All providers want to see improvement and progress in their work with patients. We want to encourage improved member outcomes by building a quality provider network. Read more about three key elements of our behavioral health provider quality network. We welcome your ideas and participation in helping us further develop them.

1. **Electronic medical records (EMR)**

   EMR has many advantages for providers. It facilitates tracking of referrals and sharing of data and information with physicians, labs, health systems and other BH providers. It helps organize records and eases access to patient information. It improves connections with payers for billing and other communication needs. If the EMR is “Meaningful-Use Compliant” providers can receive enhanced Medicare reimbursements.

2. **Evidence-based assessments**

   A patient evaluation that includes a well-constructed screening questionnaire can enhance assessment of the patient’s needs. Many patients are more comfortable and self-disclosing when answering questions as part of a self-assessment. Validated assessment tools can identify initial symptom severity. Repeated administration can demonstrate improvement or worsening of symptoms as treatment proceeds. Tracking changes during a course of treatment enables the provider to assess progress and modify treatment as needed.

3. **Adjunctive therapies and technologies**

   Technological advances have made it possible to offer computer-based, interactive therapies that reinforce a clinician’s work with a patient. Many of these protocol-driven, evidence-based programs have shown good results in enhancing therapy and improving outcomes. Computer-based service delivery can also use social media approaches, gaming, support groups, or pure educational techniques to reinforce treatment goals. Online programs such as those for cognitive behavioral therapy can build and reinforce patients’ skills between treatment sessions. Adjunctive therapies enhance the effectiveness of the primary therapy. Meditation and mindfulness for stress reduction and improved well-being is an example. Psycho-education, family-focused and interpersonal therapies can complement psychopharmacology for many patients.
Behavioral Health Provider Manual: Your guide to doing business with us

Our Behavioral Health Provider Manual gives you what you need to work with us while easing your administrative burdens — all in one easy-to-read document. The manual features information about:

- Network participation
- Clinical delivery
- Quality management programs
- Clinical practice guidelines and utilization management criteria
- Member rights and responsibilities
- Claim or coverage denials and appeals
- Contact information/how to reach us

Check out the manual online

Access our Behavioral Health Provider Manual online in the Health Care Professionals’ Provider Manuals section of our public website. For a paper version, call our Provider Service Center at 1-888-632-3862.

Quality Management Program

Aetna’s quality strategy is to provide value by facilitating more effective member-plan-provider relationships to promote desired health outcomes. Our strategy is consistent with the core set of principles of the U.S. Department of Health and Human Services National Strategy for Quality Improvement in Health Care (National Quality Strategy) and includes:

- Promoting better health and health care delivery focusing on engagement
- Attending to health needs of all patients
- Eliminating disparities in care
- Aligning public/private sectors
- Supporting innovation, evaluation and rapid-cycle learning and dissemination of evidence
- Using consistent national standards and measures
- Focusing on primary care and coordinating and integrating care across the health care system and community and
- Providing clear information so constituents can make informed decisions

The distinguishing factor in our strategy is our view towards quality itself. We don’t view quality management as an isolated, departmental function. Rather we integrate quality management and metrics into all that we do. We coordinate our quality activities across different functional areas, not just the quality department. For example, the quality department works closely with many other business areas so that the quality measures used for our provider measurement, pay-for-performance programs and high performance networks are consistent with nationally-recognized metrics.

We’re committed to Health Plan as well as Managed Behavioral Healthcare Organization (MBHO) accreditation by the National Committee for Quality Assurance (NCQA) as one means of demonstrating a commitment to Continuous Quality Improvement (CQI), meeting customer expectations, and establishing a competitive advantage among HMOs and PPOs. We produce Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) reports annually and submit them to NCQA for public reporting and accountability. HEDIS is audited in accordance with NCQA specifications by NCQA-Certified HEDIS auditors.

We design our clinical programs and initiatives to enhance the quality of care delivered to our members and to better inform members through reliance on

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1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
2 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
Quality Management Program

clinical data and industry-accepted, evidence-based guidelines. We’re committed to supporting transparency by providing participating physicians and members with credible clinical information and tools to make informed decisions.

