board Certification Exception policy.

(Exceptions to the board certification requirement are reviewed by a medical director.)

3. Malpractice insurance in amounts specified in the Aetna agreement.
4. Availability for emergencies by pager or other established procedures deemed acceptable by Aetna.
5. Submission of an application containing all applicable attestations, necessary documentation and signatures.
6. If applicant is a physician addictionologist, certification by the American Society of Addiction Medicine (ASAM).
7. Current unrestricted license.
8. Absence of current debarment or suspension from state or federal programs.

Open the door to electronic communications

Register now and go paperless:

Physicians and behavioral health care providers –

https://aetna.providerpreference.com

Hospitals and facilities –

https://aetna.providerpreference.com/facilities.php

Our electronic correspondence option allows your office to receive information from Aetna online instead of in a printed, paper format in the mail.

Read the *Aetna Behavioral Health Insights*™ provider newsletter and other time-sensitive correspondence online — you choose the time that's best for you. You'll receive an email notice when the newsletter or other communications are ready to view.

If you wish a hard copy of Insights and do not have Internet access, please call our Provider Service Center at **1-800-624-0756** for HMO-based and Medicare Advantage plans or **1-888-MD AETNA (1-888-632-3862)** for all other plans.

Site visits and monitoring

Site visits may be required for those behavioral health care professionals for whom we receive complaints. Results will be shared with the health care professionals, along with any applicable requests for corrective action plans.

We also monitor licensing boards monthly, and we continually monitor complaints about health care professionals and adverse incidents to track and trend the events and to determine if further investigation is needed. When action needs to be taken, our Credentialing and Performance Committee (CPC) will make any determination of changes in network participation status. At the time of recredentialing, any complaints and quality-of-care concerns will be forwarded to the CPC for consideration.

Notification of status changes

Behavioral health care professionals are required to notify Aetna in writing within 14 days of any changes related to the following circumstances:

- Change in professional liability insurance.
- Change of practice location, billing location, telephone number or fax number.
- Status change of professional licensure, such as suspension, restriction, revocation, probation, termination, reprimand, inactive status or any other adverse situation.
- Change in tax ID number used for claims filing.
- Malpractice event, as described in the health care professional contract (provider or specialist agreement) section "Compliance with Policies."

Providers who previously practiced only under a group and are now starting a solo practice require an individual contract.

Correspondence regarding changes may be faxed to: 859-455-8650

Your questions may be directed to: Aetna Provider Service Center (between 8 a.m. and 5 p.m.)

For HMO-based and Medicare Advantage plans — **1-800-624-0756**

For all other plans — **1-888-MD AETNA (1-888-632-3862)**

You can also make these changes online through our secure provider website.

Clinical Delivery

I. Access to care

Members may access behavioral health care in three ways:

- Direct access by the member
- Through a recommendation from the primary care physician or other treatment provider
- Through a referral from an Employee Assistance or Student Assistance Program provider

For services that require precertification and concurrent review, please use the toll-free behavioral health telephone number on the member's ID card. For Open Choice® and Traditional Choice® members, please use the toll-free Member Services telephone number on the member's ID card. You can access these toll-free numbers 24 hours a day, 7 days a week. A screening process to determine the urgency of the need for treatment may occur at the time of the call.

Calls will be classified in the following categories:

- **Emergency:** Any situation in which clear and present danger exists for the member, others, or the environment if immediate intervention does not occur. Consistent with appropriate clinical practice, attention will be paid to the ability of the environment to maintain the member safely. **Note:** Aetna follows the "prudent layperson" emergency room standard set forth in the Balanced Budget Act of 1997.

Emergencies are further classified as "life-threatening emergency" and "non-life-threatening emergency." For life-threatening emergencies, health care professionals will be requested to offer immediate appointments; for non-life-threatening emergencies, health care professionals are expected to offer appointments within six hours.

- **Urgent:** A situation in which the member has experienced significant deterioration and/or is experiencing stressors that are contributing to the member's inability to cope. Unless timely intervention is provided, further deterioration or a crisis is likely to occur. For such cases, health care professionals are expected to offer evaluation appointments and initial treatment within 48 hours.
- **Routine:** A situation in which the member is not in imminent danger and where further deterioration or a crisis is not likely to occur before the member is seen. For such cases, health care professionals are expected to offer appointments within 10 business days.

California-only requirement for after-hours care

Behavioral health care professionals located in California 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.

II. Authorization/precertification process

Authorization/precertification is the process of determining the eligibility for coverage of the proposed level of care and place of service.* To ensure Aetna members receive the highest quality of care, a comprehensive diagnostic evaluation prior to the initiation of treatment is expected. Diagnoses submitted on claims must be current and consistent with the most recent DSM criteria. Collecting complete and accurate clinical data is critical to successfully completing the authorization process. Treatment approach is expected to be evidence based, goal directed and consistent with accepted standards of care, all Aetna Clinical Policy Bulletins and Aetna Clinical Practice Guidelines.

