



Support system

Behavioral Health Provider Manual

Aetna.com

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Table of contents

Introduction 3

Our programs..... 4

Clinical delivery 7

Quality programs 15

Working electronically with us..... 22

Appendix A: Aetna® Behavioral Health treatment record review criteria and best practices 24

This Behavioral Health Provider Manual, the EAP Manual and other related communications are posted on **Aetna.com**, on the **Provider Education & Manuals** page.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies (Aetna). Aetna Behavioral Health refers to an internal business unit of Aetna.

Introduction

Welcome to the Aetna® Behavioral Health network

Our behavioral health programs focus on the important role of mental health on a person's overall well-being. We'll give you valuable tools to help you work with us and provide quality service to our members. This manual is an extension of your contract with us. All practitioners and facilities must abide by the conditions set forth in your contract and in our provider manuals.

Our guiding principles

Our behavioral health programs support our belief in the following:

- Enhancing our members' — your patients' — clinical experiences
- 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
- Educating members about the risks and benefits of available treatment options
- Developing a strong relationship with you, informing you about resources, and concentrating on continuity of care among all, for the benefit of you and your patients
- 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 make administration easier. This manual contains information about:

- Network participation
- Condition management programs
- Telemedicine
- 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 us electronically, and much more

*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 the Aetna patient management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement.

**All continental U.S. time zones; hours of operation may differ based on state regulations. In Texas: 6 AM to 6 PM CT (Monday through Friday) and 9 AM to noon CT on weekends and legal holidays. Phone recording systems are in use during all other times.

How to reach us

Our medical directors and staff are available to speak with you about utilization management issues. They're available, during and after business hours, via toll-free telephone numbers. Behavioral health medical directors make all final coverage* denial determinations involving clinical issues.

If a treating provider doesn't agree with a decision about coverage or wants to discuss an individual member's case, Aetna Behavioral Health staff are available 24 hours a day, 7 days a week. Behavioral health care providers can contact staff during normal business hours (8 AM to 5 PM, Monday through Friday)** by calling the toll-free precertification number on the member's ID card. When only a Member Services number is shown on the card, you'll be directed to the Precertification unit through either a phone prompt or a Member Services representative.

On weekends, company holidays, and after normal business hours, members and providers can use these same toll-free phone numbers to contact our staff. Our staff identify themselves by name, title and organization when they initiate or return calls about utilization management issues. We also offer TDD/TTY services for deaf, hard-of-hearing, or speech-impaired members, and language assistance for members to discuss these issues.

Our programs

Behavioral Health Condition Management program

We offer a case management program that supports patients' medical and psychological needs. Our focus is on helping our members make the best use of their benefits by coordinating behavioral health and wellness services. To support the efforts of clinicians, we also closely follow patient progress and treatment recommendation adherence and share it with you.

Through this program, we:

- Work with your practice and other health care professionals on patient progress
- Evaluate patient needs to promote full use of covered services and benefits in support of your treatment plan
- Provide educational materials and decision-support tools, both online and via mail, so patients better understand their illness
- Use case management by phone to support patient adherence to your treatment plan

This program provides additional care options for your eligible Aetna® patients.

Who may benefit from our Behavioral Health Member Support program

- Aetna members (children, adolescents and adults):
 - With co-occurring medical and behavioral health conditions
 - With complex behavioral health conditions who have had inpatient readmissions, extended hospitalization stays, or suicide attempts resulting in medical admissions
- Aetna members ages 14 and older:
 - Who have symptoms of major depression, dysthymia, depression not otherwise specified, or bipolar depression
 - Who are diagnosed with anxiety disorders, such as generalized anxiety, panic disorder, or post-traumatic stress syndrome
- Aetna members ages 18 and older who have an alcohol problem, including alcohol dependence or a more severe alcohol use disorder

Members who complete this program show significant symptom relief and improvement in overall health.

To learn more about the Aetna Behavioral Health Member Support program, call us at **1-800-424-4660 (TTY: 711)**.

We've developed a spectrum of behavioral health services for our members. In doing so, we contract with licensed psychiatrists, psychologists, social workers and other master's-prepared clinicians. Among these practitioners, numerous clinical, linguistic, 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 a diverse, well-informed, quality network. To accomplish this, we credential clinicians who are independently licensed and well trained in their particular area of expertise.

Credentialing and recredentialing

A behavioral health care professional must be credentialed by us before joining the behavioral health network.

We use a standard application and a common database through the Council for Affordable Quality Healthcare (CAQH®) to gather credentialing information.

Our recredentialing process

We reassess a provider's qualifications, practice and performance history every three years, depending on state and federal regulations and accrediting agency standards. This process is seamless to providers who are due for recredentialing and whose applications are complete within the CAQH database.

We'll send providers (whose applications aren't complete within the CAQH database) three reminder letters. The letters will ask them to update their recredentialing data. If they don't respond to the letters, we'll call them.

How can I check the status of my recredentialing application?

Call our Credentialing Customer Service department at **1-800-353-1232 (TTY: 711)**.

Just go to the "**Request participation**" section of our website to start the application process.

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

- Graduation from an accredited professional school applicable to the applicant's degree, discipline and licensure
- For physicians, completion of residency training in psychiatry and board certification, unless the physician meets the conditions delineated in our board certification exception policy; a medical director reviews exceptions to the board certification requirement
- Malpractice insurance in amounts specified in the Aetna agreement
- Availability for emergencies by mobile device or other established procedures that we deem acceptable
- Submission of an application containing all applicable attestations, necessary documentation and signatures
- If applicant is a physician addictionologist, certification by the American Society of Addiction Medicine (ASAM)
- Current, unrestricted license
- The absence of current debarment or suspension from state or federal programs

Open the door to electronic communications

Our electronic correspondence option allows your office to get information from us online instead of on paper. Read the **OfficeLink Updates™** provider newsletter and other time-sensitive correspondence online. We'll send you an email when the newsletter or other communications are ready to view.

Site visits and monitoring

We make office site visits to network practitioners after getting a member's complaint. We evaluate the physical accessibility, physical appearance, and adequacy of waiting and exam room space related to the settings in which member care is given.

We set standards for office site criteria and medical record-keeping practices. If a site visit is required for member complaints to evaluate the physical accessibility, physical appearance, or adequacy of waiting and exam room space, we also review the medical record-keeping practices. We assess methods used for keeping confidentiality of member information. We also assess methods for keeping information in a consistent, organized manner for ready accessibility.

No site visit is required for complaints about availability or medical record keeping. The office assessment criteria are stated in the practitioner agreements and business criteria of the practitioner agreements. The medical

record-keeping practice standards are stated in the medical record criteria that we distribute to practitioners. Also see **Appendix A** on page 24 for more information.

