Participating provider behavioral health precertification list for Aetna®

Effective August 1, 2024

This document is a quick guide for your office to use for behavioral health precertification with patients enrolled in Aetna health plans. This process is also known as prior authorization or prior approval.

You can use this document as an overview of best practices working with Aetna. It will be your reference for **Current Procedural Terminology (CPT®)** codes for services, programs and prescriptions that require approval for coverage.

Make sure you review and understand how to submit a precertification request to Aetna. To learn more, refer to the **How to Submit a request** section.

Check out the table of contents on the next page for a closer look at what you'll find in this guide.

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Table of contents

How to submit | General info | Services

Click on the tabs above to go directly to each section.

You can also use **Ctrl + F** on Windows® (**Command + F** on Mac®) to search the document for keywords.

This information applies to:

- Aetna® plans
- Aetna Medicare plans
- Banner|Aetna plans
- Innovation Health® plans
- Sutter Health | Aetna plans
- Texas Health Aetna plans

This information doesn't apply to members in a Traditional Choice® plan, an indemnity plan, a Foreign Service Benefit Plan, a Mail Handlers Benefit Plan or a Rural Carrier Benefit Plan.

This document was last updated on August 1, 2024.

Submission of precertification requests

IMPORTANT: As the patient's attending physician, you must complete all sections of a submission. If you don't send all medical records we ask for, it may delay our review or cause a denial of coverage.

You can save time by requesting precertification online. Doing so is fast, secure and simple. You can submit most requests through our Availity® provider portal. Go to **Availity.com** to start a request. **Note:** Your office may also send in an electronic request. Just use your own Electronic Medical Record (EMR) system. Go to **AetnaElectronicPrecert.com** to learn more about the precertification process.

What happens next

Once we have the requested information, we'll perform a clinical review. We will let you know when we make a coverage determination.

How we make coverage determinations

If you are asking for precertification for a Medicare Advantage member, we use CMS benefit policies to make our coverage decisions. This includes national coverage determinations (NCD) and local coverage determinations (LCD), when available. If there isn't an available NCD or LCD to review, we'll use the Clinical Policy Bulletin and Precertifications List. You can find them by going to the website on the back of the member's ID card.

Questions?

If you have any questions about submitting a request or about our precertification process, call us:

- Commercial plans: **1-888-632-3862 (TTY: 711)**
- Medicare plans: **1-800-624-0756 (TTY: 711)**

Or visit **AetnaElectronicPrecert.com** to learn more.

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General information

You should know

- This material is for your information only. It's not meant to direct treatment decisions.
- The review of items on this list may vary at our discretion. If you receive approval for a service or supply, it's for that service or supply only.
- Services that don't need precertification are subject to the coverage terms of the member's plan.
- Refer to the **National Precertification List** for a list of medical/surgical services that require precertification, including, but not limited to, transportation by fixed-wing aircraft (plane).

Special information for members in Texas

- For precertification in Texas, we use the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage. Precertification doesn't mean payment for care or services to fully insured HMO and PPO members as defined by Texas law.

Coverage changes and updates

- If member eligibility and plan coverage for the procedure or service you asked for hasn't changed, precertification approvals are valid for the authorized time period.
- We update the precertification list each year. We usually do this in January and July. But we may make updates to the list at other times.

Special information for members enrolled in a Dual Special Needs Plan (DSNP) in Florida

Precertification may be required for community behavioral health Medicaid covered services to eligible full duals. You can utilize your current electronic solutions to submit a precertification request or call the number listed on the member's ID card.

For more information

- Visit **Clinical Policy Bulletins** and our **online provider directory**.
- The precertification process doesn't include verbal or written requests for information about benefits or services not on the precertification lists. Our staff can assess if a caller is making an inquiry or asking for a coverage decision or organization determination.
- We don't offer all plans in all service areas. Not all plans include all services listed. For example, precertification programs don't apply to fully insured members in Indiana.

Innovation Health

- Innovation Health Insurance Company and Innovation Health Plan, Inc. (Innovation Health) are affiliates of Aetna Life Insurance Company (Aetna) and its affiliates. Aetna and its affiliates provide certain management services for Innovation Health.
- **Find more information about notification and coverage determinations**.
- We require precertification when Aetna or Innovation Health is the secondary payer.

Federal Employee Health Benefits Plans information

For members enrolled in Foreign Service Benefit Plan, Mail Handlers Benefit Plan (MHBP) or Rural Carrier Benefit Plan:

- Visit online provider directories: **Foreign Service Benefit Plan; MHBP; Rural Carrier Benefit Plan**
- Except as noted for drugs and medical injectables and special programs, for all other services:
  - **Foreign Service Benefit Plan: 1-800-593-2354 (TTY: 711)**
  - **MHBP: 1-800-410-7778 (TTY: 711)**
  - **Rural Carrier Benefit Plan: 1-800-638-8432 (TTY: 711)**

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Behavioral health services that require precertification

How to submit | General info | Services

For more information, read all general precertification guidelines.

	Procedure name/description	CPT code(s)
1.	**Inpatient confinements** For example, stays in a hospital, psychiatric hospital, substance use disorder facility or residential treatment center/facility (RTC/RTF).	
2.	**Partial hospitalization programs (PHP)**	H0035, H2036, S0201 (effective 10/1/24) Medicare Advantage only: G0410, G0411
3.	**Applied behavioral analysis (ABA)**	97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T
4.	**Gender affirmation surgery**	55970, 55980, 56805, 57335, 11950, 11951, 11952, 11954, 15771, 15772, 15775, 15776, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15824, 15825, 15826, 15828, 17380, 19318, 21270, 30400, 30410, 30420, 30430, 30435, 30450, 53430, 54125, 54400, 54401, 54405, 54406, 54408, 54410, 54411, 54415, 54416, 54417, 54520, 54660, 54690, 55175, 55180, 56625, 56800, 56810, 57106, 57107, 57110, 57111, 57291, 57292, 58150, 58180, 58260, 58262, 58275, 58280, 58285, 58290, 58291, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58661, 58720
5.	**Residential treatment center/facility (RTC/RTF)**	H0010, H0011, H0017, H0018, H0019, H2034, T2048
6.	**Transcranial magnetic stimulation (TMS)**	90867, 90868, 90869
7.	**Coverage at an in-network benefit level for out-of-network provider or facility unless services are emergent** Some plans have limited or no out-of-network benefits	

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