It is expected that treatment provided is medically necessary according to the following definition: "Medically necessary services are those health care services that a practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective

*Precertification is the process of collecting information prior to inpatient admissions and selected ambulatory procedures and services for the purpose of (1) receiving notification of a planned service or supply, or (2) making a coverage determination. It does not mean precertification as defined by Texas law, as a reliable representation of payment.

for the patient's illness, injury or disease; (c) not primarily for the convenience of the patient, physician or other health care provider; and (d) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. For these purposes, "generally accepted standards of care" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors."

- All inpatient behavioral health services must be precertified and are managed through a concurrent review process.
- Precertification requirements for intermediate levels of care, residential treatment, partial hospital and intensive outpatient vary by plan. You can obtain information regarding plan requirements by calling the toll-free behavioral health telephone number on the member's ID card or the toll-free Member Services number on the member's ID card.
- In addition to reviewing clinical information to determine coverage, the Aetna care manager will discuss treatment alternatives and the appropriate level of care. If the member meets case management criteria, the member's family, physician(s) and other health care professionals will be requested to be involved in the treatment plan and activities. We recommend that you discuss with your patient available benefits for outpatient care so that treatment can be planned accordingly.

Note: Step down to a less restrictive level of care within the same facility (for example, step down from inpatient detoxification to inpatient rehabilitation) even within the same unit of the same facility requires precertification.

At times, a member may seek treatment outside of Aetna's network (for example, a nonparticipating referral for routine outpatient behavioral health services). This is a written or verbal request reviewed by Aetna. Reasons a nonparticipating referral may be approved include:

- Specific health care professional preferred by member is not available in network (and the member's plan provides coverage for out-of-network services).
- Continuation or return to treatment with nonparticipating health care professional in certain circumstances.
- PCP's preference for local or known nonparticipating health care professional (and the member's plan provides coverage for out-of-network services).

Precertification** may not be required for individual outpatient behavioral health visits except as follows: outpatient detoxification, psychiatric home care services, psychological testing, neuropsychological testing, outpatient ECT, biofeedback, amytal interview, and Applied Behavior Analysis (ABA).

- It is important to note that outpatient care that is not consistent with evidence-based, goal-directed practices, all Aetna Clinical Policy Bulletins, and Aetna Clinical Practice Guidelines may be subject to quality-of-care and utilization reviews.
- It is expected that treatment provided is medically necessary according to the following definition: "Medically necessary services are those health care services that a practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; (c) not primarily for the convenience of the patient, physician or other health care

**This applies to all members and health care professionals in all states with the exception of Medicare members (and the health care professionals who treat these Medicare members) in the state of California, with the exception of Sante Medical Group, a delegated group for which outpatient precertification is still required. New Jersey Small Group and New Jersey Individual Plan language does not support the requirement of precertification of outpatient services. PHP and IOP should both be considered outpatient and not subjected to precertification requirements on New Jersey Small Group and New Jersey Individual Plans.

Clinical Delivery (cont.)

provider; and (d) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors."

Important note: Outpatient care inconsistent with such a treatment approach may be subject to concurrent review. It is expected that facility diagnostic evaluations assess for both co-morbid chemical dependency or co-morbid psychiatric conditions that could be impacting current presentation.

Pennsylvania only requirement for PA Act 106

In accordance with the requirements under PA Act 106, Aetna requires a written certification, signed by a licensed physician or psychologist, that includes the length and type of care. All services must be provided in facilities licensed by the **Pennsylvania Department of Health** to specifically provide alcohol and other drug addiction treatment services.

A complete list of services requiring preauthorization is available on our secure provider website on the Behavioral Health and Employee Assistance Program page. To verify outpatient preauthorization requirements for a specific member's plan, please contact our Provider Service Center.

Aetna Behavioral Health is available by telephone 24 hours a day, 7 days a week to assist members accessing behavioral health care services.

Contact information for Aetna Behavioral Health remains unchanged. Please continue to use the telephone numbers you have used in the past. Simply direct your patients to the numbers listed on their ID cards for behavioral health services.

Aetna Behavioral Health makes utilization management (UM) decisions based on appropriateness of care and service and existence of coverage. We do not specifically reward practitioners or other individuals for issuing denials of coverage or service, and financial incentives for UM decision makers do not encourage decisions that result in underutilization.

