

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna[®]

Behavioral Health Provider Manual

www.aetna.com

23.20.800.1J (10/15)



Table of Contents

Introduction 3

Network participation 4

Clinical delivery 6

Quality programs..... 13

Working electronically with Aetna 17

Appendix A: Level of Care Assessment Tool summary 19

Appendix B: Aetna Behavioral Health Treatment Record Review Criteria and best practices.....20

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

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

**All continental US time zones; hours of operation may differ based on state regulations. In Texas and Oklahoma: 6 a.m. to 6 p.m. CT (Monday through Friday) and 9 a.m. to noon CT on weekends and legal holidays. Phone recording systems are in use for all other times.

What you'll find in this manual

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

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

How to reach us

Our medical directors and staff are available to speak with you, and we are committed to providing you with the tools, education and resources needed to easily work with us. Behavioral health medical directors make all final coverage* denial determinations involving clinical issues.

If a treating provider does not agree with a decision regarding coverage or would like to discuss an individual member's case, Aetna Behavioral Health Patient Management staff members are available 24 hours a day, 7 days a week. You can contact staff through toll-free telephone numbers for provider and member inquiries regarding specific utilization management issues. Providers can contact Patient Management staff during normal business hours (8 a.m. to 5 p.m., 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 will 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, you can use these same toll-free phone numbers to contact Patient Management staff.

Network participation

Behavioral health condition management programs

Aetna offers 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. In order to augment the efforts of clinicians, we also closely follow patient progress and treatment recommendation adherence and share that with you.

Through this program, we:

- Collaborate 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 telephonic case management to assist and support patient adherence to your treatment plan

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

Our behavioral health member support programs and who can benefit:

- 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:
 - with 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 in 2016. We anticipate redesigning the program in 2016, including a standard and buy-up option.

To learn more about the Aetna Behavioral Health member support program, call us at **1-800-424-4660**.

Behavioral health Outpatient Care Management Program

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

This Behavioral Health Provider Manual, the EAP Manual and other related communications are posted on the Health Care Professionals Education & Manuals page of our website at www.aetna.com.

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 through a diverse, 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.

The Council for Affordable Quality Healthcare (CAQH) initiative simplifies the credentialing process by reducing the paperwork you need to fill out. 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 (Exceptions to the board certification requirement are reviewed by a medical director.)
3. Malpractice insurance in amounts specified in the Aetna agreement
4. Availability for emergencies by pager or other established procedures deemed acceptable by Aetna
5. Submission of an application containing all applicable attestations, necessary documentation and signatures
6. If applicant is a physician addictionologist, certification by the American Society of Addiction Medicine (ASAM)
7. Current unrestricted license
8. Absence of current debarment or suspension from state or federal programs

Open the door to electronic communications

Register now and go paperless:

Physicians and behavioral health care providers –
<https://aetna.providerpreference.com>

Hospitals and facilities –
<https://aetna.providerpreference.com/facilities.php>

Our electronic correspondence option allows your office to receive information from Aetna online instead of in a printed, paper format in the mail. Read the *Aetna Behavioral Health Insights™* provider newsletter and other time-sensitive correspondence online — you choose the time that's best for you. You'll receive an e-mail when the newsletter or other communications are ready to view.

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 in order 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 "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**.

If you have questions, call our Provider Service Center (between 8 a.m. and 5 p.m.). For HMO-based and Medicare Advantage plans, call **1-800-624-0756**. For Aetna LeapSM and all other plans, call **1-888-MD AETNA (1-888-632-3862)**. You can also make these changes online on our website at **https://www.aetna.com/provider/forms_secure/bh_form.html**.

Update your office's demographic data online

If you need to change or update your office's demographic information — new e-mail addresses, or a new mailing address, phone or fax numbers — you should do it through our **[secure provider website](#)**.

Having your correct e-mail address on file is very important to us. It's our preferred way of communicating important information to you.

Online security is more important than ever in today's high-tech world. Our secure site 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 demographic changes or they may give access to others.

You'll need to register for our secure website

To use the secure website you must first **[register](#)**. Registration is easy. Once registered, you'll also be able to submit claims transactions, check member eligibility and benefits and even verify referrals.