Aetna was the first health care organization to sign on and embrace the Health and Human Services Four Cornerstones of the President’s Executive Order to further health care transparency. We were one of the first health plans to support the Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs (Patient Charter). The Patient Charter creates a national set of principles to guide measuring and reporting to consumers about doctors’ performance. Embracing the Patient Charter will facilitate consumers’ and physicians’ understanding and trust as to how health plans rate doctors’ performance. Our support includes a commitment to review by an endorsed independent reviewer to assess compliance with the Patient Charter.

Quality Management Program goals

Quality Management (QM) Program goals include:
• To promote the principles and spirit of CQI.
• To operate the QM program in compliance with and responsive to applicable requirements of plan sponsors, federal and state regulators and appropriate accrediting bodies.
• To address racial and ethnic disparities in health care that could negatively impact quality health care.
• To institute company-wide initiatives that improve the safety of our members, our communities, and foster communications about the QM program.
• To implement a standardized and comprehensive QM program that addresses and is responsive to the health needs of our population including but not limited to serving members with complex health needs across the continuum of care.
• To increase the knowledge/skill base of staff and to facilitate communication, collaboration and integration among key functional areas relative to implementing a sound and effective QM program.
• To measure, monitor, and improve the clinical care of our behavioral health members. We look at both quality and safety.
• To maintain effective, efficient and comprehensive practitioner/provider selection and retention processes through credentialing and recredentialing activities.
• To measure, monitor, and improve the clinical care of our behavioral health members. We look at both quality and safety.
• To maintain effective, efficient and comprehensive practitioner/provider selection and retention processes through credentialing and recredentialing activities.
• National Quality Oversight Committee (NQOC) empowered to oversee and address quality improvement activities
• National Quality Advisory Committee (NQAC) which sets direction for clinical quality improvement initiatives

We use quality reports to monitor, communicate and compare key indicators. Finally, we develop relationships with various professional entities and provider organizations that may provide feedback about structure and implementation of QM program activities or work collaboratively on quality improvement projects.

Quality Management Program scope

The scope and content of the QM Program are designed to continuously monitor, evaluate and improve the quality and safety of clinical care and service provided to members. Specifically, the QM Program includes, but is not limited to:
• Providing our members with clear information so they can make good decisions
• Reviewing the behavioral health care services we cover and how care is coordinated
• Encouraging providers to communicate with one another
• Developing, carrying out and monitoring patient safety plans
• Monitoring the effectiveness of our programs
• Making sure we comply with all the rules on regulation and accreditation
• Studying the accessibility of our network providers
• Setting standards on keeping all medical records. We also look at ways to audit these records
Quality Management Program

- Monitoring the overuse and underuse of services
- Performing credentialing and recredentialing activities
- Assessing member and provider satisfaction

Aetna Behavioral Health (BH) Quality Management (QM) Program outcomes

We evaluate our BH QM Program annually to monitor progress against goals. Significant events for 2013 include:

1. Integration planning and preparation activities are underway to transition the MHNet business to Aetna management. During 2013, Aetna BH and MHNet staff completed the following activities:
   - The BH Chief Medical Officer developed an integrated clinical model incorporating input from stakeholders in multiple organizations across both legacy companies.
   - Workgroups began to review and integrate parallel policies and procedures.
   - We also began the review of workflows across both organizations.

2. In June 2013 Aetna BH convened the 3rd annual BH Summit which highlighted opioid abuse an important public health and safety issue challenging the country’s resources nationally and locally. We identified the lack of treatment and therapy coordination among patients and providers as the primary contributor to the ongoing problem as an opportunity for Aetna BH.

3. BH Quality Management successfully completed the 2013 NCQA Managed Behavioral Healthcare Organization (MBHO) Survey for the Northeast/Southeast region and Mid America/West region accreditable entities with scores of 100 percent for both.

4. BH Utilization Management staff in all regions successfully migrated to the Aetna Total Clinical ViewSM (ATV) utilization management system platform.

