

Behavioral Health Provider Manual

November 2009



We want you to knowSM



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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.
- Developing a strong relationship with you 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've 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
- 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 management
- 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.

We will 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 website for physicians, hospitals and health care professionals via NaviNet[®] through www.aetna.com, selecting “for Health Care Professionals,” “Service Solutions,” then “Log In” or “Register Now!” Once logged in, select “Aetna Support Center,” then “Doing Business with Aetna.” Select “Aetna Benefit Products,” followed by “Aetna Behavioral Health and Employee Assistance Program.”

If you wish 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 benefits plans) or 1-888-MD AETNA (1-888-632-3862) (for indemnity and PPO-based benefits 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 link "Aetna's Behavioral Health Specialty Programs Flyer."

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

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 Manual, the EAP manual and other related communications are posted on our secure provider website via NaviNet available through 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 masters-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 Universal 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.
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 ASAM.
7. Current unrestricted license.
8. Absence of current debarment or suspension from state or federal programs.

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 section “Compliance with Policies.”

Correspondence regarding changes may be faxed to: **1-859-455-8650**

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

For HMO-based benefits plans — **1-800-624-0756**

For indemnity and PPO-based benefits plans — **1-888-MD AETNA (1-888-632-3862)**

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

Open the door to electronic communications

Register now at <https://aetna.providerpreference.com> and go paperless.

Our new 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 benefits plans or **1-888-MD AETNA (1-888-632-3862)** for indemnity and PPO-based benefits plans.

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 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 where 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 Lay Person" emergency room policy 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 which 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 appointments 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 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.* Collecting complete and accurate clinical data is critical to successfully completing the authorization process.

- All inpatient behavioral health services must be precertified and are managed through a concurrent review process.
- Precertification requirements for intermediate levels of care, 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.

*The term precertification here means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage. It does not mean precertification as defined by Texas law, as a reliable representation of payment.

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 nonpar referral for routine outpatient behavioral health services). This is a written or verbal request reviewed by Aetna. The most common reasons for approved nonpar referrals 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 is **no longer required** for individual outpatient behavioral health visits except as follows. The following services will still require precertification, including: outpatient detox, behavioral health home health care services, psychological testing, neuropsychological testing, outpatient ECT, biofeedback, amytal interview, hypnosis and residential treatment.** (Previously, we waived the precertification requirement for the first eight visits only.) For self-insured Open Choice plans that have expressly purchased precertification of outpatient services, precertification is required for all outpatient visits.

A complete listing of services requiring preauthorization is available on our secure provider website. To verify outpatient preauthorization requirements for a specific member's plan, please contact Provider Services.

We've made these changes to ease the administrative burden and give members easier access to behavioral health visits.

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 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.

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, which includes the length and type of care. All services must be provided in facilities licensed by the **Pennsylvania Department of Health** and specifically to provide alcohol and other drug addiction treatment services.*

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, and 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.

**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.

Clinical Delivery (continued)

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

■ **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.

■ **The Aetna Mixed Services Guidelines:** The Aetna Mixed Services Guidelines (MSG) help determine appropriate levels and types of care, and the kinds of collaboration necessary among both caregivers and utilization management personnel, for patients with combinations of medical/surgical and psychiatric/addiction conditions and diagnoses.

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. Additional information can be found 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](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=28&pt=1&ch=3&sch=HH&rl=Y)

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.

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 in 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 benefit limitations, at the new/preferred plan benefit level. In some states, regulatory requirements may mandate that Aetna continue coverage beyond 90 days.

VII. Member and provider denials & appeals

We recently updated the appeal process to assist you in determining 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 “for Health Care Professionals,” “Medical” and “Dispute 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 wish 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 benefits plans or **1-888-MD AETNA (1-888-632-3862)** for indemnity and PPO-based benefits plans.

*State or contractual requirements may modify this time frame.

