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Aetna Better Health® of Michigan

Utilization management

Utilization management (UM) is a system for reviewing eligibility for benefits for the care that has been or will be provided to patients. The UM department is composed of Prior Authorization and Concurrent Review.

To support UM decisions, we use nationally recognized and/or community-developed, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Medical necessity is based upon clinical standards and guidelines as well as clinical judgment. All clinical standards and guidelines used in the UM program have been reviewed and approved by physicians who practice and participate in our network. You can receive a copy of our clinical criteria and guidelines by calling your network management/Provider Relations Representative.

The medical director makes all final decisions regarding the denial of coverage when the services are reviewed via our UM program. The provider is advised that the decision is a payment decision and not a denial of care. The responsibility for treatment remains with the

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Provider Newsletter
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Utilization management

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attending physicians. The medical director is available to discuss denials with attending physicians and other providers during the decision process. Notification includes the criteria used; the clinical reason(s) for the adverse decision; peer-to-peer rights; and a contact person's name, address and telephone number.

The policy on payment for services helps ensure that the UM decision-making process is based on consistent application of appropriate criteria and policies rather than financial incentives.

- UM decisions are based only on appropriateness of care and service and the existence of coverage
- We do not reward practitioners, providers or other individuals conducting utilization review for issuing denials of coverage or service and care.
- The compensation that we pay to practitioners, providers and staff assisting in utilization-related decisions does not encourage decisions that result in underutilization or barriers to care or service.

How to contact the UM department

UM staff is available to discuss specific cases or UM questions by phone weekdays, 8:30 AM to 5:00 PM, by calling **1-866-874-2567 (TTY: 711)**. UM staff is available on holidays and weekends by voicemail and fax. The UM department can receive faxed information 24 hours a day, 7 days a week at **1-866-603-5535**. When initiating or returning calls regarding UM issues, staff will identify themselves by name, title and organization name.

Members who need language assistance can call Member Services at the number on the back of their ID card.

24-hour nurse line

Medically necessary services must be available to members 24 hours a day, 7 days a week. When a member has a medical question, they can call our 24-hour nurse line. Our nurses can help answer specific health questions and give advice on what to do when the member needs health care.

The toll-free number for the nurse line is **1-866-711-6664**. Members can also find the nurse line number on the back of their Aetna Better Health ID card.

Appointment access standards and hours of operation parity

We use accessibility and availability standards based on requirements from NCQA and state and federal regulations. Aetna Better Health requires participating practitioners and providers to comply with the following appointment access standards:

Specialty Care Appointments	Standard
New patient initial visit	Within 90 calendar days
Existing patient follow-up visit	Within 30 calendar days
Urgent care appointment	Within 48 hours
Emergency care appointment	Seen immediately or referred to ER facility
PCP Appointments	**Standard**
Regular/routine care appointment	Within 21 calendar days
EPSDT service	Scheduled in accordance with EPSDT guidelines and periodicity schedule within 30 days
Urgent care appointment	Within 48 hours
Emergency care appointment	Seen immediately or referred to ER facility
After-hours care	24 hours day/7 days per week

Behavioral Health Care Appointments	Standard
Initial visit for routine care	Within 10 business days
Routine/follow-up (non-urgent, asymptomatic conditions)	Within 60 calendar days
Emergency care	Immediately, or referred to ER
Urgent care (no immediate danger to self or others and/or if the situation is not addressed within 48 hours, it may escalate)	Within 48 hours
Non-life-threatening emergency (no immediate danger to self or others and/or if the situation is not addressed within 6 hours, it may escalate)	Within 6 hours
Discharge follow-up visit	Within 7 calendar days of discharge
Maternity Appointments	**Standard**
Initial prenatal visit	Within 14 calendar days of pregnancy confirmation

The access standards are communicated to practitioners and providers via the Aetna Better Health website and the Provider Manual. Members are notified about access standards in the Member Handbook and on the Aetna Better Health website.

Federal law requires that participating practitioners and providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid members. If the practitioner or provider serves only Medicaid recipients, hours offered to managed care members must be comparable to those for Medicaid fee-for-service members. Practitioners and providers that do not meet Aetna Better Health of Michigan access standards are given recommendations for improvements in order to meet the set standards.

Childhood blood lead testing in Michigan

Data brief for health care providers

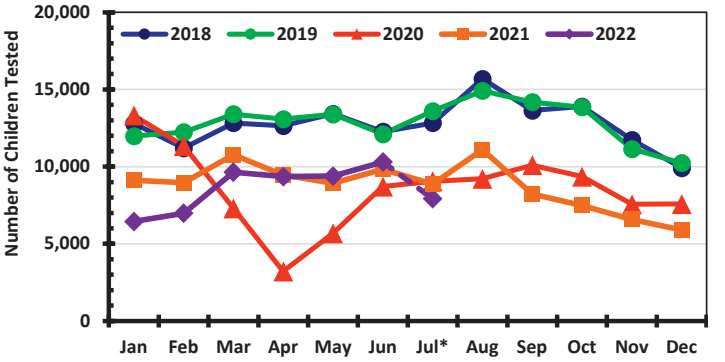
- Blood lead testing remains lower than pre-pandemic levels, and lead exposure can go undetected due to this drop in testing.
- Lead is a neurotoxin. There is no safe level of lead in blood.