Notification of status changes

Federal provider directory regulations require Aetna and providers to work together to maintain accurate provider directory lists. It is important for you and Aetna to keep your information current and to periodically confirm its accuracy every ninety (90) days, as well as upon request. Behavioral health care professionals are required to notify us 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 "Compliance with Policies" section of the health care professional contract (provider or specialist agreement)

Note:

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

Please fax correspondence about changes to **859-455-8650**.

Questions?

- General: call our Provider Service Center, which is available from 8 AM to 5 PM.
- Health maintenance organization (HMO)-based and Aetna Medicare Advantage plans: call **1-800-624-0756 (TTY: 711)**.
- All other plans: call **1-888-MDAetna (TTY: 711)** or **1-888-632-3862 (TTY: 711)**, or visit **Availity.com**, our provider portal.

Update your office's contact information online

If you need to change or update your office's contact information (new email, mailing address, phone/fax numbers), go to **Availity.com** and access our provider portal.

Having your correct email address on file is very important to us. It's our preferred and efficient way of communicating important information to you.

Behavioral health care provider access-to-care standards*

Service	Time frame
Non-life-threatening emergency needs	Within 6 hours of request
Urgent needs	Within 48 hours of request
Routine office visits	Initial visit within 10 business days of request Follow-up visits should be available within 5 weeks for behavioral health practitioners who prescribe medications, and within 3 weeks for behavioral health practitioners who don't prescribe medications.
Following emergency department visit for behavioral health condition or alcohol or other drug abuse or dependence	Within 7 days of emergency department visit
Following hospital discharge for a behavioral health condition	Within 7 days of the inpatient discharge date
After-hours and emergency care	Each behavioral health practitioner must have a reliable 24 hours a day, 7 days a week live answering service or voicemail message. <ul style="list-style-type: none">• MDs must have a notification system or designated practitioner backup.• Non-MDs, at a minimum, must have a message system that provides 24-hour contact information to a licensed professional.

Online security is more important than ever in today's high-tech world. Our provider portal lets you validate the information you submit. It also ensures that unauthorized individuals aren't submitting incorrect information about your office or facility. Your security officer can make changes to your information, or they may give access to others.

You'll need to register for our provider portal

To use the provider portal, you must first **register**. And it's easy! Then, you'll also be able to submit claims transactions, check member eligibility and benefits, and verify referrals.

*More stringent state requirements supersede these accessibility standards.

Clinical delivery

Access to care

Members may access behavioral health care in three ways:

1. Through direct access to the behavioral health provider
2. Through a recommendation from the primary care physician or other treatment provider
3. Through a referral from an employee assistance or student assistance program provider

For a list of services that require precertification and concurrent review, go to **AetnaElectronicPrecert.com** and click “Check our precertification lists.” To request precertification, use our provider portal at **Availity.com** or any other website that allows you to send precertification requests electronically. (You can register at **Availity.com** for our provider portal via Availity®.) You may also use the toll-free behavioral health telephone number on the member’s ID card. For Open Choice® and Traditional Choice® plan members, use the toll-free Member Services telephone number on the member’s ID card. These numbers are accessible 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.

Authorization and 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 Diagnostic and Statistical Manual of Mental Disorders (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, Aetna Clinical Policy Bulletins and Aetna clinical practice guidelines.

It is also expected that treatment provided is medically necessary: “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 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.”

Some employers have specific preauthorization requirements for their employees, so always check with our Provider Service Center at **1-800-624-0756 (TTY: 711)** for HMO and Medicare Advantage plans and **1-888-MDAetna (1-888-632-3862) (TTY: 711)** for all other plans.

- All inpatient behavioral health services must be precertified and are managed through a concurrent or retrospective review process.
- Intermediate levels of care, such as residential treatment, and partial hospitalization also require precertification. For more information, go to **AetnaElectronicPrecert.com** and click “Check our precertification lists.”

*Precertification is the process of collecting information before 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 doesn’t mean precertification as defined by Texas law as a reliable representation of payment.

Exceptions:

This policy applies to all Aetna® plans with the exception of behavioral health benefits that we administer but don't manage and self-funded plans with plan sponsors that have expressly purchased precertification requirements.

- In addition to reviewing clinical information to determine coverage, our utilization management clinician will discuss treatment alternatives, the appropriate level of care and explore discharge planning opportunities. If Aetna case management is involved, we will request that the member's family, physician(s), and other health care professionals be involved in the treatment plan and activities. We recommend that you discuss the available benefits for outpatient care with your patient, so that treatment can be planned accordingly.

You can submit a precertification request in one of three ways:

1. Through **Availity.com** (our provider portal)
2. Through one of our vendors — go to **Aetna.com/provider/vendor** to see our list
3. By calling our Provider Service Center at **1-800-624-0756 (TTY: 711)**

Learn more.**Note:**

Stepping down to a less restrictive level of care within the same facility (for example, a 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 our network (for example, a nonparticipating referral for routine outpatient behavioral health services). This is a written or verbal request that we review. Reasons that a nonparticipating referral may be approved include:

- When a specific health care professional preferred by the member isn't available in network (and the member's plan provides coverage for out-of-network services)
- When the member is continuing, or returning to, treatment with a nonparticipating health care professional, in certain circumstances
- When the primary care practitioner identifies a local or known nonparticipating health care professional with expertise in the treatment of the member's condition (and the member's plan provides coverage for out-of-network services)

More about precertification of behavioral health services

It's important to note that outpatient care that isn't consistent with evidence-based, goal-directed practices, Aetna Clinical Policy Bulletins and Aetna clinical practice guidelines may be subject to quality-of-care and utilization reviews.

Also note that outpatient care inconsistent with such a treatment approach may be subject to a concurrent review.

It's expected that facility diagnostic evaluations assess for either comorbid chemical dependency or comorbid psychiatric conditions that could be impacting current presentation.

Go to **Aetna.com** for more information on **services requiring precertification** and **electronic precertification**.

A complete **list** of behavioral health services requiring authorization and precertification is available at **Aetna.com** in the "For Providers" section. Some employers have specific precertification requirements for their employees. To verify outpatient precertification requirements for a specific member's plan, contact our Provider Service Center.

Precertification for ABA

Applied behavior analysis (ABA) services require precertification. To get ABA services precertified, call the number on the member's Aetna® ID card and speak to a Member Services representative.

You can access our medical necessity guidelines for ABA [here](#). We've used the American Medical Association Category I CPT codes (97151–97158) for Adaptive Behavior Treatment as of January 1, 2019, and Category III CPT codes (0362T and 0373T).

Coverage determinations and utilization management (UM)

We use evidence-based clinical guidelines from nationally recognized authorities to make UM decisions. We base decisions on the appropriateness of care and service. We review coverage requests to determine if the requested service is a covered benefit under the terms of the member's plan and is being delivered consistently with established guidelines. Aetna offers providers an opportunity to present additional information and discuss their cases with a peer-to-peer reviewer as part of the utilization review coverage determination process. The timing of the review incorporates state, federal, Centers for Medicare and Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) requirements. If we deny a request for coverage, the member (or a physician acting on the member's behalf) may **appeal** this decision through the complaint and appeal process.