III. Medical necessity criteria and Clinical Practice Guidelines

Four sets of medical necessity criteria guidelines assist in making and overseeing coverage decisions regarding level, type and duration of care:

- **Level of Care Assessment Tool:** The Aetna Level of Care Assessment Tool, or LOCAT instrument, helps determine appropriate levels and types of care for patients in need of evaluation and treatment for mental health conditions and diagnoses, and for patients in need of placement in specialized psychiatric or mental health facilities or units.
- **The American Society of Addiction Medicine Patient Placement Criteria:** The American Society of Addiction Medicine (ASAM) criteria and guidelines help determine appropriate levels and types of care for patients in need of evaluation and treatment for chemical dependency and substance abuse conditions and diagnoses. They also apply for patients in need of placement in specialized chemical dependency detoxification or rehabilitation facilities or units. These medical necessity criteria were developed by ASAM and are nationally recognized.

American Society of Addiction Medicine (ASAM) Second Edition — Revised of Patient Placement Criteria (ASAM PPC-2R). These criteria are copyrighted but can be purchased by contacting:

American Society of
Addiction Medicine
4601 North Park Ave
Arcade Suite 101
Chevy Chase, MD 20815
Telephone: 301-656-3920
Fax: 301-656-3815
Contact ASAM at:
Email@asam.org

Aetna Behavioral Health supplies relevant pages of ASAM criteria upon request. Direct requests to our Provider Service Center, which will connect you with the Aetna Behavioral Health Care Management Center.

- **State-Required Criteria:** In Texas, the Texas Department of State Health Services oversees the *Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers (formerly TCADA)*, which are substituted for the ASAM guidelines noted above.

You can find these standards at **http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=28&pt=1&ch=3&sch=HH&rl=Y**

- For Applied Behavior Analysts treating pervasive developmental disorders such as autism, national certification is needed from the Behavior Analyst Certification Board (BACB).

The criteria noted above are only guidelines. Their use does not preclude the requirement that trained, licensed, credentialed and experienced behavioral health professionals must exercise their independent professional judgment when providing behavioral health care services to Aetna members.

Referrals for evaluation and/or treatment of chemical dependency and mental health issues will be reviewed by a psychiatrist or licensed clinician to determine the appropriate level of care.

Refer to Attachment A for a summary of the LOCAT criteria. For full LOCAT guidelines, go to the Aetna Behavioral Health and Employee Assistance Program page on our secure provider website.

Aetna Behavioral Health has also adopted Clinical Practice Guidelines (CPGs) from recognized national associations. For current information on our CPGs, please visit the Clinical Resources page of our secure provider website.

If you need hard copies of any of Aetna Behavioral Health's UM criteria, or CPGs, please contact our Provider Service Center.

IV. Care management

Care management is a collaborative process that involves assessment, planning, implementing, coordinating, monitoring and evaluating services to meet an individual member's needs. For some members, additional intensive care management services are necessary.

V. Discharge review

Discharge planning includes all of the following components:

- If a patient needs to be admitted to a different level of care, discharge information will be provided to the health care professional/facility at the time of referral for admission.
- Facilities will designate a clinical staff member to be responsible for coordinating discharge planning activity.
- A written discharge plan must exist for each member, and discharge planning should begin at the time of admission.
- Where required, Aetna will verify that the inpatient facility, partial hospital program, intensive outpatient program or other involved health care professional has obtained a release of information from the member that meets all state and federal confidentiality regulations and, if obtained, the provider will facilitate coordination of care and collaboration with the PCP and EAP/SAP as appropriate for the release of information to Aetna.
- **Facilities should arrange for follow-up appointments within seven days for each member discharged from an inpatient stay. Health care professionals are asked to schedule such appointments within seven days.**

VI. Continuity of care

We may allow members to continue for a specified period of time with a behavioral health care professional who has left the network so that their course of treatment is not interrupted. The length of time may vary and is dependent upon regulatory requirements, company policies and the health care professional's willingness to continue to treat the member. A health care professional may not continue to care for a member under the in-network benefit if Aetna determines that a quality-of-care issue may negatively impact the member's care.

Inpatient level of care

Members who, at the time of enrollment, are being treated at an inpatient level of care should complete their single, uninterrupted course of care under the plan of benefits or policy active at the time of admission.

All other levels of care

Aetna allows new members who have met certain requirements to continue an "active course of treatment" with a nonparticipating practitioner for up to 90 days without penalty, within the benefits limitations, at the new/preferred plan benefits level. In some states, regulatory requirements may mandate that Aetna continue coverage beyond 90 days.

VII. Collaboration of care

Behavioral health care professionals/ communication with other medical health care professionals:

In the interest of treatment coordination, Aetna requires that network behavioral health care professionals share appropriate clinical information with primary care physicians (PCPs) or other treating specialists with appropriate member authorization.

It is particularly important that information regarding prescribed medications be shared between the psychiatrist and the member's PCP.

Obtaining member permission to release information consistent with state and federal regulations:

To protect a member's right to keep medical information private, behavioral health care professionals must obtain signed permission from the member regarding, in part, the amount and type of information that can be released.