VIII. Collaboration of care Behavioral health care professionals/ communication with other medical health care professionals:

In the interest of treatment coordination, Aetna requires that our network behavioral health care professionals share appropriate clinical information with primary care physicians (PCPs) or other 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:

In order 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 primary care physician 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 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 for our Behavioral Health/Medical Provider Communication Form and select “Aetna Support Center,” “Doing Business with Aetna” and “Forms Library.” We will be monitoring random records for communication with primary care physicians and other behavioral health providers.

Quality Management

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 Management 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

Participating behavioral health care professionals are required to support our Behavioral Health Quality Management 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 as warranted (after obtaining a signed release).
- Adherence to treatment record standards, as outlined in **Attachment C**.
- 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 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 Management Program information and Program Evaluation results are detailed on the Behavioral Health and Employee Assistance Program page of our secure provider website. If you wish a hard copy of our QM Program Evaluation or Description and do not have Internet access, please call our Provider Service Center at **1-800-624-0756** for HMO-based

benefits plans or **1-888-MD AETNA (1-888-632-3862)** for indemnity and PPO-based benefits plans and ask to speak with someone at Aetna Behavioral Health Quality Management Department.

II. Accreditation

Aetna Behavioral Health is accredited by NCQA and URAC. 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 is contained in the Member Handbook, and though the language may vary depending upon the state law applicable to each plan, they all include (but are not necessarily limited to) the items listed in **Attachment B**.

IV. Participating behavioral health practitioner treatment record review and documentation standards criteria

Refer to **Attachment C**.

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.

VI. 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 who are treating the same patient.

VII. 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.

VIII. 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 six months 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.

IX. 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
- Complaints
- 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 (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.”

X. Member satisfaction survey

We seek to enhance our Quality Management 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 behavioral health care professional

- Availability of the behavioral health care professional
- Acceptability
- Claims
- Appeals

XI. Provider satisfaction survey

We seek to enhance our Quality Management 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

XII. HIPAA

Refer to Section V (Confidentiality).

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 “for Health Care Professionals,” “Service Solutions,” then “Electronic Connectivity.” Or, call **1-888-247-1023** and one of our Aetna Provider eSolutions representatives will contact you.

Our secure website for physicians, hospitals and health care professionals via NaviNet

Our newly-renovated secure provider website is a great resource! The site offers free tools and transactions, including 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.
- Access an array of resources and tools for behavioral health providers, such as the latest *Aetna Behavioral Health Insights*TM 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*TM 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 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 “for Health Care Professionals,” then “Service Solutions.” You can select “Log In” or “Register Now!”

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.” Select “Doing Business with Aetna,” then “Aetna Benefit Products,” followed by “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

Practice Location (State)

AL, AK, AR, AZ, CA, FL, GA, HI, LA,
MS, NC, NM, NV, OR, SC, UT, TN, WA

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 Payer ID – 60054

Aetna Paper Claims Address

Aetna
P.O. Box 14079
Lexington, KY 40512-4079

Aetna
P.O. Box 981106
El Paso, TX 79998-1106

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

Our secure provider website via NaviNet

- Go to www.aetna.com.
- Select "for Health Care Professionals."
- Choose "Service Solutions" and "Log In" or "Register Now!" for first-time users.

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.

Chickering (student health plans):

For questions about eligibility, benefits and claims payment, please call the Chickering 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: Chickering 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/bh_profile_update.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 benefits plans or **1-888-MD AETNA (1-888-632-3862)** for indemnity and PPO-based benefits plans. You may also fax the information to Aetna at **1-860-975-1578**, 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 **1-859-455-8650**.

Attachment A: Level of Care Assessment Tool Summary

The Aetna Level of Care Assessment Tool, or “LOCAT,” helps determine the appropriate levels and types of care for patients in need of evaluation and treatment for behavioral health conditions and diagnoses. It also applies for patients in need of placement in specialized behavioral health care facilities or units.