Depending on the specific circumstances, the appeal may be made to a government agency, the plan sponsor, or an external utilization review organization that uses independent physician reviewers, as applicable.

We don't reward physicians or other individuals who conduct utilization reviews in order to issue denials of coverage or create barriers to care or service. Financial incentives for utilization management decision makers don't encourage denials of coverage or service. Rather, we encourage the delivery of appropriate health care services. In addition, we train utilization review staff to focus on the risks of underutilization and overutilization of services. We don't encourage utilization-related decisions that result in underutilization.

Learn more

Our medical directors are available 24 hours a day for specific utilization management issues. Contact us by:

- Visiting [our website](#)
- Calling us at **1-800-624-0756 (TTY: 711)**
- Calling Patient Management staff using the Member Services number on the member's ID card



How we determine coverage

Our medical directors make all coverage decisions that involve clinical issues. Only licensed medical directors, psychiatrists/psychologists and pharmacists make denial decisions for reasons related to medical necessity. (Licensed pharmacists and psychologists review coverage requests, as permitted by state regulations.)

Where state law mandates, utilization review coverage denials are made, as applicable, by a physician or a pharmacist who is licensed to practice in that state. Patient Management staff use evidenced-based clinical guidelines from nationally recognized authorities to guide utilization management decisions involving precertification, inpatient review, discharge planning and retrospective review. Staff use the following criteria as guides in making coverage determinations, which are based on information about the specific member's clinical condition.

1. **Level of Care Utilization System:***

The Level of Care Utilization System Tool, or LOCUS, is a nationally recognized level of care tool used to help determine the resource intensity needs of individuals who receive adult mental health services. It is used for patients 18 years and older who are in need of placement in specialized psychiatric or mental health facilities or units. This person-centered approach aims to find the best fit between individual needs and behavioral health services. For more information about LOCUS, visit the American Association of Community Psychiatry (AACP) website at CommunityPsychiatry.org.

The Child and Adolescent Level of Care Utilization System, or CALOCUS, and the Child and Adolescent Service Intensity Instrument, or CASII, are nationally recognized tools used to determine the appropriate level of care placement for a child or adolescent. These tools are used for children and adolescents from 6 to 18 years of age. For more information about these tools, visit the American Academy of Child and Adolescent Psychiatry (AACAP) website at AACAP.org.

2. **The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions**

This is a nationally recognized criteria set that helps determine appropriate levels and types of care for patients in need of evaluation and treatment for chemical dependency and substance abuse conditions and diagnoses. The third edition is compliant with the DSM-5 and also applies for

patients who are in need of placement in specialized chemical dependency detoxification or rehabilitation facilities or units.

Note:

We supply relevant pages of ASAM's criteria upon request. Please call us by any of the ways below to submit a request.

- Provider Service Center: **1-800-624-0756 (TTY: 711)**
- HMO and Aetna® Medicare Advantage plans: **1-800-624-0756 (TTY: 711)**
- All other plans: **1-888-MDAetna (TTY: 711)** or **1-888-632-3862 (TTY: 711)**

3. **State-specific criteria**

The Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) is used for chemical dependency treatment that takes place in New York. They are available [online](#).

4. **Our Applied Behavior Analysis (ABA) Medical Necessity Guide for the treatment of autism spectrum disorders**

The ABA Medical Necessity Guide is a clinical behavioral health patient-management instrument used to guide and track treatment decisions for our members in need of ABA. For practitioners treating autism spectrum disorders using ABA, either national certification is needed from the Behavior Analyst Certification Board (BACB), or the practitioner must be licensed as a behavior analyst in the state in which they practice.

5. **Aetna Clinical Policy Bulletins (CPBs)**

These are based on evidence in peer-reviewed, published medical literature; technology assessments and structured evidence reviews; evidence-based consensus statements; expert opinions of health care providers; and evidence-based guidelines from nationally recognized professional health care organizations and government public health agencies. CPBs are detailed technical documents that explain how we make coverage decisions for members under our health benefits plans. They spell out what medical, dental, pharmacy and behavioral health technologies and services may, or may not, be covered.

*The LOCUS and CALOCUS/CASII are instruments that an Aetna clinician uses to aid in the decision-making process. They help determine the level of care appropriate for effective treatment for a mental health patient. "Aetna clinician" may mean a care manager, an independent physician reviewer working on our behalf or an Aetna medical director. LOCUS and CALOCUS/CASII guidelines don't constitute medical advice. Treating providers are solely responsible for medical advice and treatment of members.

You can learn more about these guidelines on [our website](#).

Participating practitioners can ask for a hard copy of the criteria we used to make a determination. Just call us at **1-888-632-3862 (TTY: 711)**.

Both new and revised CPB drafts undergo a comprehensive review process that includes review by our Clinical Policy Council. Our chief medical officer (or designee) approves CPBs. The Aetna® Clinical Policy Council evaluates the safety, effectiveness, and appropriateness of medical technologies (that is, drugs, devices, medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided) that are covered under our medical plans, or that may be eligible for coverage under our medical plans.

In making this determination, the Clinical Policy Council reviews and evaluates evidence in the peer-reviewed, published medical literature; information from the U.S. Food and Drug Administration and other federal public health agencies; evidence-based guidelines from national medical professional organizations; and evidence-based evaluations by consensus panels and technology evaluation bodies.

The criteria noted above are only guidelines. Their use doesn't 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 our 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.

For current information on our medical necessity criteria or Clinical Policy Bulletins, visit [Aetna.com/health-care-professionals/clinical-policy-bulletins.html](https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html) for our Clinical Policy Bulletins page.

If you need hard copies of any of Aetna Behavioral Health utilization management criteria or CPBs, call us at **1-888-632-3862 (TTY: 711)**.

Some states have specific requirements or laws in place for practitioners and facilities. For more information on [state-specific requirements](#), see our public website.

Clinical practice guidelines (CPGs)

Consult behavioral health CPGs as you care for patients

The National Committee for Quality Assurance (NCQA) requires health plans to regularly inform practitioners about the availability of CPGs.

The following behavioral health CPGs are based on nationally recognized recommendations and peer-reviewed medical literature. We adopt and encourage the use of CPGs to help practitioners in screening, assessing and treating common disorders. Recognized professional practice societies, such as the American Psychiatric Association and the American Academy of Pediatrics, publish recommended guidelines. Before we adopt each guideline, we review relevant scientific literature and get practitioner input through our Quality Advisory Committee. Network practitioner feedback then goes to a National Quality Oversight Committee for adoption.

Once implemented, we review each guideline at least every two years for continued applicability and update them as needed. We report guideline changes through our online newsletter, OfficeLink Updates, posted on the [newsletters page](#) of our public website.