Clinical delivery

Access to care

Members may access behavioral health care in three ways:

1. Direct access to the BH 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, please visit our website at www.aetnaelectronicprecert.com and click on the link for “Check our precertification lists.” To request precertification, please use our free secure provider website on NaviNet® at <https://connect.navinet.net> or any other website that allows you to send precertification requests electronically. (You can register for NaviNet at <https://connect.navinet.net/enroll>.) You may also 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. These toll-free 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/precertification process

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

It is also expected that treatment provided is medically necessary according to this definition: “Medically necessary services are those health care services that a practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; (c) not primarily for the convenience of the patient, physician or other health care provider; and (d) not more costly than an alternative service

Behavioral Health Care Provider Access to Care Standards**

SERVICE	TIME FRAME
Non-life-threatening emergency needs	Within 6 hours
Urgent needs	Within 48 hours
Routine office visits	Within 10 working days
Following hospital discharge for a behavioral health condition	Within 7 days
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. The acceptable answering options for members to receive when contacting you after hours include reaching: <ol style="list-style-type: none"> 1. The practitioner or a person with the ability to patch the call through to the practitioner (e.g., answering service); or 2. An answering machine with instructions on how to contact the practitioner or his/her backup; or 3. An answering machine that allows messages to be automatically forwarded to a phone (e.g., practitioner’s cell phone or pager) that allows the practitioner to retrieve and respond to those after-hours messages for life-threatening emergencies, as soon as possible.

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

**Unless state requirements are more stringent.

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 **1-888-MD AETNA (1-888-632-3862)** for Aetna LeapSM and all other plans and **1-800-624-0756** for HMO and Medicare Advantage plans.

- All inpatient behavioral health services must be precertified and are managed through a concurrent review process
- Intermediate levels of care such as residential treatment, partial hospitalization and intensive outpatient also require precertification. For more information go to www.aetna.com
Exceptions: This policy applies to all Aetna plans with the exception of behavioral health benefits that we administer but do not manage and self-funded plans with plan sponsors who have expressly purchased precertification requirements.
- In addition to reviewing clinical information to determine coverage, the Aetna utilization management clinician 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.

You can submit a precertification request by electronic data interchange (EDI), in one of three ways:

- 1. Our secure provider website**
- 2. Though one of our vendors**
- 3. With Post-N-Track solution**

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

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

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

Precertification requirements apply unless state law expressly dictates otherwise.

Effective **January 1, 2016**, the following services no longer require precertification/authorization: outpatient electroconvulsive therapy (ECT), biofeedback and Amytal interview.

- It is important to note that outpatient care that is not 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 concurrent review.

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

A complete **list** of services requiring authorization/precertification is available on the Health Care Professionals section of our website at www.aetna.com. 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.

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

Aetna Behavioral Health is available by telephone 24 hours a day, 7 days a week to assist members accessing behavioral health care services. Simply direct your patients to the numbers listed on their ID card for behavioral health services.

Aetna Behavioral Health does not make employment decisions or reward physicians or other individuals who conduct utilization reviews for issuing denials of coverage or for creating barriers to care or service. Financial incentives for utilization management decision-makers do not encourage denials of coverage or service. Rather, we encourage the delivery of appropriate behavioral health care services. In addition, we train Utilization Review staff to focus on the risks of under-utilization and over-utilization of services.

We use evidence-based clinical guidelines from nationally recognized authorities to make utilization management (UM) decisions. UM decision making is based only on appropriateness of care and service and existence of coverage. Aetna does not specifically reward practitioners or employees for issuing denials of coverage or creating barriers to care or service. Aetna does not encourage utilization-related decisions that result in underutilization.

Medical necessity criteria and Clinical Policy Bulletins

Five sets of medical necessity criteria/guidelines help in making and overseeing coverage decisions about level, type and duration of care:

- **Level of Care Assessment Tool***: The Aetna Level of Care Assessment Tool, or LOCAT guidelines help determine appropriate levels and types of care for patients in need of evaluation and treatment for mental health disorders. It also applies for patients in need of placement in specialized psychiatric or mental health facilities or units.
- **The American Society of Addiction Medicine (ASAM) Patient Placement Criteria**: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions 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 in need of placement in specialized chemical dependency detoxification or rehabilitation facilities or units. *Note*: For treatment provided in Texas, Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers (28 TAC

§§3.8001-3.8030) are utilized in place of ASAM. *American Society of Addiction Medicine (ASAM) Third Edition*. Criteria are copyrighted but can be purchased by contacting:

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

Aetna Behavioral Health supplies relevant pages of ASAM criteria upon request. Please direct requests to our Provider Service Center. For HMO-based and Medicare Advantage plans, call **1-800-624-0756**. For Aetna LeapSM and all other plans, call **1-888-MD AETNA (1-888-632-3862)**.