How can my practice respond?

- Make lead exposure screening and blood lead testing a priority in your practice.
- Blood lead test results are in the Michigan Care Improvement Registry (MCIR). Please review and contact your patients who are due for blood lead testing.

To learn more about lead poisoning prevention and blood lead testing, contact the Childhood Lead Poisoning Prevention Program at **517-335-8885** or **Michigan.gov/MiLeadSafe**.

Monthly Number of Michigan Children <6 Years Old Tested for Blood Lead: January 2018 to July 2022



*Data for July 2022 are provisional and shown as a dashed line.
Data Source: MDHHS Data Warehouse, Data Current as of 08/17/2022

MDHHS-Pub-1327 (12-22)
Updated 12/2022

Who should be tested for blood lead?

All children with a positive lead exposure questionnaire. The American Academy of Pediatrics Bright Futures Periodicity Schedule recommends questionnaire screening for lead exposure at well-child exams conducted at 6 months through 6 years.

- The Michigan Department of Health and Human Services lead exposure questions can be found on the Pediatric Blood Lead Level Quick Reference for Primary Care Providers at **www.michigan.gov/mdhhs/-/media/Project/Websites/mileadsafe/Healthcare-providers/ProviderQuickReference.pdf**. A "Yes" or "I don't know" response indicates a positive screen.

Children enrolled in Medicaid. Blood lead testing is required at:

- 12 and 24 months.
- Between 36 and 72 months, if not previously tested. (Medicaid Provider Manual, Section 9.6: **https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf**)

Children enrolled in WIC. If a child has not had a blood lead test, they must be referred for blood lead testing. (Social Welfare Act, MCL § 400.111l: **http://legislature.mi.gov/doc.aspx?mcl-400-111l**)

Children who are refugees ages 6 months through 16 years. The Centers for Disease Control and Prevention recommends a blood lead test within 90 days of arrival in the U.S.

- Retest after 3 to 6 months for refugee children less than 6 years. (Immigrant, Refugee, and Migrant Health: **cdc.gov/immigrantrefugeehealth/guidelines/lead-guidelines.html**)

Change Healthcare update

Aetna Better Health® Premier Plan is partnering with Change Healthcare to introduce the new EFT/ERA Registration Services (EERS), a better and more streamlined way for our providers to access payment services.

What is EERS?

EERS will offer providers a standardized method of electronic payment and remittance while also expediting the payee enrollment and verification process. Providers will be able to use the Change Healthcare tool to manage EFT and ERA enrollments with multiple payers on a single platform.

How does it work?

EERS will give payees multiple ways to set up EFT and ERA in order to receive transactions from multiple payers. If a provider's tax identification number (TIN) is active in multiple states, a single registration will auto-enroll the payee for multiple payers. Registration can also be completed using a national provider identifier (NPI) for payment across multiple accounts.

Providers who currently use Change Healthcare as a clearinghouse will still need to complete EERS enrollment, but providers who currently have an application pending with Change Healthcare will not need to resubmit. Once enrolled, payees will have access to the Change Healthcare user guide to aid in navigation of the new system.

How and when do I enroll?

All Aetna Better Health plans will migrate payee enrollment and verification to EERS. To enroll in EERS, please visit **PayerEnrollServices.com**.

For questions or concerns, please reach out to your Aetna Provider Relations team or visit the Change Healthcare FAQ page at **PayerEnrollServices.com/FAQ**.

Members have direct access to women's health specialists

We provide female members direct access to women's health specialists for routine and preventive health care services. Routine and preventive health care services include, but are not limited to, prenatal care, breast exams, mammograms and Pap tests. Women's health specialists include obstetricians, gynecologists, nurse practitioners and certified nurse midwives.

Direct access means that Aetna Better Health cannot require women to obtain a referral or prior authorization as a condition to receiving such services from specialists in the network. Direct access does not prevent us from requesting or requiring notification from the practitioner for data collection purposes.

Grievances and appeals

Aetna Better Health has an Inquiry, Grievance, and Appeals process for members and providers to dispute a claim authorization or an Aetna Better Health decision. Our process includes both administrative and clinical decisions. A provider has 90 days from the Notice of Action to file an appeal and 90 days to file a grievance. Members have 60 days from the Notice of Action to file an appeal, and members can file a grievance at any time. Members and providers have a one-level internal appeal process through Aetna Better Health.

There are no punitive actions to members or providers for filing a complaint. Members and providers have the right to submit written comments at all levels of the process.

Provider inquiries and grievances

To ensure a high level of satisfaction, we will provide a mechanism for providers to express dissatisfaction with a decision. Providers may express questions or dissatisfactions through our provider inquiry and grievances process.

If a provider has questions regarding member benefits or eligibility, claim status or payment, remittance advice, authorization inquiries, etc., please access the provider portal or contact Claims Inquiry/Claims Research (CICR). Provider inquiries are typically handled and resolved during the initial contact.