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

Dimension 1, 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/ Cognitive Factor, helps assess a patient’s appearance, mood, etc. The sub-dimensions of this factor are Appearance, Speech, Affect, Delusions, Hallucinations, Thought Content, Behavioral/ Neurovegetative and Orientation.

Dimension 4, Substance Use/Abuse/ Dependence, helps assess whether or not substance abuse is contributing to the patient’s current symptoms. The sub-dimensions are Scope of Use/Abuse, Patterns of Use/Abuse and Withdrawal Potential.

Dimension 5, Medical Illness, helps determine whether or not medical illnesses are contributing to the patient’s behavioral health symptoms.

Dimension 6, the Environment Stress Factor, helps examine what additional outside influences may be affecting the patient. Sub-dimensions include Family Stress, Stress from Non-Family Members, Housing, and School or Job.

Dimension 7, the Support System, helps measure the amount of support a patient has available to help cope with an illness.

The LOCAT instrument does not replace medical judgment, where a provider believes that a different level of care or course of treatment is necessary. Treating providers are solely responsible for medical 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 wish 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 benefits plans or **1-888-MD AETNA (1-888-632-3862)** for indemnity and PPO-based benefits plans.

Attachment B: Member Rights and Responsibilities

As an Aetna HMO, PPO or Medicare member, you have a right to:

Information

- Know the names and qualifications of health care professionals involved in your medical treatment.
- Get up-to-date information about the services covered or not covered by your plan, and any applicable limitations or exclusions.
- Know how your plan decides what services are covered.
- Get information about copayments and fees that you must pay.
- Get up-to-date information about the health care professionals, hospitals and other providers that participate in the plan.
- Be told how to file a complaint or appeal with the plan.
- Know how the plan pays network health care professionals for providing services to you.
- Receive information from health care professionals about your medications, including what the medications are, how to take them and possible side effects.

- Receive from health care professionals as much information about any proposed treatment or procedure as you may need in order to give an informed consent or refuse a course of treatment. Except in an emergency, this information should include a description of the proposed procedure or treatment, the potential risks and benefits involved, any alternate course of treatment (even if not covered) or non-treatment and the risks involved in each, and the name of the health care professional who will carry out the procedure or treatment.
- Be informed by participating health care professionals about continuing health care requirements following discharge from inpatient or outpatient facilities.
- Be advised if a health care professional proposes to use an experimental treatment or procedure in your care. You have the right to refuse to participate in research projects.
- Receive an explanation regarding non-covered services.
- Receive a prompt reply when you ask the plan questions or request information.
- Receive a copy of the plan's Member Rights and Responsibilities statement.

Access to care

- Obtain primary and preventive care from the primary care physician you chose from the plan's network.
- Change your primary care physician to another available primary care physician who participates in the plan.
- Obtain necessary care from participating network specialists, hospitals and other health care professionals.

- Be referred to participating network specialists who are experienced in treating your chronic illness.
- Be told by your health care professionals how to schedule appointments and get health care during and after office hours, including continuity of care.
- Be told how to get in touch with your primary care physician or a back-up physician 24 hours a day, every day.
- Call 911 (or any available emergency response service) or go to the nearest emergency facility when you have a medical condition that manifests itself by acute symptoms of sufficient severity so that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health.
- Receive urgently needed medically necessary care.

The freedom to make decisions

- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care.
- Have any person who has legal responsibility to make medical care decisions for you exercise these rights on your behalf.

Attachment B: Member Rights and Responsibilities (continued)

- Refuse treatment or leave a medical facility, even against the advice of doctors (providing you accept responsibility and the consequences of the decision).
- Complete an Advance Directive, Living Will or other directive and give it to your health care professionals.
- Know that you or your health care professional cannot be penalized for filing a complaint or appeal.

Personal rights

- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when permitted by law or with your approval.
- Help your health care professionals make decisions about your health care.

Input

- Have your health care professionals' help in decisions about the need for services and in the complaint process.
- Suggest changes in the plan's policies and services.