- **Texas 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.
- **Aetna's Applied Behavior Analysis (ABA) Medical Necessity Guideline 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 Aetna members in need of ABA. For practitioners treating Autism Spectrum Disorders using Applied Behavior Analysis, either national certification is needed from the Behavior Analyst Certification Board (BACB), or the practitioner must be licensed as a behavioral health professional in the state in which he/she practices.
- **Aetna Clinical Policy Bulletins (CPBs)**: 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 and 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 Level of Care Assessment Tool (LOCAT) is an instrument that an Aetna clinician uses to aid in the decision-making process. It helps determine the level of care appropriate for effective treatment and medically necessary for a mental health patient. "Aetna clinician" may mean a care manager, an independent physician reviewer working on Aetna's behalf or an Aetna medical director. LOCAT guidelines do not constitute medical advice. Treating providers are solely responsible for medical advice and treatment of members.

New, revised and updated CPBs become effective when published on Aetna's CPB websites. You'll find a complete index of published CPBs on the Aetna website at

<http://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>.

Both new and revised CPB drafts undergo a comprehensive review process that includes review by Aetna's Clinical Policy Council and external practicing clinicians. The Aetna 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 Aetna medical plans, or that may be eligible for coverage under Aetna 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 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 Appendix A, page 19, for a summary of the LOCAT criteria. For full LOCAT guidelines, visit our website at **<http://www.aetna.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html>**.

For current information on our medical necessity criteria or Clinical Policy Bulletins, visit our Clinical Policy Bulletin page on **<http://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>**. If you need hard copies of any of Aetna Behavioral Health's UM criteria or CPBs, contact our Provider Service Center at **1-888-632-3862**.

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

Consult Behavioral Health Clinical Practice Guidelines as you care for patients

The National Committee for Quality Assurance (NCQA) requires health plans to regularly inform practitioners about the availability of Clinical Practice Guidelines (CPGs). The following Behavioral Health CPGs are based on nationally recognized recommendations and peer-reviewed medical literature. They are posted on our **secure provider website** at Plan Central/Aetna Health Plan/Support Center/Clinical Resources/Clinical Practice Guidelines or see links on the upper left column of page 10 of this manual for ADHD, alcohol and depression guidelines. Aetna adopts and encourages the use of CPGs to assist practitioners in screening, assessing and treating common disorders. Recognized professional practice societies, such as the American Psychiatric Association, the American Academy of Pediatrics and the National Institute on Alcohol and Alcoholism, publish recommended guidelines. Prior to our adopting each guideline, we review relevant scientific literature and get practitioner input through our Quality Advisory Committee. Network practitioner feedback then goes to a National Guideline Committee for adoption.

Once implemented, we review each guideline at least every two years for continued applicability and update guidelines as needed. We report guideline changes through our online newsletter, *Aetna Behavioral Health Insights™* and the *Aetna Behavioral Health Quality Management Bulletin*, 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 augment, not replace, sound clinical judgment. We welcome your feedback and will consider all suggestions and recommendations in our next review. You may contact our Quality Management department at **QualityImprovement2@aetna.com**.

To support clinical decision making, we provide all adopted practice guidelines to Aetna's behavioral health staff and distribute them to contracted network professionals.

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

Behavioral Health Clinical Practice Guidelines currently adopted by Aetna:

- **Attention-Deficit/Hyperactivity Disorder:** Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment in Children and Adolescents
- **Helping Patients Who Drink Too Much**
- **Treating Patients with Major Depressive Disorder**

For a copy of a specific CPG, call our Provider Service Center at **1-888-632-3862**.

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

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 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. Health care professionals are also asked to schedule such appointments within seven days.

Continuity/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 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. Company policy states that participating providers leaving the network will work with Aetna to transition the member to a par provider when in-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 in-network benefit if Aetna

determines that a quality-of-care issue may negatively impact the member's care.