How the guidelines help in clinical decision making

When used in clinical decision making, adherence to these recognized guidelines helps to ensure that care authorized for acute and chronic behavioral health conditions meets national standards for excellence. We measure adherence through use of the Healthcare Effectiveness Data and Information Set (HEDIS®) measures.*

Our adopted guidelines are intended to support, not replace, sound clinical judgment. We welcome your feedback and will consider all suggestions and recommendations in our next review. You can contact our Quality Management department at

QualityImprovement2@Aetna.com.

To support clinical decision making, we provide all adopted practice guidelines to our behavioral health staff and distribute them to contracted network professionals when requested to do so.

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

Behavioral health clinical practice guidelines we currently adopt:

- **American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents.**
- **American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Major Depressive Disorder**
- **APA Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder**
- **APA Practice Guideline for the Treatment of Patients with Substance Use Disorders**

There are several other behavioral health guidelines to help support your patient care decisions on the **APA website**.

For a copy of a specific CPG, call us at **1-888-632-3862 (TTY: 711)**.

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, the inpatient facility, partial hospital program, intensive outpatient program or other involved health care professional will obtain a release of information from the member that meets all state and federal confidentiality regulations. If a release is obtained, the provider will facilitate coordination of care and collaboration with the primary care practitioner and/or other appropriate health care specialist.
- Facilities should arrange for follow-up appointments within seven days for each member discharged from an inpatient stay. We also ask that health care professionals to schedule such appointments within seven days.



Continuity and transition of care

We may allow members to continue care for a specified period of time with a behavioral health care professional who has left the network. This will ensure that the member's course of treatment isn't interrupted.

The length of time may vary and depends on regulatory requirements, company policies, and the health care professional's willingness to continue to treat the member. Company policy states that participating providers leaving the network will work with us to transition the member to a participating provider when network benefits are requested and the care will exceed the 90-day transition period. A health care professional may not continue to care for a member under the network benefit if we determine 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 benefits plan or policy that's active at the time of admission.

All other levels of care

Patients who have met certain requirements are allowed to continue an "active course of treatment" with a nonparticipating practitioner. They can continue for up to 90 days without penalty, within the benefits limitations, at the new or preferred plan benefits level as outlined in the provider contract. In some states, regulatory requirements may mandate that we continue coverage beyond 90 days.

Collaboration and coordination of care

We appreciate the importance of the therapeutic relationship and strongly encourage continuity, collaboration and coordination of care. Whenever a transition-of-care plan is required, whether the transition is to another outpatient provider or to a less intensive level of care, the transition is designed to allow the member's treatment to continue without disruption whenever possible.

We also believe that collaboration and communication among providers who are participating in a member's health care are essential for the delivery of integrated, quality care. There are several ways to ensure continuity, collaboration and coordination of care, including:

- **Ambulatory follow-up**

Members being discharged from an inpatient stay should have a follow-up appointment scheduled before discharge. The appointment should occur within seven days of discharge.

- **Emergency department follow-up**

Members seen in an emergency department setting for a behavioral health condition or for alcohol or other drug abuse or dependence should have a follow-up

appointment within 7 days of discharge. Emergency department staff should assist with appointment set-up if possible. Behavioral health care professionals should have available appointments within 7 days for members recently treated in an emergency department.

- **Timely and confidential exchange of information**

With written authorization from the member, it's important that you communicate key clinical information in a timely manner to all other health care providers participating in a member's care, including the member's primary care practitioner.

- **Timely access and follow up for medication evaluation and management**

Members should receive timely access and regular follow-up for medication management.

Behavioral health care professional responsibilities for all levels of care

- Explain to the member the purpose and importance of communicating clinical information and coordinating care with other relevant health care providers treating the same patient.
- Obtain written authorization from the member to communicate significant clinical information to other relevant providers.
- Obtain, at the initial treatment session, the names and addresses of all relevant health care providers involved in the member's care.
- Subject to applicable law, include the following in the Authorization to Disclose document signed by the member in both outpatient office and higher-levels-of-care settings:
 - A specific description of the information to be disclosed
 - Name of the individual(s) or entity authorized to make the disclosure
 - Name of the individual(s) or entity to whom the information may be disclosed
 - An expiration date for the authorization
 - A statement of the member's right to revoke the authorization, any exceptions to the right to revoke and instructions on how the member may revoke the authorization
 - A disclaimer that the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected
 - A signature and date line for the member
 - If the authorization is signed by the member's authorized representative, a description of the representative's authority to act for the member

If needed, an acceptable Behavioral Health/Medical Provider Communication Form is located at **Aetna.com** in the "For Providers" section.

- Contact the member's primary care practitioner 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
 - Primary care practitioner or specialist support for a treatment plan would enhance member compliance and/or treatment outcome
 - Primary care practitioner or specialist has requested immediate feedback
- Upon obtaining appropriate authorization, communicate in writing to the primary care practitioner or other appropriate specialist, at a minimum, at the following points in treatment:
 - Initial evaluation or assessment
 - Significant changes in diagnosis, treatment plan or clinical status
 - When medications are initiated, discontinued or significantly altered
 - Termination of treatment

It's recommended that communication occur within two weeks of the above situations.

- Work with medical practitioners to support the appropriate use of psychotropic drugs.
- Collaborate with our Patient Management staff to develop and implement discharge plans before the member is discharged from an inpatient setting.
- Cooperate with follow-up verification activities and provide verification of kept appointments when requested, subject to applicable federal, state, and local confidentiality laws.
- Work with us to establish discharge plans that include a post-discharge scheduled appointment within seven days of discharge from an inpatient stay or an emergency department visit.
- Notify us immediately if a member misses a post-discharge appointment.
- Promptly complete and submit a claim for services rendered, confirming that the member kept the after-care appointment.
- Provide suggestions to us on how we can continue to improve the collaboration-of-care process.

We annually audit random behavioral health care professional records to check for communication and coordination with primary care physicians and other behavioral health providers and appropriate specialists. The communication should either be in the form of a professional letter or in a format that we accept.

We have the right to access confidential medical records of our members for the purposes of claims payment; assessing quality of care, including medical evaluations and audits; and performing utilization management functions. The Health Insurance Portability and Accountability Act (HIPAA) privacy regulations allow for the sharing of protected health information for purposes of making decisions around treatment, payment or health plan operations.

HIPAA and release of information

Most health care professionals are familiar with the Health Insurance Portability and Accountability Act, most commonly known as **HIPAA**, and the importance of upholding its requirements. In short, HIPAA works to protect the confidentiality of people receiving medical and behavioral health treatment.

At Aetna®, we work to support your efforts to coordinate care among our medical and behavioral health providers. It's important to follow HIPAA and relevant federal and state privacy laws to safeguard personally identifiable information (PII) and protected health information (PHI).

Helpful tips

There is a difference between how behavioral health practitioners share information with medical providers and how medical providers share information among themselves.