A behavioral health care professional should discuss with a member the purpose of communicating with the PCP and request written permission through a signed consent form. If the member does not permit release of information, refusal should be documented in the patient's treatment record.

Communication without a signed release form can only occur where there are emergency or safety needs, as defined by state and federal regulations. Behavioral health care professionals should understand and comply with applicable privacy requirements directed at practitioners.

Contact the primary care physician or other specialists

A behavioral health care professional should contact the member's PCP when a member enters care and promptly when there is an emergency, or, with member consent, under circumstances such as the following:

- Medical comorbidities and/or medication interactions are a possibility.
- Clinical information needs to be exchanged to aid in diagnosis and/or treatment.
- PCP or specialist support for a treatment plan would enhance member compliance and/or treatment outcome.
- PCP or specialist has requested immediate feedback.

Send reports to the primary care physician or other appropriate specialists within two weeks of:

- The first visit
- Termination of care
- A significant change in level or type of care

The report should either be in the form of a professional letter or in a format accepted by Aetna. Please visit our secure provider website to access our Behavioral Health/ Medical Provider Communication Form. On the website, select "Aetna Support Center," "Doing Business with Aetna," then "Forms Library."

We will audit random records for communication with PCPs and other behavioral health providers.

VIII. Coordination of care

It is the health care professional's role to explain to the member the importance of coordination of care and communication among health care professionals treating the same patient.

IX. Provider denials & appeals

We recently updated the appeal process to help you determine when and where to submit a request for a review of a claim or clinical coverage decision. This information is located on our website at **www.aetna.com**. Select "Health Care Professionals," "Policies & Guidelines" and "Dispute and Appeal Process." There, you will find information on our appeal process, a quick reference guide and frequently asked questions. This update is another step in our continuing effort to make doing business with us easier. Behavioral health care professionals have 180 days* from the date of the Explanation of Benefits (EOB) to request an appeal.

If you would like a hard copy of this information and do not have Internet access, please call our Provider Service Center at **1-800-624-0756** for HMO-based and Medicare Advantage plans or **1-888-MD AETNA (1-888-632-3862)** for all other plans.

*State or contractual requirements may modify this time frame.

Quality Programs

I. Quality program overview

We are committed to a continuous quality improvement program and encourage health care professional involvement through committee participation. The Aetna Quality Program includes:

- Utilization Management Program
- Quality improvement activities
- Prevention programs
- Disease management programs
- Member and provider satisfaction studies
- Outcome studies
- Treatment record review studies
- Oversight of availability and access to care
- Member safety
- Complaints, non-authorizations and appeal processes
- Medical necessity criteria
- Clinical Practice Guidelines

Participating behavioral health care professionals are required to support our Behavioral Health Quality Program, be familiar with our guidelines and standards, and apply them in their clinical work. Specifically, behavioral health care professionals are expected to demonstrate:

- Adherence to all Aetna policies and procedures, including those outlined in this manual.
- Communication with the member's primary care physician or specialists (after obtaining a signed release).
- Adherence to treatment record standards, as outlined in **Attachment B.**
- Timely response to inquiries by our Behavioral Health staff.
- Cooperation with our behavioral health complaint process.
- Adherence to continuity-of-care and transition-of-care standards when the member's benefits are exhausted or if you leave the network.
- Cooperation with on-site audits or requests for treatment records.
- Timely return of completed annual provider satisfaction surveys when requested.
- Participation in treatment plan reviews or sending in necessary requests for treatment records in a timely fashion.
- Submission of claims with all requested information completed.
- Adherence to patient safety principles.
- Compliance with state and federal laws, including confidentiality standards.

Annual Quality Program information and program evaluation results are detailed on the Behavioral Health and Employee Assistance Program page of our secure provider website. If you would like a hard copy of our quality program evaluation or description and do not have Internet access, please call our Provider Service Center at **1-800-624-0756** for HMO-based and Medicare Advantage plans or **1-888-MD AETNA (1-888-632-3862)** for all other plans and ask to speak with someone in the Aetna Behavioral Health Quality Department.

II. Accreditation

Aetna Behavioral Health is accredited by NCQA (HMO) and URAC (PPO). Many of our policies and procedures are guided by national accreditation standards.

III. Member rights and responsibilities

We honor the rights of all members, and communicate member rights and responsibilities to them. A copy of our commercial and Medicare Member Rights and Responsibilities statements can be found on the web at **www.aetna.com** under Member Guidelines.

IV. Participating behavioral health practitioner treatment record review criteria and best practices

Refer to **Attachment B**.

V. Confidentiality

Protecting our members' health information is one of our top priorities. To this end, Aetna notifies our members about our policy regarding the confidentiality of member information. As a participating health care professional, you should be aware that we distribute the following notice to our members.