Inpatient level of care

Members who, at the time of enrollment, are being treated at an inpatient level of care should complete their single, uninterrupted course of care under the benefits plan or policy 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/preferred plan benefits level as outlined in the provider contract. In some states, regulatory requirements may mandate that Aetna continue coverage beyond 90 days.

Collaboration and coordination of care

We appreciate the importance of the therapeutic relationship and strongly encourage continuity, collaboration and continuation 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 participating in a member's health care is 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 prior to discharge. The appointment should occur within seven days of discharge.
- **Timely and confidential exchange of information** – With written authorization from the member, it is 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 level 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 BH/Medical Provider Communication Form is located in the **Health Care Professionals** section of www.aetna.com.

- 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/assessment
- Significant changes in diagnosis, treatment plan or clinical status
- When medications are initiated, discontinued or significantly altered
- Termination of treatment

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

- Collaborate with medical practitioners to support the appropriate use of psychotropic drugs
- Collaborate with our Patient Management staff to develop and implement discharge plans prior to the member being 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
- 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 Aetna 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 PCPs and other behavioral health providers/appropriate specialists. The communication should either be in the form of a professional letter or in a format accepted by Aetna.

Aetna has the right to access confidential medical records of Aetna members, for the purpose of claims payment, assessing quality of care, including medical evaluations and audits, and performing utilization management functions. HIPAA privacy regulations allow for sharing of PHI for purposes of making decisions around treatment, payment or health plan operations.

Aetna resources

We encourage our behavioral healthcare professionals to share patient information and promote complete patient care. You can find our communication form on the Health Care Professionals Forms page under Physician Communications on our website:

- **Behavioral Health/Medical Provider Communication Form**

Provider claim or coverage denials and appeals

You can find up-to-date information regarding the appeal process on our website at **<http://www.aetna.com/health-care-professionals/disputes-appeals.html>**.

This will help you determine when and where to submit a request for a review of a claim or clinical coverage decision. On the website, select “Health Care Professionals,” “Working with Us” and choose “Dispute & Appeal Process.” There, you will find information on our appeal process, a quick reference guide and frequently asked questions.

This update is another step in our continuing effort to make doing business with us easier. Behavioral health care professionals have 180 days* from the date of the Explanation of Benefits (EOB) to request an appeal.

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



Quality programs

Quality program overview

We're committed to a continuous quality improvement program and encourage your involvement through committee participation. The Aetna Quality Program includes:

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

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

- Adhere to all Aetna policies and procedures, including those outlined in this manual
- Communicate with the member's primary care physician or specialists (after obtaining a signed release)
- Adhere to treatment record review standards, as outlined in Appendix B 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 you leave the network
- Cooperate with on-site audits or requests for treatment records
- Return completed annual provider satisfaction surveys when requested
- Participate in treatment plan reviews or sending 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

*State or contractual requirements may modify this time frame.

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

Accreditation

Aetna Behavioral Health is accredited by the National Committee for Quality Assurance (NCQA) for both Commercial and Medicare HMO and PPO products. Many of our policies and procedures are guided by national accreditation standards.

For more information visit www.ncqa.org.

Member rights and responsibilities

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

A copy of our commercial and Medicare Member Rights and Responsibilities statements can be found on our website at <http://www.aetna.com/individuals-families/member-rights-resources.html> in the Individuals & Families section under Member Rights & Resources.

The language may vary depending upon the state law applicable to each plan. If you would like a hard copy of this information and do not have Internet access, call our Provider Service Center at **1-800-624-0756** for HMO-based and Medicare Advantage plans or **1-888-MD AETNA (1-888-632-3862)** for Aetna LeapSM and all other plans.

Non-discrimination 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 or 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 regarding non-discrimination. 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.

Participating behavioral health practitioner treatment record review criteria and best practices

Each year, Aetna Quality Management randomly selects Aetna Behavioral Health network practitioners to participate in our treatment record review. This audit procedure is a key part of Behavioral Health's Quality Management Program. It is 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 BH practitioners participate in our quality management programs.

Refer to Appendix B of this manual for our treatment record review criteria and best practices.

These additional resources are available upon request. Contact us at QualityImprovement2@aetna.com for a copy.

- Treatment Record Review Provider Sample Forms
- Treatment Record Review Provider Sample Corrective Action Plan

Confidentiality and HIPAA

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.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean information that can identify you as a person, as well as your financial and health information.

Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

Summary of the Aetna Privacy Policy

When necessary for your care or treatment, the operation of our health plans, or other related activities, we use personal information within our company, share it with our affiliates, and may disclose it to:

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Other insurers
- Vendors
- Government departments
- Third party administrators

We obtain information from many different sources – particularly you, your employer or benefits plan sponsor if applicable, other insurers, HMOs or third-party administrators (TPAs), and health care providers.

These parties are required to keep your information private as required by law.

Some of the ways in which we may use your information include:

- Paying claims
- Making decisions about what the plan covers
- Coordination of payments with other insurers
- Quality assessment
- Activities to improve our plans
- Audits

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your requests within a reasonable amount of time. If we don't agree with the change you can file an appeal.

If you'd like a copy of our privacy notice, call the toll-free number on your ID card or visit us at www.aetna.com.

Behavioral health screening programs

Substance abuse screening for adolescents with major depression, anxiety and other mood disorders

Our *Substance Abuse Screening for Adolescents with Depression and/or Anxiety (SASADA)* prevention program targets adolescents ages 12–17 and those who turn 18 while in treatment in higher levels of care.

Upon identification and screening, Aetna Behavioral Health care management helps ensure that comprehensive treatment and discharge plans are in place, and that they address the complexity of the mental health diagnosis and substance abuse. The program also includes an informational mailing for outpatient practitioners treating these adolescents at least every two years and/or when the program is updated.

We encourage members and providers who wish to speak to an Aetna Behavioral Health representative about depression and/or anxiety and substance abuse in adolescence to contact us. Simply call the telephone number on the member's ID card and ask to speak with a behavioral health utilization management clinician.

Depression screening for pregnant women

We collaborate with Aetna National Care Management to facilitate depression prevention and screening for pregnant women.

This includes all members who qualify for postpartum calls during the postpartum period. The Beginning Right® Maternity Program assists members and providers to help ensure a healthy, term delivery. Depression screening is a key element of the program.

We offer depression screening to all women who enroll in the program and complete the Pregnancy Risk Survey. We encourage women who screen positive for depression to access their behavioral health benefits. They may also be eligible for Aetna Behavioral Health's Medical Psychiatric High-Risk Case Management Program.

Program elements

- Clinical case management process that focuses on members holistically including behavioral health and condition assessment, case formulation, care planning and focused follow-ups.
- Beginning Right refers all members with positive depression screens to our Med/Psych program if they have the benefit
- Behavioral Health Medical Integration initiative — a BH specialist supports the Beginning Right team to enhance identification and effective engagement for members with BH concerns

- Beginning Right nurses outreach members who have experienced fetal demise to offer condolences and behavioral health resources
- Members who enroll before the 16th week of pregnancy receive a reward

How to contact us

Maternity members who have the Beginning Right benefit can enroll in the Beginning Right Maternity program, or providers who wish to refer a member can call

1-800-CRADLE-1 (1-800-272-3531). Just call the member services number on the back of their ID card to find out if they have the program benefit.

Members and providers who want to speak to an Aetna Behavioral Health specialty program representative about depression and pregnancy can call Aetna Behavioral Health's Specialty Program line at **1-800-424-4660**.

Adverse incident reporting

We investigate reports of potential quality-of-care incidents, any adverse incident that takes place while the member is in care, or any completed suicide or homicide that takes place within 30 days of discharge from care if the member is still an Aetna member at the time. Health care professionals are required to inform Aetna Patient Management (using the phone 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.

Dispute and appeal process

You can use the Aetna dispute and appeal process if you do not agree with a claim or utilization review decision.

The process includes:

- Reconsiderations: Formal reviews of claims reimbursements or coding decisions, or claims that require reprocessing
- Level 1 appeals: Requests to change a reconsideration decision, an initial utilization review decision, or an initial claim decision based on medical necessity or experimental/investigational coverage criteria
- Level 2 appeals: Requests to change a Level 1 appeal decision

To help us resolve the dispute, we'll need:

- The reasons why you disagree with our decision
- A copy of the denial letter or Explanation of Benefits letter
- The original claim
- Documents that support your position (for example, medical records and office notes)

Note: The process may vary due to state-specific requirements.

Questions?