For behavioral health information such as general progress reporting and sharing of details like medication lists, a signed release may be required by relevant federal or state law. This release may be required even if the medical provider seeking the information is also the one that referred the member to the behavioral health provider. State and/or other laws may apply. Learn more about **mental health HIPAA requirements** and **substance use disorder requirements**.

Psychotherapy notes that contain the content of conversations are not covered under a general release. **Psychotherapy notes** require a separate release of information.

Confidentiality laws govern what and how information can be shared, and they vary by state. We encourage both **behavioral health and medical providers** to find out about and follow their state regulations.

To enhance coordination of care, obtaining a release of information from your patient is one way to facilitate information sharing with other providers and practitioners.

Legal disclaimer

The information in this article does not, and is not intended to, constitute legal advice; instead, all information, content and materials are for general informational purposes only. Information may not constitute the most up-to-date legal or other information. Links are provided only for the convenience of the reader, and Aetna® does not recommend or endorse the contents of third-party sites.

Readers should contact their attorney to obtain advice with respect to any particular legal matter. No reader should act or refrain from acting on the basis of information contained in this article without first seeking legal advice from counsel in the relevant jurisdiction. Only your individual attorney can provide assurances that the information contained in this article — and your interpretation of it — is applicable or appropriate to your particular situation.

Aetna resources

We encourage our behavioral health care professionals to share patient information and promote complete patient care. You can find our communication forms in the “For Providers” section of our website:

- **Behavioral Health/Medical Provider Communication Form**
- **Make the connection**
- **Sample behavioral health forms**

Quality programs

Quality program overview

We're committed to a continuous quality improvement program and encourage your involvement. The Aetna Behavioral Health Quality program includes:

- A utilization management program
- Quality improvement activities
- Screening programs
- Condition management programs
- Member and provider satisfaction studies
- Outcome studies
- Provider treatment record review studies
- Oversight of availability and access to care
- Member safety
- Complaint, nonauthorization and appeal processes
- Medical necessity criteria
- Clinical practice guidelines

- Investigations of potential facility and provider quality-of-care concerns

Participating behavioral health care professionals are required to support and cooperate with our Aetna 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:

- Adhere to all Aetna policies and procedures, including those outlined in this manual
- Cooperate with quality improvement activities
- Communicate with the member's primary care physician and any specialists (after obtaining a signed release)
- Adhere to treatment record review standards, as outlined in **Appendix A** on page 24 of this manual
- Respond in a timely manner to inquiries by our behavioral health staff
- Cooperate with our behavioral health complaint process
- Adhere to continuity-of-care and transition-of-care standards when the member's benefits are exhausted or if they leave the network
- Cooperate with onsite audits or requests for treatment records
- Return completed annual provider satisfaction surveys when requested
- Participate in treatment plan reviews or send in necessary requests for treatment records in a timely fashion
- Submit claims with all requested information completed
- Adhere to patient safety principles
- Comply with state and federal laws, including confidentiality standards, by maintaining the confidentiality of member information and records

Annual quality program information and program evaluation results are detailed on the **Quality Management & Improvement Efforts** page on our website. If you want a hard copy of our quality program evaluation and don't have Internet access,

- HMO and Aetna Medicare Advantage plans: **1-800-624-0756 (TTY: 711)**.
- All other plans: **1-888-MDAetna (TTY: 711)** or **1-888-632-3862 (TTY: 711)**

Quality, accreditation, review and reporting activities

As a participating provider, you agree to cooperate with any company quality activities, as well as review of the

company, a payer or a plan conducted by, as applicable, the National Committee for Quality Assurance (NCQA) or other accrediting organizations, or a state or federal agency with authority over the company and/or the plan. Providers must also comply with Healthcare Effectiveness Data and Information Set (HEDIS) and similar data collection and reporting requirements as required by the company.

Accreditation

Aetna® Behavioral Health is accredited by the NCQA for both commercial and Medicare health maintenance organization (HMO) and preferred provider organization (PPO) products. Many of our policies and procedures are guided by national accreditation standards.

Visit [NCQA.org](https://www.ncqa.org) for more information.

Member rights and responsibilities

We honor the rights of all members and communicate their rights and responsibilities to them.

Please visit our website at [Aetna.com/individuals-families/member-rights-resources.html](https://www.aetna.com/individuals-families/member-rights-resources.html) to see our commercial member rights and responsibilities statements. The language may vary depending upon the state law applicable to each plan. Medicare members should refer to their Evidence of Coverage documents for member rights and responsibilities. Practitioners can refer to the [Office Manual for Health Care Professionals](#).

If you want a hard copy of this information and don't have Internet access, call us at **1-800-624-0756 (TTY: 711)** for HMO-based and Medicare Advantage plans. Or **1-888-MDAetna (1-888-632-3862) (TTY: 711)** for all other plans.

Nondiscrimination policy

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of race, ethnicity, color, gender, creed, ancestry, lawful occupation, marital status, health status, place of residence, national origin, religion, age, mental or physical disability, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, source of payment for services, cost or extent of services required, or any other grounds prohibited by law.

All participating physicians, behavioral health providers and practitioners should have a documented policy about nondiscrimination. All participating physicians, health care professionals and behavioral health providers may also have an obligation under the federal Americans with Disabilities Act to provide access to their offices and

reasonable accommodations for patients and employees with disabilities.

All participating physicians and behavioral health care professionals who are covered entities under the Section 1557 Nondiscrimination in Health Programs and Activities Final Rule must also provide access to medical services. This includes diagnostic services to an individual with a disability.

Participating physicians and behavioral health care professionals may use different types of accessible medical diagnostic equipment. Or they may ensure they have enough staff to help transfer the patient, as may be needed, to comply.

Participating behavioral health practitioner treatment record review criteria and best practices

Each year, our quality management program randomly selects Aetna Behavioral Health network practitioners, in states where it is required, to participate in our treatment record review. This audit procedure is a key part of our quality program. It's important for the network to comply with standards set by Aetna Behavioral Health, our customers and external agencies.

Your Aetna Behavioral Health Agreement requires that you participate in our quality management program.

Refer to [Appendix A](#) on page 24 of this manual for our treatment record review criteria and best practices.

This additional resource is available by clicking the link below:

- [Sample behavioral health forms](#)

Or contact us at QualityImprovement2@Aetna.com for a copy.

Privacy practices

Protecting our members' health information is one of our top priorities. To support this, we tell members of our policy about the confidentiality of member information. As a participating physician or behavioral health care professional, you should know that we distribute the following notice to our members:

Notice of privacy practices

We consider personal information to be confidential and have policies and procedures in place to protect against unlawful use and disclosure. "Personal information" means 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 doesn't include publicly available information or information that is available or reported in a summarized or aggregate fashion, but doesn't 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 provider organizations, employers that sponsor self-funded health plans or share responsibility for the payment of benefits, and others that may be financially responsible for payment for the services or benefits a member receives under their plan), other insurers, third-party administrators, vendors, consultants, and government authorities and their respective agents. These parties are required to keep personal information confidential, as provided by applicable law. Participating network physicians and behavioral 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.