5. An “Evidence-Based Treatment” pilot launched in December 2013 to encourage the use of standardized clinical assessment tools. Used appropriately as part of a broader assessment, formalized screening tools provide a consistent approach to testing for the presence or absence of a disorder and help patients receive effective treatment. We reimburse groups participating in the program for implementing any formal standardized assessment tool.

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

- Cooperate with the Aetna BH QM Program
- Adhere to all Aetna policies and procedures, including those outlined in the Aetna Behavioral Health Provider Manual
- Communicate with the member’s primary care physician as warranted (after obtaining a signed release)
- Comply with treatment record standards, as outlined in our provider manual
- Respond promptly to inquiries by our behavioral health staff
- Cooperate with our complaint process
- Follow continuity-of-care and transition-of-care standards when the member’s benefits are exhausted, or if you leave the network
- Support on-site audits or requests for treatment records
- Complete and return annual provider satisfaction surveys when requested
- Participate in treatment plan reviews or promptly send in necessary requests for treatment
- Submit claims with all requested information completed
- Adhere to patient safety principles
- Comply with state and federal laws, including confidentiality standards
- Cooperate with quality improvement activities

If you have questions about our Quality Management Program, or to get a copy of the program description summary or annual Quality Management Evaluation summary of results, e-mail our Quality Management staff at QualityImprovement2@aetna.com. Or you can call our Provider Service Center at 1-888-632-3862.
Aetna Medical Directors make all coverage decisions that involve clinical issues. Only Aetna Medical Directors (board certified and licensed psychiatrists, psychologists, or pharmacists) make decisions not to cover a requested treatment or level of care for reasons related to medical necessity. (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 pharmacist licensed to practice in that state.

Our utilization management clinicians use objective, evidence-based clinical guidelines and criteria established by nationally recognized sources and based on peer-reviewed medical literature to guide utilization management (UM) decisions. These decisions may involve precertification, concurrent review, discharge planning and retrospective review. Staff use the following criteria as guidelines in making coverage determinations, which are based on information about the specific member’s clinical condition:

- Aetna’s Clinical Policy Bulletins
- Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and the Medicare Benefit Policy Manual
- MCG™ guidelines (Seattle, WA: MCG Health, LLC)
- Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers (28 TAC §§3.8001-3.8030) (formerly known as TCADA is used in place of ASAM for treatment in Texas)
  - You can find these standards online.
- Applied Behavioral Analysis (ABA) Guidelines for the treatment of Autism Spectrum Disorders
- Level of Care Assessment Tool (LOCAT) for mental health care

If requested in writing or by phone, we provide participating practitioners with the criteria used to make a determination. Call 1-888-632-3862 for that information. Criteria are also available online at www.aetna.com here.

We make coverage determinations based on the medical necessity and appropriateness of care and service. We review requests for coverage to determine if the service requested is a covered benefit under the terms of the member’s plan and is being delivered consistent with established guidelines. If a request for coverage is denied, the member (or the member’s authorized representative, or a practitioner acting on behalf of the member) 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.

How we determine coverage

- The term precertification means the utilization review process to determine whether the requested service or procedure meets the company’s clinical criteria for coverage. It does not mean precertification as defined by Texas law, as a reliable representation of payment of care or services to fully insured HMO and PPO members.
Coverage decisions

We do not make employment decisions or reward practitioners, employees 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 our utilization review staff to focus on the risks of under and over utilization of services.

Role of medical directors

Our medical directors and staff are available to speak with you. 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 practitioner does not agree with a decision regarding coverage or would like to discuss an individual member’s case, behavioral health utilization management staff is available 24 hours a day, 7 days a week. For provider and member inquiries regarding specific utilization management issues, you can contact staff through toll-free telephone numbers on the member’s ID card.

How to contact us for specific utilization management issues

• You can contact Utilization 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’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, you can use these same toll-free phone numbers to contact Utilization Management staff.

*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 our utilization 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 Oklahoma and Texas: 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.

Member Rights and Responsibilities available online

You can find our Commercial and Medicare Member Rights and Responsibilities statements at www.aetna.com in the Individuals & Families section under Your Rights & Resources here. (The language may vary depending upon the state law applicable to each plan.) They’re also available in our Behavioral Health Provider Manual in the Health Care Professionals’ Provider Manual section of our public website.