Just contact our Provider Service Center at **1-800-624-0756** for HMO-based and Medicare Advantage plans or **1-888-MD AETNA (1-888-632-3862)** for all other plans. You can also view more information on our **appeal process**.

Aetna has a formal process for Medicare Advantage plan provider dispute resolution for non-contracted providers. To learn more, review this information:

<http://www.aetna.com/health-care-professionals/disputes-appeals/medicare-appeals.html>

Member experience survey

Another aspect of our Quality Program and the services we provide to members is the Member Experience Survey. We obtain feedback from our members annually, and the survey covers the following areas:

- Services provided by Aetna Behavioral Health and our network of behavioral health care practitioners and providers
- Ease of accessibility to our staff and our network providers
- Availability of appropriate types of behavioral health practitioners, providers and services
- Acceptability (regarding cultural competence to meet member needs)
- Claims processing and cost of care
- Utilization management process

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 practitioner office site

Provider experience survey

The Provider Experience Survey is an additional Quality Program activity to get feedback on satisfaction with the services we provide. We obtain feedback from health care professionals annually, and the survey covers:

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

Working electronically with Aetna

Electronic solutions for health care professionals

In addition to our secure provider website, 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 submission, 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 secure provider website, 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, computer software and telephone.

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/provider/vendor.

Our secure provider website

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

- Use our Payment Estimator tool to obtain a reliable estimate of your patients' out-of-pocket expenses and Aetna's payment
- Access an array of resources and tools for behavioral health providers, such as Clinical Practice Guidelines
- Access pharmacy materials, including formulary information, Pharmacy Clinical Policy Bulletins and pharmacy forms
- Explore our Education Site for Health Care Professionals at www.AetnaEducation.com, featuring a broad array of education courses and live webinars and CMEs designed for you and your office staff. No registration is required for the site.

Our site is available to everyone, whether you access the Internet through a Mac® computer, or by using the Google Chrome™ browser, the Firefox® browser or the Safari® application programs.*

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 assistance with system setup.

Submitting claims	
Electronic claims	Aetna payer ID – 60054

Register for our secure provider website at <https://connect.navinet.net/enroll>. Already registered? Go to <https://connect.navinet.net>.

Register and visit the site often, as it will help keep you updated and informed.

*Google Chrome is a trademark of Google Inc. Firefox is a registered trademark of the Mozilla Foundation. Safari and Mac OS are registered trademarks of Apple Inc.

Provider data changes

We require that you notify Aetna of data changes within 14 days of the date of the change. Update your profile online, quickly and easily at https://www.aetna.com/provider/forms_secure/bh_form.html. Registered users of our secure provider website may 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 will receive a confirmation screen that indicates that changes will be made in 7 to 10 business days.

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

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

How to find this manual online

We update this manual as needed to ensure you have the most up-to-date, accurate information. If you are not currently viewing this document online, you can find it on www.aetna.com in the Health Care Professionals section under **Education & Manuals**.

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



Appendix A: Level of Care Assessment Tool summary

The Aetna Level of Care Assessment Tool or “LOCAT” is an instrument used to help in the decision-making process that determines the level of care appropriate for effective treatment and medically necessary for a patient with symptoms of a mental health condition.

Further, LOCAT is used as a guideline to help practitioners:

- Determine the appropriate levels and types of care for patients who need evaluation and treatment for behavioral health symptoms and diagnoses
- Evaluate a patient’s symptoms by identifying and scoring various behavioral health dimensions, and by narrowing down some of those dimensions into sub-dimensions to further help provide a more complete clinical picture of the patient
- Apply the guideline to patients who need treatment in a variety of settings, from routine outpatient offices through to placement in specialized behavioral health care facilities or units

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

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

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

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

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

Dimension 6: Global Indicators, helps assess the level of care and intensity of service offered related to the condition to be treated.

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

For full LOCAT guidelines, visit our website at <http://www.aetna.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html>. LOCAT criteria are updated annually.