As an Aetna HMO, PPO or Medicare member, you have a responsibility to:

Exercise your rights

- Choose a primary care physician from the plan's network and form an ongoing patient-physician relationship.
- Help your health care professional make decisions about your health care.

Follow instructions

- Read and understand your plan and benefits. Know the copayments and what services are covered and what services are not covered.
- Follow the directions and advice you and your health care professionals have agreed upon.
- See the specialists your primary care physician refers you to.
- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Show your member ID card to health care professionals before getting care from them.
- Pay the copayments required by your plan.
- Promptly follow your plan's complaint procedures if you believe you need to submit a complaint.
- Treat doctors and all health care professionals, their staff, and the staff of the plan with respect.
- Not be involved in dishonest activity directed to the plan or any health care professional.

Communicate

- Tell your health care professionals if you do not understand the treatment you receive and to ask if you do not understand how to care for your illness.
- Tell your health care professional promptly when you have unexpected problems or symptoms.
- Consult with your primary care physician for referrals to non-emergency covered specialist or hospital care.
- Understand that network doctors and other health care professionals who care for you are not employees of Aetna and that Aetna does not control them.
- Call Member Services about your plan if you do not understand how to use your benefits.
- Give correct and complete information to doctors and other health care professionals who care for you.
- Advise Aetna about other medical insurance coverage you or your family members may have.
- Ask your treating doctor about all treatment options and the doctor's compensation arrangement with Aetna.

You may have additional rights and responsibilities depending upon any state law applicable to your plan.

Attachment C: Participating Behavioral Health Practitioner Treatment Record Review and Documentation Standards Criteria

The following criteria are required on all member treatment records:

- The record is legible to someone other than the writer.
- The member's personal data is documented: address, gender, date of birth, home phone numbers, marital/legal status and guardianship (if relevant).
- The member's name or unique identifier is on every page.
- All entries in the record contain the author's legible signature or electronic identifier with title (if applicable) and degree.
- All entries are dated.
- There is a clear presenting problem.
- There is documentation of a thorough risk assessment.
- There is a complete mental status exam.
- There is a substance abuse assessment for all those over 12 years of age.
- There is a behavioral health treatment history documented.
- There is a comprehensive family and psychosocial history.
- There is a medical history that could include medical conditions and a medication history.
- There is a DSM IV TR diagnosis with axes I, II and III completed.
- The diagnosis is consistent with the assessment.
- For children and adolescents, there is a developmental history that could include prenatal and perinatal events and physical, psychological, social, intellectual, academic and educational history.
- For suicidal and homicidal members, or members who are otherwise at risk, there is a documented risk assessment at every session.
- The treatment plan documentation is thorough and complete. The goals are consistent with the assessment and diagnosis.
- There is documentation to reflect that the provider requested the member's permission to communicate with the primary medical practitioner.
- There is documentation that the member granted permission to communicate with the primary medical practitioner, if applicable.
- If the member granted permission, there is documentation that the provider communicated with the primary medical practitioner.
- There is documentation of other behavioral health specialists or consultants treating the member.
- There is documentation that the member granted permission to communicate with the other behavioral health specialists.
- There is evidence that the provider communicated with other specialists or consultants after receiving written permission, if applicable.
- There is a progress note present for every session.
- There is documentation of Advance Directives (Medicare members only).
- There is clear documentation of psychotropic medications, dosages and dates of changes. (criteria applicable to psychiatrists only)
- There is documentation of member education on medications and understanding of information. (criteria applicable to psychiatrists only)
- The recommended treatment is consistent with the assessment and diagnosis. (criteria applicable to psychiatrists only)

‡ 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 Health of the Carolinas Inc., Aetna Life Insurance Company, Aetna Health Insurance Company of New York, Aetna Health Insurance Company, Aetna Health Administrators, LLC, Cofinity, 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 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 the addendum, the terms of this addendum will control.