If you’d like a hard copy of this information and don’t have Internet access, call our Provider Service Center at 1-800-624-0756 for HMO-based and Medicare Advantage plans or 1-888-632-3862 for all other benefits plans.
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. From the Aetna Plan Central home page, click on Support Center, Clinical Resources, then Clinical Practice Guidelines.

- **Attention-Deficit/Hyperactivity Disorder**: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment in Children and Adolescents  
  Adopted 2/2014
- **Helping Patients Who Drink Too Much**  
  Adopted 2/2014
- **Treating Patients with Major Depressive Disorder**  
  Adopted 2/2014

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

ADHD training available free of charge

The National Association of Continuing Education (NACE) developed the ADHD training “Getting with the Guideline” to help pediatricians and primary care providers to implement the procedures in the American Academy of Pediatrics 2011 ADHD guideline. Practitioners can get PI CME certificate upon course completion. The training also meets the ABP Performance in Practice (Part 4) of Maintenance of Certification (MOC) requirements for pediatricians. Learn more and register online today.

Updates to Aetna’s Behavioral Health Screening and Prevention Programs

**Help for teens with depression and anxiety**

Aetna’s Behavioral Health Substance Abuse Screening for Adolescents with Depression and/or Anxiety (SASADA) 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 annual informational mailing for outpatient practitioners treating these adolescents.

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 at-risk and high-risk program for members 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 the 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 enhancements include:**

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

**How to contact us**

- Maternity members who wish to 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).
- 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.
Provider accessibility standards available online

All network providers are accountable for upholding the Aetna Behavioral Health member access-to-services standards. The standards are available in the Behavioral Health Provider Manual posted on www.aetna.com. The standards* are:

- 10 business days for routine appointments
- 48 hours for urgent appointments
- 6 hours for non-life-threatening emergency appointments

Improved member satisfaction results for provider accessibility

Each year Aetna Behavioral Health measures accessibility to provider offices by analyzing member satisfaction survey results and access-related complaints. The most recent member satisfaction survey results showed:

- 87.9 percent satisfaction with obtaining a non-life-threatening emergency appointment within 6 hours — an increase from 82.8 percent in 2013
- 86.2 percent satisfaction with obtaining an urgent appointment within 48 hours — an increase from 82.9 percent in 2013
- 89.6 percent satisfaction with obtaining a routine appointment within 10 business days — an increase from 88.8 percent in 2013

Treatment record review criteria, results, best practices — coming soon!

We completed our annual provider treatment record review in July 2014. We’ll share results of this annual audit, as well as review criteria and best practices in the Fall 2014 Aetna Behavioral Health Insights™ newsletter. To see last year’s results, read our BH Insights Fall 2013 edition.

*Unless state requirements are more stringent.
HEDIS® spotlight

Diabetes screening for bipolar/schizophrenic patients on antipsychotic medication

As part of our ongoing efforts to support best practices and identify opportunities for improvement, we are highlighting different HEDIS\(^1\) quality-of-care behavioral health measures. This time we’re focusing on the Diabetes Screening among People with Bipolar Disorder and Schizophrenia who are on an Antipsychotic Medication (SSD) measure.

Due to their serious mental illness, people with schizophrenia are at a greater risk of metabolic syndrome. Screening for diabetes is important for anyone with schizophrenia or bipolar disorder, and the added risk associated with antipsychotic medications contributes to the need to screen these patients. Diabetes screening may lead to earlier identification and treatment.

Schizophrenia, bipolar disorder and major depressive disorder are among the major psychiatric disorders related to increased morbidity and mortality from a range of medical causes, including cardiovascular disease and diabetes mellitus. Data from several states during 1997 – 2000 have demonstrated that patients with major psychiatric disorders die 25 to 30 years earlier than unaffected individuals, mainly as the result of premature cardiovascular disease\(^2\). Major mental illness is associated with increased frequency of modifiable risk factors for diabetes and cardiovascular disease, such as overweight/obesity, dyslipidemia, hyperglycemia, hypertension, and smoking\(^3\).