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, 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 don't want to receive unsolicited marketing materials unrelated to their health benefits. We don't 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 our practices in more detail concerning the use and disclosure of personal information, call the

toll-free Member Services number on the member's ID card or visit our **[website](#)**.



Medical record documentation: standards and criteria

Our participation agreements require you to treat personal health information (PHI) as confidential. PHI includes: identity of the individual, the relationship of the individual with us, physical or behavioral health status or condition, and payment information for the provision of health care.

We established medical record criteria to provide a guideline for fundamental elements of organization, documentation of diagnostic procedures and treatment, communication, and storage of medical records. These criteria are applicable to all benefits plans. Performance goals are established to assess the quality of medical record-keeping practices, and audits are conducted annually. Our performance goal is 85% compliance.

Our participation agreements require you to keep medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards. This requirement survives the termination of the contract, regardless of the cause for termination. You must keep our members' information confidential and stored securely. You must also ensure your staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

We have the right to access confidential medical records of our members for the purpose of claims payment,

assessing quality of care, including medical evaluations and audits, and performing utilization management functions. Medical records may be requested as part of our participation in the Healthcare Effectiveness Data and Information Set (HEDIS). Health Insurance Portability and Accountability Act (HIPAA) privacy regulations allow for sharing of PHI for purposes of making decisions around treatment, payment or health plan operations.

Maintenance of information and records requirements

The provider agrees:

- a) To keep information and records in a current, detailed, organized and comprehensive, accurate and timely manner, and according to customary medical practice, applicable federal and state laws, and accreditation standards
- b) That all member medical records and confidential information will be treated as confidential and according to applicable laws, including but not limited to, the requirements set forth in 42 C.F.R. §§ 422.118 and 423.136
- c) Keep the information and records for the longer of six years after the last date provider services were provided to member, or the period required by applicable law

This requirement survives the termination of your agreement, regardless of the cause of the termination.

California Assembly Bill 2193 requires maternal mental health screening

As of July 1, 2019, California Assembly Bill (AB) 2193 requires all licensed health care practitioners who provide prenatal or postpartum care to a patient to screen or offer to screen mothers for maternal mental health conditions. Mental health concerns include not only depression but conditions like anxiety disorders and postpartum psychosis that are often missed or mistaken as “normal” within pregnancy and postpartum periods. Careful screening can identify those with mental health conditions and improve the outcome for at least two patients, if not the whole family.

Practitioners serving Aetna® members can use the following screening tools:

- **The Pfizer Patient Health Questionnaire-9 (PHQ-9)** is appropriate for prenatal screening. This is available for download at no cost.
- **The Edinburgh Postnatal Depression Scale** is for postnatal screening. This is available at no cost.

Scoring references are included for each, and recommendations are made below. However, the final determination for referral to treatment resources belongs to the screening/treating professional.

For prenatal screening with the PHQ-9, any score under 4 requires no immediate action. For a score of 5 to 14, it is recommended to refer the member to a behavioral health counselor via the Member Services number on the member ID card (ask for Aetna Behavioral Health customer service). And for a score of 15 or over, refer directly to Aetna Behavioral Health condition management services by calling **1-800-424-4660 (TTY: 711)**.

For postnatal screening with the Edinburgh Scale, any score from 7 to 13 warrants a referral to Aetna Behavioral Health, which can then make referrals to behavioral health providers. Any score of 14 or above suggests a referral directly to Aetna Behavioral Health condition management services by calling **1-800-424-4660 (TTY: 711)**.

Note: Scores of 1 or higher on question #10 (self-harm) should be referred to Aetna Behavioral Health condition management services immediately for follow-up.

These screening services are reimbursable. Submit your claim with the following billing combination: CPT

codes 96127 or G0444 (brief emotional and behavioral assessment) in conjunction with diagnosis code Z13.31 (screening for depression).

Behavioral health screening programs

Opioid Overdose Risk Screening program

In an effort to address the rising opioid epidemic, we've implemented a screening program to identify members at risk for opioid overdose. When our clinicians assess a case involving opioid dependence, they discuss the potential benefits of adding naloxone (common brands include NARCAN® and EVZIO®) to the member's treatment plan as an intervention, in the event of relapse and future overdose.*

Naloxone reverses the effects of an opioid overdose. Providing naloxone rescue kits to laypeople reduces overdose deaths, is safe, and is cost effective. Other elements supporting this potentially life-saving intervention include telling patients and their family and support network about signs of overdose and about administering naloxone.

Coverage of naloxone rescue kits varies by individual plans and can be verified by calling the number on the member ID card. We waive copays for the naloxone rescue medication NARCAN for fully insured commercial members.

Screening for coexisting behavioral health and substance use disorders

Do you have Medicare-Medicaid Dual-eligibility Special Needs Program (D-SNP) members? Our behavioral health clinical team works with D-SNP members to identify those who may have a behavioral health and/or substance use disorder diagnosis.

These members will receive:

- An initial screening for coexisting mental health and substance use disorders using evidenced-based screening tools
- A individualized care plan (if the screening shows the co-existing conditions)
- A behavioral health care manager who, as a part of the care team, will help maintain continuity of care

How to make a referral

Help make sure these members get the quality care they need. Refer them to Aetna® D-SNP.

Resources

- [**Aetna emotional well-being resources**](#)
- [**U.S. Centers for Medicare & Medicaid Services Roadmap to Behavioral Health**](#)
- [**U.S. Substance Abuse and Mental Health Services Administration**](#)

Depression screening for pregnant and postpartum women

We work with our medical management team to help identify depression and behavioral health factors for pregnant women. The Aetna Maternity Program gives educational support to members and providers. We help them reach their goal of a healthy, full-term delivery.

Program elements

- The clinical case management process focuses on members holistically. This includes behavioral health and comorbidity assessment, case formulation, care planning, and focused follow-ups.
- The Aetna Maternity Program refers members with positive depression or general behavioral health screens to behavioral health condition management if they have the benefit and meet the program criteria. We assess members who have enrolled for any need, including depression. We case manage members with a history of any behavioral health issues, as well as a positive depression screening. We make postpartum calls to screen for depression. Then, we refer members to their behavioral health benefit and providers as appropriate, based on our assessment and screening.
- A behavioral health specialist supports the Aetna Maternity Program team. They help enhance effective engagement and identify members with behavioral health concerns.
- Aetna Maternity Program nurses reach out to members who have lost their babies to offer condolences and behavioral health resources.

How to contact us

- Members and providers can call **1-800-272-3531 (TTY: 711)** to verify eligibility or register for the program. Members can complete enrollment with a representative, and you can also refer members by calling this number. This includes members who are pregnant, as well as members who have experienced a loss.

- Members can also enroll online through their member website.