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



Appendix B: Aetna Behavioral Health Treatment Record Review Criteria and best practices

	STANDARD	BEST PRACTICE INSTRUCTIONS
A. TREATMENT RECORD-KEEPING PRACTICES		
1.	Is the record legible to someone other than the writer, i.e., does not cause a problem to read some or a majority of record? (If the answer is no, mark all questions 'N' and end review.)	<i>The handwriting should be easy to read, and the reviewer should not have to make more than two attempts to read documentation within the medical record.</i>
2.	Is the patient's personal data documented: address, gender, date of birth, home phone numbers, emergency contact, marital/legal status and guardianship (if relevant)?	<i>All personal demographic data should be included.</i>
3.	Is the member's name or unique identifier on every page?	<i>Either the member's name or ID should be on each page.</i>
4.	Do all entries in the record contain the author's signature or electronic identifier with title (if applicable) and degree?	<i>Each entry should contain a signature, even if there are multiple entries within the same page.</i>
5.	Are all entries dated?	<i>All entries should be dated, even if there are multiple entries within the same page.</i>
B. ASSESSMENT & TREATMENT PLAN		
6.	Is there a presenting problem including history and current symptoms & behaviors, including behavior onset and development?	<i>Presenting problem documentation should include the history, current symptoms & behaviors as well as behavior onset and development.</i>
7.	Is there documentation of a thorough risk assessment including presence or absence of suicidal or homicidal thoughts?	<i>Risk assessment should cover past and present thinking including presence and absence of suicidal or homicidal thoughts.</i>
8.	Is there a complete mental status examination including affect, mood, thought content, insight, judgment, speech, attention, concentration, and impulse control?	<i>This may be documented on an assessment tool or in a progress note and will include at least 5 of the 9 elements in the standard.</i>
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?	<i>The evaluation should be thorough and include evidence of inquiry about use of alcohol, illicit drugs, illicit misuse of prescription drugs and OTC drugs. If there is documentation of abuse or dependence, there should also be documentation of the history of usage. "For members under age 12, mark "N/A."</i>
10.	Is there behavioral health treatment history documented?	<p><i>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.</i></p> <p>Find network laboratories and other providers online</p> <p><i>To see our national list of network laboratories, go to www.aetna.com:</i></p> <ol style="list-style-type: none"> <i>1. Select "Online Provider Directory" under "Quick Links."</i> <i>2. Select "Labs-Including Quest Diagnostics" from the "Search for" drop down menu.</i> <i>3. Select "National Lab Listing" under "Type."</i>

B. ASSESSMENT & TREATMENT PLAN		
11.	Is there a comprehensive family and psychosocial history and cultural variables which could include family, social, legal, educational and history, and does it include the informant? Does the cultural history take into account cultural variables that may affect therapy?	<i>This section should comprehensively describe family and psychosocial history and areas that could be noted include cultural variables with relevant family, social, legal and educational history.</i>
12.	Is there a medical history which could include medical conditions and a medication history that includes medications taken (prescriptions as well as over the counter), dosages, dates, responses to medications, allergies?	<i>Medication history could include medication names, how long the member was on the medications (for both prescription and over-the-counter [OTC] medications), responses to medication and ongoing illnesses.</i>
13.	Is there a DMS diagnosis Documented?	<i>Diagnosis should include comorbid and relevant psychosocial factors .</i>
ASSESSMENT & TREATMENT PLAN, continued		
14.	Is the diagnosis consistent with the assessment?	<i>The DSM diagnosis should be consistent with presenting problems, history, mental status exam and/or other assessment data.</i>
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?	<i>Developmental history could include areas such as normal or problem pregnancy, mother's drug use, abnormal birth weights, if child was routinely followed by pediatrician for first five years, developmental milestones within normal time frames, began school on time or delayed learning disabilities, diagnosis of hyperactivity and/or any medications prescribed.</i>
16.	For suicidal and homicidal patients, or patients who are otherwise at risk, are there risk assessments at every session?	<i>For suicidal (or homicidal) members, there should be risk assessments at every session. If the member's condition is deteriorating, the record must indicate that more intense levels of care have been arranged, for example, IOP, partial, detox, residential or IP.</i>
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?	<i>(For all psychotherapy) Treatment plan goals that are vague will not be credited.</i>
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); 28CCR 1300.80 (b)(6)(B)		
18.	If member is age 0 – 6 years, was there screening for autism spectrum disorder?	<i>This may be documented on an assessment tool or the findings summarized in a progress note.</i>
19.	If autism spectrum disorder diagnosis, is there documentation to support this diagnosis?	<i>The DSM diagnosis should be consistent with presenting problems, behaviors, developmental and/or appropriate screening tool assessment data.</i>
20.	Does the treatment plan reflect evidence-based therapies for autism spectrum disorder?	<i>Does the treatment plan reflect the outcome of the assessment and indicate plans to utilize evidence-based therapies?</i>