What’s the definition of this HEDIS® measure?

**Description:** The percentage of individuals 18 – 64 years of age with schizophrenia or bipolar disorder, who were prescribed any antipsychotic medication, and who received a diabetes screening during the measurement year.

What are best practices for treatment?

Patients with major mental illness can benefit from the services of a multidisciplinary team of health care professionals, including a primary care provider and a psychiatrist. However, a substantial number of patients lack access to key resources, including primary care physicians (PCPs). Therefore, psychiatrists are often in the position of being the sole physician caring for their patients, who may require regular monitoring for both their psychiatric disorder and comorbid medical conditions.

The psychiatrist is well-positioned to:

- Lead a team of qualified professionals, who may include the primary care physician or appropriate specialist, case manager, psychiatric nurse, dietitian, certified diabetes educator, ophthalmologist, podiatrist, and others
- Coordinate a treatment plan individualized to the patient’s specific needs and resources
- Facilitate a high degree of intercommunication among these specialists
- Be aware of diabetes screening results, ensure ongoing monitoring and change treatment plans accordingly

The increased cardiometabolic risks associated with psychiatric disorders and the medications used to treat them highlight the need for all members of the health care team to be aware of these risks, especially the psychiatrist who in many cases is the physician with the highest frequency of patient contact\(^4\).

Additional resources online

For more information visit the American Diabetes Association website. Or check out the provider toolkit online here.

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\(^1\)The Healthcare Effectiveness Data and Information Set (HEDIS\(^\circledR\)) is a set of standardized performance measures designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans. HEDIS\(^\circledR\) is a registered trademark of the National Committee for Quality Assurance (NCQA).


\(^3\)McEvoy JP, Meyer JM, Goff DC, et al. Prevalence of the metabolic syndrome in patients with schizophrenia: baseline results from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia trial and comparison with national estimates from NHANES III. *Schizophr Res* 2005; 80: 19–32.

Online:

www.aetna.com

Access our secure provider website on NaviNet® available through our public website. Once there:

- Select “Health Care Professionals,” then “Secure Site Log In.”
- Under “Provider Secure Website,” choose “Log In” or “Register Now!”

Already registered? Go to https://connect.navinet.net.

To access the Aetna Behavioral Health and Employee Assistance Program page:

- Log in to our secure provider website.
- Choose “Aetna Support Center” from the upper left menu.
- Select “Doing Business with Aetna” followed by “Aetna Benefit Products.”

By phone:

Aetna Behavioral Health:
- For general questions about Aetna Behavioral Health – 1-888-632-3862.
- For HMO-based and Medicare Advantage plans claims, benefits, eligibility or demographic changes – 1-800-624-0756.
- For all other plans claims, benefits, eligibility or demographic changes – 1-888-MDAETNA (1-888-632-3862).
- For all HMO-based and Medicare Advantage plans precertification or case management – 1-800-624-0756.
- For all other plans precertification or case management – 1-888-MDAETNA (1-888-632-3862).
- For questions about joining the Aetna Behavioral Health network – 1-800-999-5698.

Aetna Behavioral Health – Quality:

For questions about or a copy of our UM criteria, questions about a coverage decision for one of your Aetna Behavioral Health patients or if you need to speak with one of our clinical reviewers (24 hours a day, 7 days a week), contact us at 1-800-624-0756 for HMO-based and Medicare Advantage plans, or 1-888-632-3862 for all other plans.

If you have questions or want more information on provider quality efforts, you can also e-mail our Quality Management staff at QualityImprovement2@aetna.com.

EAP Call Center: Call 1-888-238-6232.

By mail:

Aetna Behavioral Health
1425 Union Meeting Road
P.O. Box 5
Blue Bell, PA 19422

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.

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The EAP is administered by Aetna Behavioral Health, LLC, Horizon Behavioral Health Services, LLC and Resources For Living, LLC. In California for Knox-Keene plans, Aetna Health of California, Inc. and Health and Human Resources Center, Inc.

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48.22.808.1-Q3 B (7/14)