[**Learn more.**](#)

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The Institute of Medicine encourages use of the SBIRT model, which calls for community-based screening for health risk behaviors, including substance use.

We'll reimburse you for screening patients for alcohol and substance use disorder, providing brief intervention, and referring them to treatment. You can help increase the adoption of the SBIRT process in your practice. The patient must have Aetna medical benefits to be eligible.

The SBIRT practice supports health care professionals in all health care settings. Overall, our goal is to improve both the quality of care for patients with alcohol and substance use disorders conditions, as well as outcomes for patients, families and communities.

[**Click here**](#) to get started.

Helpful app screens for abuse

The [**SBIRT app**](#) is available as a free download.

The app provides evidence-based questions to screen for alcohol, drugs and tobacco use. If warranted, a screening tool is provided to further evaluate the specific substance use. The app also provides steps to complete a brief intervention and/or referral to treatment for the patient, based on motivational interviewing.

Adverse incident reporting

We investigate reports of potential quality-of-care concerns, which include any adverse incident that takes place while a member is in care. Examples of potential quality-of-care concerns include, but aren't limited to any completed suicide, serious suicide attempt, or homicide that takes place within 30 days of discharge from care; violent member behavior; or adverse outcomes requiring hospitalization from psychotropic medication. Behavioral health care professionals and facilities are required to inform us (using the phone number listed on the member ID card) as soon as they become aware of a potential quality-of-care concern for any member in their care.

Teladoc® and other telemedicine services

Telemedicine is the use of telecommunications and information technology to provide clinical health care from a distance. It's used to overcome distance barriers and improve access to services. There are some states that have mandates that require coverage of telemedicine services for fully insured members.

Aetna® Behavioral Health offers telemedicine services to all commercial fully insured members and to all commercial self-insured plan sponsors, unless those self-insured plan sponsors opt out of telemedicine services. Providers must act within the scope of their license and ensure that they have the proper licensure based on state requirements.

Dispute and appeal process

We've developed a formal complaint and appeal policy for physicians, behavioral health care professionals and facilities. The complaint and appeal process has:

- One level of appeal

Physician, behavioral health care professional and facility appeals involve payment decisions (claims) but don't include dissatisfaction with pre-service or concurrent medical necessity decisions, which are handled through the member appeal process.

Note:

The process may vary due to state-specific requirements. For more information on complaints or appeals, contact your local Aetna office.

Physician/behavioral health care professional post-service appeals are classified as payment appeals. They aren't considered "on behalf of the member" unless:

- The appeal explicitly states "on behalf of the member"
- The physician or behavioral health care professional also submits specific written authorization from the member

View more information on our appeal process.

Or go to **Aetna.com** and click "Learn about disputes and appeals." According to Centers for Medicare & Medicaid Services (CMS) requirements, we have a formal process



for **Medicare Advantage plan provider** dispute resolution for non-contracted providers.*

Questions?

Just call us at **1-800-624-0756 (TTY: 711)** for HMO-based and Medicare Advantage plans or **1-888-MDAetna (1-888-632-3862) (TTY: 711)** for all other plans.

National principles of care

In November 2017, we were one of 16 major health care payers to commit in writing to the National Principles of Care for Substance Abuse Treatment. The principles are derived from the **Surgeon General's Report on Alcohol, Drugs, and Health** and are backed by three decades of research.

We support these principles, and our goal for all our members is that they receive these services:

1. Universal screening for substance use disorders across medical care settings
2. Personalized diagnosis, assessment and treatment planning
3. Rapid access to appropriate substance use disorder care
4. Engagement in continuing long-term outpatient care with monitoring and adjustments to treatment
5. Concurrent, coordinated care for physical and mental illness
6. Access to fully trained and accredited behavioral health professionals
7. Access to The U.S. Department of Food and Drug Administration (FDA)-approved medications
8. Access to non-medical recovery support services

Learn more here.

Along with health care providers and the broader community, we were involved on the task force to implement needed changes to confront the opioid crisis. We continue to partner with providers to help implement these principles, including establishing measurements of the adoption of these eight key principles. We believe that universal screening is important to identification of needs for substance abuse care. And medication-assisted treatment is critical in the delivery of high-quality, evidence-based care.

Member experience survey

Another aspect of our quality program and the services we provide to our members is the member experience survey. We get feedback from our members at least annually. The survey covers the following areas:

- Ease of accessibility to our staff and our network providers

- Availability of appropriate types of behavioral health practitioners, providers and services
- Acceptability (cultural competence to meet member needs)
- Utilization management process
- Coordination of care

We also annually evaluate member complaints, appeals and denials. We collect data in these categories:

- Quality of care
- Access
- Attitude and service
- Billing and financial issues
- Quality of the practitioner's office site

Practitioner survey

The practitioner experience survey is an additional quality program activity to get feedback on satisfaction with the services we provide. We obtain feedback from behavioral health care professionals annually, and the survey covers:

- Utilization management process
- Accessibility (self-report)
- Continuity and coordination of care
- Referral to complex case management program

Working electronically with us

Electronic solutions for health care professionals

We offer a variety of easy-to-use electronic options that are cost-effective and streamline the administrative process. They make it easy for you to submit eligibility and benefits inquiries, precertification requests, claims, and claims status inquiries. 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

If you don't use our provider portal, we also 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, by computer software and by telephone.

*Aetna Medicare Advantage plans must comply with CMS requirements and time frames when processing appeals and grievances received from Aetna Medicare Advantage plan members. Refer to the Medicare section of the **Office Manual for Health Care Professionals** for more information.

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.

Go to **[Aetna.com/provider/vendor](https://www.aetna.com/provider/vendor)** to view our vendor list.

Our provider portal

Our **[provider portal](#)** is a great resource.

You can:

- Check eligibility and benefits
- Send professional claims
- Request precertification
- Look up claims status and precertification
- Get electronic copies of Explanation of Benefits statements
- Access your patients' personal health records
- Upload clinical information that's needed for the precertification process

You can also:

- Use our cost estimator tool to get a reliable estimate of your patients' out-of-pocket expenses and our payment
- Access resources and tools for behavioral health providers, such as clinical practice guidelines
- Access pharmacy materials, including formulary information, pharmacy clinical policy bulletins, and pharmacy forms

Remember: you can file claims electronically

Filing a claim electronically is easy. 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 help with system setup.



Go to **Availity.com** to register or sign in to our provider portal.

Provider data changes

We require that you tell us of data changes within 14 days of the date of the change. Update your profile online, quickly and easily, on our **provider portal**. Registered users can also update their information on the site.

This process takes only a few minutes to complete. You can easily update addresses, affiliations and demographics. Following submission, you'll get a confirmation screen that shows that changes will be made in seven to ten business days.

- HMO and Aetna® Medicare Advantage plans call: **1-800-624-0756 (TTY: 711)**.
- All other plans call: **1-888-MDAetna (TTY: 711)** or **1-888-632-3862 (TTY: 711)**
- All plans can fax the information to us at **860-975-1578** (Attention: MDP Alignment)

All tax ID number changes/additions (unless you're joining an existing Aetna health care professional group) require you to fax a copy of your W-9 form to **859-455-8650**.