Notice of Privacy Practices

Aetna considers personal information to be confidential and has policies and procedures in place to protect against unlawful use and disclosure. By "personal information," we mean information that relates to a patient's physical or mental health or condition, the provision of health care to the patient, or payment for the provision of health care to the patient. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the patient.

When necessary or appropriate for your care or treatment, the operation of our health plans or other related activities, we use personal information internally; share it with our affiliates; and disclose it to health care professionals (doctors, dentists, pharmacies, hospitals and other caregivers), payers (health care professional organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third-party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential, as provided by applicable law. Participating network physicians and health care professionals are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claims payment; utilization review and management; coverage reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third-party administrators; underwriting activities; and due-diligence activities in connection with the purchase or sale of some or all of our business.

We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without patient consent. However, we recognize that many patients do not want to receive unsolicited marketing materials unrelated to their health benefits. We do not disclose personal information for these marketing purposes unless the patient consents. We also have policies addressing circumstances in which patients are unable to give consent.

For a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, call the toll-free Member Services number on the member's ID card or visit the Aetna website at **www.aetna.com**.

Quality Programs (cont.)

VI. Prevention programs

We develop programs to help prevent or identify behavioral health illnesses early and educate members on the need to seek treatment. Our current programs are aimed at early diagnosis and treatment of postpartum depression and identification and treatment of substance use in depressed adolescents.

Additional program updates can be found on the Behavioral Health and Employee Assistance Program page of our secure provider website.

If you would like a paper copy of our prevention programs, please call our Provider Service Center.

VII. Adverse incident reporting

We investigate every report of a potential quality-of-care incident, an adverse incident that takes place while the member is in care, or any completed suicide or homicide that takes place within 30 days of discharge from care (if the member is still an Aetna member at the time). Health care professionals are required to inform the Aetna Care Management Center (CMC) (using the behavioral health number listed on the member ID card) as soon as they become aware of the death, suicide or serious suicide attempt, or violent member behavior for any member in their care. Adverse outcomes requiring hospitalization from psychotropic medication also need to be reported.

VIII. Member and health care professional complaints

A complaint is any oral or written expression of dissatisfaction by a member or a health care professional regarding:

- Quality of service
- Administrative processes, including payment disputes

Health care professional complaints do not include dissatisfaction with preservice, concurrent or urgent medical necessity coverage decisions, as these types of concerns would be classified as member medical necessity grievances or appeals (which may be filed by a health care professional on behalf of a member) and would follow the Member Complaint and Appeal Policy. Aetna Behavioral Health provides health care professionals with a formal process for inquiries and complaints.

For additional details, go to the Claims page of our secure provider website and select "Policy Information."

IX. Member satisfaction survey

We seek to enhance our Quality Program through feedback from members. To that end, we conduct a member satisfaction survey annually. The survey covers the following areas:

- Services from Aetna and the behavioral health care professional
- Accessibility to Aetna and the Aetna network of behavioral health care providers and practitioners
- Availability of the behavioral health care professional
- Acceptability (regarding cultural competence to meet member needs)
- Claims
- Appeals and denials

X. Provider satisfaction survey

We seek to enhance our Quality Program through feedback from health care professionals. To that end, we conduct a provider satisfaction survey annually. The survey covers the following areas:

- Credentialing
- Access to Aetna network and care management staff
- Services
- Accuracy of information
- Communications
- Claims
- Appeals
- Reimbursement
- Utilization management services
- Continuity and coordination of care with other providers

XI. HIPAA

Refer to Section V (Confidentiality).

Aetna Provider eSolutions℠

Aetna Provider eSolutions for health care professionals

Aetna Provider eSolutions offers a variety of easy-to-use electronic and telephonic options that are cost-effective and streamline the administrative process, making it easy for you to work with us. These transactions reduce:

- Clerical, administrative and training costs
- Phone calls and reimbursement time
- Paper claims, forms, faxes and duplicate billing
- Errors, lost claims and multiple claims office addresses

We work with various vendors and clearinghouses to offer a suite of products ranging from no-cost stand-alone solutions to integrated systems for electronic transactions. Product options are available through the Internet, computer software, telephone and point-of-service terminals.

If spending less time on the phone and having the flexibility to submit electronic transactions 24 hours a day, 7 days a week would benefit your office, we invite you to learn more about our vendor and clearinghouse connectivity options.

To view a vendor list, visit **www.aetna.com**, select "Health Care Professionals," "Claims & Administration," then click on the "vendors" link in the "Get started" section." Or, use the "Contact Us" link at the bottom of the Health Care Professionals page to learn more.