C. DOCUMENTATION & PRACTITIONER COMMUNICATION		
21.	Is there documentation to reflect that the provider requested member's permission to communicate with the primary medical practitioner?	<i>A signed consent from the member must be obtained before the practitioner corresponds with the member's primary medical practitioner.</i>
22.	Did the member grant permission to communicate with the primary medical practitioner?	<i>This is a non-scored item.</i>
23.	If the member did grant permission, is there documentation that the provider communicated with the primary medical practitioner?	<i>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, e-mail correspondence or a letter.</i>
24.	If there is documentation about other behavioral health specialists or consultants treating the patient, is there documentation to reflect the provider requested the patient's permission to communicate with the other behavioral health specialist or consultant?	<i>Other behavioral health specialists may include psychiatrists, ancillary providers, treatment programs/institutions/facilities or other behavioral health providers or consultants.</i>
25.	Did the patient grant permission to communicate with the other behavioral health specialists?	<i>Self-explanatory. (This is a non-scored item. Marked N/A if Q21=N)</i>
DOCUMENTATION & PRACTITIONER COMMUNICATION, continued		
26.	If the patient did grant permission, is there documentation the provider communicated with the other behavioral health specialist or consultant?	<i>There must be a separate release for each provider/practitioner treating the member prior to the practitioner releasing any type of information about the member. (Scored N/A if Q22=N or N/A)</i>
27.	Is a progress note present for every session?	<i>Self-explanatory.</i>
28.	Does the documentation include a discharge plan?	<i>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.</i>
29.	Is there documentation about Advance Directives?	<i>Advance Directives must be present for Medicare patients only.</i>
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); 28CCR 1300.80 (b)(6)(B)		
30.	Is there documentation of collaboration, consultation and/or continuity of care?	<i>Evidence would include appropriate release of information and documentation of a phone conversation, e-mail correspondence or a letter (examples may include the referring party, the educational system or any other medical or behavioral specialist).</i>
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?	<i>Records will be reviewed to ensure that there is documentation of Aetna member's preferred language.</i>
32.	Is there documentation of offer of a qualified interpreter?	<i>Records will be reviewed to ensure that Aetna members are offered language assistance. This item is N/A if member is a non-CA resident.</i>
33.	If there was offer of qualified interpreter services does documentation indicate refusal or acceptance of services?	<i>This question is rated N/A if response to question #31 or #32 is "No" or the member is a non-CA resident.</i>

D. PSYCHIATRISTS ONLY		
34.	Is there clear documentation of psychotropic medications, dosages and dates of changes?	<i>Psychiatrist may use medication flow sheet, order sheet or progress note to document psychotropic medications, dosages and dates of changes</i>
35.	Is there documentation of member education regarding the risks and benefits of the prescribed medications and member's understanding of information?	<i>If psychiatrist uses a preprinted medication information sheet, there still needs to be documentation that the risks and benefits information is explained to the member (regarding the possible side effects and why the medication is being prescribed). This is in addition to the sheet being given.</i>
36.	Is the recommended treatment consistent with the assessment and diagnosis?	Recommended treatment should be consistent with the assessment and diagnosis.
37.	If a member is prescribed BH medication(s), is there documentation to indicate the member was asked if medication is taken as prescribed?	<i>If medication has been prescribed, there should be documentation that the prescriber attempted to determine if the medication is being taken as prescribed. Appropriate follow-up should occur as indicated. This item will be scored for psychiatrists only.</i>
38.	If a member is prescribed BH medication(s), is there documentation that any barriers and challenges with adherence were discussed?	<i>Is there a progress note that documents that medication adherence issues/challenges were discussed? This item will be scored for psychiatrists only.</i>

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

This material is for informational purposes only and is not medical advice. Health benefits and health insurance plans contain exclusions and limitations. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a therapist, physician or other health care professional. Information is believed to be accurate as of the production date; however, it is subject to change.

This *Behavioral Health Provider Manual* is an addendum to the Office Manual for Health Care Professionals, 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 Office Manual are directly in conflict with the terms of this addendum, the terms of this addendum will control.

www.aetna.com

©2015 Aetna Inc.
23.20.800.1 J (10/15)

aetna[®]