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're not currently viewing this document online, you can find it at **Aetna.com** in the "For Providers" section, under **Provider Education & Manuals**.

If you want a hard copy of this manual and don't have Internet access, call us at:

1-800-624-0756 (TTY: 711) for HMO-based and Aetna Medicare Advantage plans

1-888-MDAetna (TTY: 711) or **1-888-632-3862 (TTY: 711)** for all other plans

Appendix A: The 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, doesn't 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 shouldn't 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)?	Self-explanatory
3.	Is the member's name or unique identifier on every page?	Self-explanatory
4.	Do all entries in the record contain the author's signature or electronic identifier with title (if applicable) and degree?	Self-explanatory
5.	Are all entries dated?	Self-explanatory

STANDARD		BEST PRACTICE INSTRUCTIONS
B. ASSESSMENT AND TREATMENT PLAN		
6.	Is there a presenting problem, including history and current symptoms and behaviors, including behavior onset and development?	Self-explanatory
7.	Is there documentation of a thorough risk assessment, including presence or absence of suicidal or homicidal thoughts?	Self-explanatory
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 most 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?	For members under age 12, mark N/A.
10.	Is there behavioral health treatment history documented?	Behavioral health history could include treatment dates, providers/facilities, current treating clinicians, response to treatment, lab tests and consultation reports (if applicable), and relevant behavioral health treatment history.
11.	Is there a comprehensive assessment of the family, psychosocial history and cultural variables that could also include legal and educational variables? Does it include the source(s) of the information?	Self-explanatory
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, or allergies?	Self-explanatory
13.	Is there a diagnosis documented?	Diagnosis should include comorbid and relevant psychosocial factors.
14.	Is the diagnosis consistent with the assessment?	The 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?	Self-explanatory (If the member is an adult, then this question will be scored N/A.)
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, intensive outpatient, partial, detox, residential or inpatient. This question will be scored N/A for members who don't have these symptoms.
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 won't be credited.

STANDARD

BEST PRACTICE INSTRUCTIONS

CA-only members (autism spectrum disorders): Reference California Code of Regulations Title 28 CCR 1300.67.1(d), 28 CCR 1300.80(b)(4), 28 CCR 1300.80(b)(5)(E), 28 CCR 1300.80(b)(6)(B). Non-CA residents will be scored as N/A.

18.	If member is age 0–6 years, was there screening for autism spectrum disorder?	This may be documented on an assessment tool or the findings summarized in a progress note. Score N/A if member is a non-CA resident.
19.	If autism spectrum disorder is the diagnosis, is there documentation to support this diagnosis?	The diagnosis should be consistent with presenting problems, behaviors, developmental and/or appropriate screening tool assessment data. Score N/A if member is non-CA resident.
20.	Does the treatment plan show evidence-based therapies for autism spectrum disorder?	Does the treatment plan reflect the outcome of the assessment and indicate plans to use evidence-based therapies? Score N/A if member is a non-CA resident.

C. DOCUMENTATION AND PRACTITIONER COMMUNICATION

21.	Is there documentation to show that the provider requested the 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.
22.	Did the member grant permission to communicate with the primary medical practitioner?	This is a non-scored item. (Score N/A if Q21 = N.)
23.	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. (Score N/A if Q21 and Q22 = N.)
24.	If there is documentation about other behavioral health specialists or consultants treating the patient, is there documentation to show 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.
25.	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 Q24 = N.)
26.	If the patient did grant permission, is there documentation that the provider communicated with the other behavioral health specialist or consultant?	There must be a separate release for each provider/practitioner treating the member before the practitioner releases any type of information about the member. (Score N/A if Q25 = N or N/A.)
27.	Is a progress note present for every session?	Self-explanatory
28.	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. Score N/A if member is still in treatment at the time the record is submitted for audit.
29.	Is there documentation about advance directives?	Advance directives must be present for Medicare patients only. All others are scored N/A.

CA-only members (autism spectrum disorders): Reference California Code of Regulations Title 28 CCR 1300.67.1(d), 28 CCR 1300.80(b)(4), 28 CCR 1300.80(b)(5)(E), 28 CCR 1300.80(b)(6)(B).

STANDARD		BEST PRACTICE INSTRUCTIONS
30.	Is there documentation of collaboration, consultation and/or continuity of care?	Evidence would include appropriate release of information and documentation of a phone conversation, email correspondence or a letter (examples may include the referring party, the educational system, or any other medical or behavioral specialist). Score N/A if member is a non-CA resident.
CA-only members: Reference California Code of Regulations Title 28 CCR 1300.67.04(c)(4)(A) and 28 CCR 1300.70.		
31.	Is there documentation indicating the patient's preferred language?	We'll review records to ensure there is documentation of the member's preferred language. Score N/A if member is a non-CA resident.
32.	Is there documentation of offer of a qualified interpreter?	We'll review records to ensure that providers offer our members language assistance. This item is N/A if response to Q31 is "No" or the member is a non-CA resident.
33.	If there was an offer of qualified interpreter services, does documentation indicate refusal or acceptance of services?	This question is rated N/A if response to Q31 or Q32 is "No" or the member is a non-CA resident.
D. PRESCRIBING PRACTITIONERS ONLY: These questions are scored as N/A for all non-prescribing practitioners.		
34.	Is there clear documentation of psychotropic medications, dosages and dates of changes?	Prescribing practitioner may use medication flow sheet, order sheet or progress note to document psychotropic medications, dosages and dates of changes.
35.	Is there documentation of member education about the risks and benefits of the prescribed medications and member's understanding of information?	If prescribing practitioner uses a preprinted medication information sheet, there still needs to be documentation that the risks and benefits information is explained to the member (about the possible side effects and why the medication is being prescribed). This is in addition to the sheet being given.
36.	Is the recommended treatment consistent with the assessment and diagnosis?	Self-explanatory
37.	If a member is prescribed behavioral health medication(s), is there documentation to indicate the member was asked if medication is taken as prescribed?	Self-explanatory
38.	If a member is prescribed behavioral health medication(s), is there documentation that any barriers and challenges with adherence were discussed?	Is there a progress note documenting that medication adherence issues/challenges were discussed?
E. NON-SCORED ITEMS		
39.	Was there timely medical practitioner communication following patient assessment?	Evidence of communication could be documentation of a telephone conversation, email correspondence, or a letter written within 30 days of assessment and/or at key stages of the member's treatment. Communication with a psychiatrist or a primary medical provider would satisfy this coordination requirement.
40.	Did the communication with the medical practitioner contain sufficient and accurate clinical information about the member?	This requires a diagnosis consistent with documented symptoms and specific medications prescribed (if applicable) in the initial communication with the medical practitioner.

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