Our secure provider website via NaviNet

Our secure provider website is a great resource! The site offers free tools and transactions, including access to clinical information through online Care Considerations and Personal Health Records, submission of eligibility and benefits inquiries, precertification requests and status inquiries, claims and encounter submission, claims status inquiries, electronic remittance advice, and electronic funds transfers. In addition, you can do the following:

- Update your profile, including address, affiliations and demographics.
- Use our Payment Estimator tool to obtain a reliable estimate of your patients' out-of-pocket expenses and Aetna's payment.
- Access an array of resources and tools for behavioral health providers, such as the latest *Aetna Behavioral Health Insights* newsletter, Clinical Practice Guidelines, EAP information and more.
- View Aetna's Health Care Professional Toolkit, your guide to working with us, and access communications, including *Aetna OfficeLink Updates*™, member rights and responsibilities, and an archive of mailings.
- Access pharmacy materials, including formulary information, Pharmacy Clinical Policy Bulletins and pharmacy forms.
- Explore our Education Site for Health Care Professionals at **www.AetnaEducation.com**, featuring a broad array of education courses and CMEs designed for you and your office staff.

To register, simply log in to **www.aetna.com**, select "Health Care Professionals," then "Secure Site Log In."
Already registered? Go to **https://connect.navinet.net**.

We encourage you to register and visit the site often, as it will help keep you updated and informed.

To access online tools, resources and information specific to behavioral health providers on our secure provider website, choose "Aetna Support Center," then "Doing Business with Aetna," "Aetna Benefit Products" and "Aetna Behavioral Health and Employee Assistance Program."

We're streamlining the claims submission process for you! We consolidated numerous post office boxes during the past two years. As a result, we're asking you to validate and update your records. Please ensure you have the most updated Aetna post office box on all your patient records by using the addresses shown here for claims submissions.

Submitting claims

Electronic claims	Aetna Payer ID – 60054
Practice Location (State)	**Aetna Paper Claims Address**
AL, AK, AR, AZ, CA, FL, GA, HI, LA, MS, NC, NM, NV, OR, SC, UT, TN, WA	Aetna P.O. Box 14079 Lexington, KY 40512-4079
CO, CT, DC, DE, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MT, NE, ND, NH, NJ, NY, OH, OK, PA, RI, SD, TX, VA, VT, WI, WV, WY	Aetna P.O. Box 981106 El Paso, TX 79998-1106

NOTE: Patient ID cards may not reflect these updated post office boxes.

Our secure provider website

- Go to **www.aetna.com**.
- Select "Health Care Professionals."
- Choose "Secure Site Log In." Already registered? Go to **https://connect.navinet.net**.

Remember: You can file claims electronically

We encourage you to file claims electronically. Some practice management or hospital information systems establish electronic claims submission based on mailing addresses within claims records or billing systems. As you validate and update your Aetna mailing information, ensure that all Aetna claims are flagged in your system for electronic submission. Contact your vendor for assistance with system setup.

Missed Appointment/Late Cancellation Policy

If a member fails to show for an appointment, health care professionals can charge a member the lowest rate that has been accepted for payment from any first- or third-party payer.

The following statements must apply to the missed appointment:

- The appointment was not the member's first visit.
- The member has previously been informed of the policy.
- The cancellation was not due to an emergency.
- The member failed to cancel the appointment with 24 hours' notice.
- The health care professional's policy is consistent with other policies for other patients in the practice.

Aetna Student Health Plans:

For questions about eligibility, benefits and claims payment, please call the Aetna Student Health toll-free telephone number on the student's ID card. You may submit electronic claims using Aetna's payer ID 60054. If you must submit paper claims, please mail these claims to the following address: Aetna Student Health Claims Administrators, P.O. Box 15708, Boston, MA 02215-0014.

For more information about submitting claims and verifying eligibility electronically, please visit **www.aetna.com**.

Provider data changes

We require that you notify Aetna of data changes within 14 days of the date of the change. Update your profile online, quickly and easily at **https://www.aetna.com/provider/forms_secure/bh_form.html**. This process takes only a few minutes to complete. You can easily update addresses, affiliations and demographics. Following submission, you will receive a confirmation screen that indicates that changes will be made in 7 to 10 business days.

If you do not have Internet access, call our Provider Service Center at **1-800-624-0756** for HMO-based and Medicare Advantage plans or **1-888-MD AETNA (1-888-632-3862)** for all other plans. You may also fax the information to Aetna at **860-975-1578**, Attn: MDP Alignment.

All TIN changes/additions (unless you are joining an existing Aetna health care professional group) require you to fax a copy of your W9 form to **859-455-8650**.

Attachment A: Level of Care Assessment Tool Summary

The Aetna Level of Care Assessment Tool, or "LOCAT" is an instrument used to aid in the decision-making process that determines the level of care appropriate for effective treatment and medically necessary for a patient with symptoms of a mental health condition. LOCAT is used as a guideline to help determine the appropriate levels and types of care for patients in need of evaluation and treatment for behavioral health symptoms and diagnoses. It is applicable to patients in need of treatment in a variety of settings, ranging from routine outpatient offices through to placement in specialized behavioral health care facilities or units.

LOCAT is used as a guideline to help evaluate a patient's symptoms by identifying and scoring various behavioral health dimensions, and by narrowing down some of those dimensions into sub-dimensions to further assist in providing a more complete clinical picture of the patient.

Dimension 1, Acute Dangerousness, assists in determining whether a patient is exhibiting dangerous symptoms. The four sub-dimensions are Suicidal Intent, Self-Injuriousness, Homicidal Intent and Irritability/Aggression/Mania.

Dimension 2, Functional Impairment, helps determine the severity of impairment in functioning by assessing the following sub-dimensions: Social Isolation, Nutritional Impairment, Sleep Disturbance and School or Work Impairment.

Dimension 3, the Mental Status and Comorbid Factors, helps assess a patient's mental status, (including appearance, speech, affect, delusions, hallucinations, thought process/content, behavioral/neurovegetative and orientation); co-occurring substance use and co-occurring medical illness.

Dimension 4, Psychosocial Factors, helps assess outside influences that may be affecting the patient. Sub-dimensions include family stress, stress from non-family members, housing, school or job, and the support system.

Dimension 5, Additional Modifiers, examines other factors relevant to determining the appropriate level and type of care needed. Sub-dimensions include treatment history, personal resources and past history of dangerousness.

The LOCAT instrument does not replace clinical judgment, where a provider believes that a different level of care or course of treatment is necessary. Treating providers are solely responsible for clinical advice and treatment of members.

For the complete LOCAT criteria, please visit the Behavioral Health and Employee Assistance Program page of our secure provider website.

If you would like a hard copy of this information and do not have Internet access, please call our Provider Service Center at **1-800-624-0756** for HMO-based and Medicare Advantage plans or **1-888-MD AETNA (1-888-632-3862)** for all other plans.

Our complete, updated LOCAT Guidelines are posted on our secure provider website as of June 2010.

Attachment B: Aetna Behavioral Health Treatment Record Review Criteria and Best Practices

STANDARD		BEST PRACTICE INSTRUCTIONS
A. TREATMENT RECORD-KEEPING PRACTICES		
1.	Is the record legible to someone other than the writer, that is, does not cause a problem to read some or a majority of record? (If the answer is no, mark all questions "N" and end review.)	The handwriting should be easy to read, and the reviewer should not have to make more than two attempts to read documentation within the medical record.
2.	Is the patient's personal data documented: address, gender, date of birth, home phone number, emergency contact, marital/legal status and guardianship (if relevant)?	All personal demographic data should be included.
3.	Is the member's name or unique identifier on every page?	Either the member's name or ID should be on each page.
4.	Do all entries in the record contain the author's signature or electronic identifier with title (if applicable) and degree?	Each entry should contain a signature, even if there are multiple entries on the same page.
5.	Are all entries dated?	All entries should be dated, even if there are multiple entries on the same page.
B. ASSESSMENT AND TREATMENT PLAN		
6.	Is there a presenting problem, including history and current symptoms and behaviors, including behavior onset and development?	Presenting problem documentation should include the history, current symptoms and behaviors, as well as behavior onset and development.
7.	Is there documentation of a thorough risk assessment, including presence or absence of suicidal or homicidal thoughts?	Risk assessment should cover past and present thinking, including presence and absence of suicidal or homicidal thoughts.
8.	Is there a complete mental status examination, including affect, mood, thought content, insight, judgment, speech, attention, concentration, and impulse control?	This may be documented on an assessment tool or in a progress note and will include at least five of the nine elements in the standard.
9.	Is there a substance abuse assessment for all those over 12 years of age and a history, including substances used, amount, frequency and prior treatment history?	The evaluation should be thorough and include evidence of inquiry about use of alcohol, illicit drugs, illicit misuse of prescription drugs and OTC drugs. If used, documentation should include history. For members under age 12, mark "N/A."
10.	Is behavioral health treatment history documented?	Behavioral health history could include treatment dates, providers/facilities, current treating clinicians, response to treatment, lab tests, consultation reports (if applicable) and relevant medical treatment history.
11.	Is there a comprehensive family and psychosocial history and cultural variables that could include family, social, legal, educational and history, and does it include the informant? Does the cultural history take into account cultural variables that may affect therapy?	This section should comprehensively describe family and psychosocial history and areas that could be noted include cultural variables with relevant family, social, legal and educational history.

Attachment B: Aetna Behavioral Health Treatment Record Review Criteria and Best Practices (cont.)

STANDARD		BEST PRACTICE INSTRUCTIONS
12.	Is there a medical history that could include medical conditions and a medication history that includes medications taken (prescriptions as well as over the counter), dosages, dates, responses to medications, allergies?	Medication history could include medication names, how long the member was on the medications (for both prescription and over-the-counter [OTC] medications), responses to medication and ongoing illnesses.
13.	Is there a DSM IV diagnosis with all five axes completed?	Axis I: Clinical Disorder, Axis II: Personality Disorder/ Mental Retardation, Axis III: General Medical Conditions, Axis IV: Psychosocial and Environmental Factors Contributing to the Disorder, Axis V: Global Assessment of Functioning, or Children's Global Assessment Scale for children under 18.
14.	Is the diagnosis consistent with the assessment?	The DSM IV TR diagnosis should be consistent with presenting problems, history, mental status exam and/or other assessment data.
15.	For children and adolescents, is there a developmental history that could include prenatal and perinatal events, physical, psychological, social, intellectual, academic, and educational history?	Developmental history could include areas such as normal or problem pregnancy, mother's drug use, abnormal birth weights, if child was routinely followed by pediatrician for first five years, developmental milestones within normal time frames, began school on time or delayed, learning disabilities, diagnosis of hyperactivity, and/or any medications prescribed.
16.	For suicidal and homicidal patients, or patients who are otherwise at risk, are there risk assessments at every session?	For suicidal (or homicidal) members, there should be risk assessments at every session. If the member's condition is deteriorating, the record must indicate that more intense levels of care have been arranged, for example, IOP, partial, detox, residential or IP.
17.	Is the treatment plan documentation thorough and complete? Are treatment plan and goals consistent with assessment and diagnosis? Does each goal have an estimated time frame?	(For all psychotherapy) Treatment plan goals that are vague will not be credited.
C. DOCUMENTATION AND PRACTITIONER COMMUNICATION		
18.	Is there documentation to reflect that the provider requested member's permission to communicate with the primary medical practitioner?	A signed consent from the member must be obtained before the practitioner corresponds with the member's primary medical practitioner.
19.	Did the member grant permission to communicate with the primary medical practitioner?	This is a non-scored item.
20.	If the member did grant permission, is there documentation that the provider communicated with the primary medical practitioner?	Primary medical practitioner communication may occur after the initial evaluation, as a result of a significant change in member status, after a psychiatric evaluation if medications are initiated or treatment/diagnosis warrants such communication, or after significant changes in medication. Evidence of communication could be documentation of a phone conversation, email correspondence or a letter.

STANDARD		BEST PRACTICE INSTRUCTIONS
21.	If there is documentation about other behavioral health specialists or consultants treating the patient, is there documentation to reflect the provider requested the patient's permission to communicate with the other behavioral health specialist or consultant?	Other behavioral health specialists may include psychiatrists, ancillary providers, treatment programs/ institutions/facilities or other behavioral health providers or consultants. (This is a non-scored item.)
22.	Did the patient grant permission to communicate with the other behavioral health specialists?	Self-explanatory. (This is a non-scored item. Mark N/A if Q21=N)
23.	If the patient did grant permission, is there documentation the provider communicated with the other behavioral health specialist or consultant?	There must be a separate release for each additional provider/practitioner treating the member prior to the practitioner releasing any type of information about the member. (Score N/A if Q22=N or N/A)
24.	Is a progress note present for every session?	There should be a progress note for each session.
25.	Does the documentation include a discharge plan?	A discharge plan could include follow-up as necessary, outreach documentation, crisis numbers, and/or an opportunity to return to the provider in the future.
26.	Is there documentation about advance directives?	Advance directives must be present for Medicare patients only.
D. PSYCHIATRISTS ONLY		
27.	Is there clear documentation of psychotropic medications, dosages and dates of changes?	Psychiatrist may use medication flow sheet, order sheet or progress note to document psychotropic medications, dosages and dates of changes.
28.	Is there documentation of member education on medications and member's understanding of information?	If psychiatrist uses a preprinted medication information sheet, there still needs to be documentation that the information is explained to the member (regarding the possible side effects and why the medication is being prescribed). This is in addition to the sheet being given.
29.	Is the recommended treatment consistent with the assessment and diagnosis?	Recommended treatment should be consistent with the assessment and diagnosis.

‡Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits coverage include Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company, Aetna Health Insurance Company of New York, Aetna Health Insurance Company, Aetna Health Administrators, LLC, Cofinity, Inc., and Strategic Resource Company. Aetna Behavioral Health refers to an internal business unit of Aetna. EAP is administered by Aetna Behavioral Health, LLC and Aetna Health of California Inc. (Aetna)

This *Behavioral Health Provider Manual* is an addendum to the Health Care Professional Toolkit (HCPT), which is a provider manual for all participating providers (including all Aetna behavioral health care professionals) in the Aetna network. If any terms of the HCPT are directly in conflict with the terms of this addendum, the terms of this addendum will control.

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