To submit a dissatisfaction regarding an issue with Aetna Better Health, you may contact our Provider Experience Department at **1-866-314-3784 (TTY: 711)**. Complaints received will be documented and forwarded to appropriate personnel for resolution. The resolution will be registered and conveyed to the complainant within our internal system.

After following these steps, if you are still dissatisfied, you may have the right to file an appeal. Please refer to the **appeals** section for instructions on filing an appeal.

Members and providers also have the right to request and receive a written copy of Aetna Better Health utilization management criteria in cases where the appeals are related to a clinical decision/denial.

If required, Aetna Better Health members will receive assistance from our Member Services Department to file either a grievance or an appeal.

A member may request or file a continuation of benefits during an Aetna Better Health Plan appeal review or a State Fair Hearing within 10 days of the Notice of Action mail date. If the Health Plan's action is upheld in a hearing, the member may be liable for the cost of any disputed services furnished while the appeal was pending determination.

Claim reconsideration vs. provider appeal

Aetna Better Health has two separate and distinct processes designed to assist providers with issue resolution. The chart on the next page illustrates filing a claims reconsideration or resubmission versus a provider appeal. If the provider has a dispute with the resolution of a claim, they may challenge the claim denial or adjudication by filing a request to appeal. However, before filing an appeal, the provider should verify the claim does not qualify as a claim resubmission or reconsideration.

Reconsiderations vs. appeals

Information	Reconsideration	Non-Par Provider Appeal Dispute	Par Provider Approval
Form (online)	Resubmission/ Reconsideration Form	Non-Par Provider Appeal Form	Par Provider Appeal Form
Address	Aetna Better Health of Michigan Attn: Reconsiderations P.O. Box 982963 El Paso, TX 79998-2963	Aetna Better Health of Michigan Medicaid Attn: Grievance & Appeals P.O. Box 81040 5801 Postal Road Cleveland, OH 44181	Aetna Better Health of Michigan Attn: Reconsiderations P.O. Box 982963 El Paso, TX 79998-2963
Appropriate Categories	Claim resubmissions Corrected claims (including missing/ incomplete/invalid diagnosis, procedure, or modifier denials)	Denied days for IP (inpatient) stays	Denied days for IP (in-patient) stays Authorization denials
	Timely Filing COB (missing/illegible primary explanation of benefits)	Claim denial for no authorization/ precertification/medical necessity not met Services denied per the finding of a review organization Disclaimer: All Tenet appeal is 365 days from denial date.	Claim denial for no authorization/ precertification/medical necessity not met Services denied per the finding of a review organization
Time frame	180 days from the date of processing/denial	Claim denial appeals must be submitted within 90 days of the date of service.	Claim denial appeals must be submitted within 90 days of the date of service.
		Authorization denial appeals must be submitted within 90 days of the date of the adverse action (denial letter). Disclaimer: All Tenet appeal is 365 days from denial date.	Authorization denial appeals must be submitted within 90 days of the date of the adverse action (denial letter).

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Grievances and appeals

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Provider dispute of claim reconsideration action

Providers may dispute any adverse claim action. Before disputing a claim action, providers may contact our CICR department for claim information. In many cases, claim denials are the result of inaccurate filing practices. Please follow the filing practices listed in the above sections, as well as the steps below, to minimize claims issues. Contact our CICR department at **1-866-314-3784 (TTY: 711)** as the first step to clarify any denials or other actions relevant to a claim. A representative will assist a provider with a possible resubmission of a claim with modifications. If, after speaking to an Aetna Better Health representative or after submitting a claim resubmission, the issue is still not resolved, network providers may challenge actions of a claim denial or adjudication by filing a claim dispute.

Providers must file the dispute using the Aetna Better Health Claim Dispute form found on the Aetna Better Health website at: **AetnaBetterHealth.com/michigan/providers/forms**.

Example of appeals:
- Denied as not medically necessary

Tips for writing an effective appeal

If a provider disagrees with Aetna Better Health Plan's decision regarding requested services or benefit coverage, we have provided tips for writing an effective grievance or appeal letter:
- Include the name, address, and a phone number where the appealer can be reached in case there are any questions.
- Include the patient's name, date of birth, and insurance ID number.
- Describe the service or item being requested.
- Include the prior authorization number.
- Address issues raised in our denial letter.
- Address the medical necessity of the requested service.

- Include information about the patient's medical history:
  - Prior treatments
  - Surgery date
  - Complications
  - Medical condition and diagnosis

If applicable to an appeal situation, please also provide:
- Any unique patient factors that may influence our decision
- Why alternate methods or treatments are not effective or available
- The expected outcome or functional improvement
- An explanation of the referral to an out-of-network provider

When submitting an appeal, provide the necessary information to describe the patient, treatment, and expected outcomes as described above.

Expedited appeal requests

Expedited requests are available for circumstances when the application of the standard appeal time frames would seriously jeopardize the life or health of the member or the member's ability to attain, maintain or regain maximum function. To request an expedited review, send a fax to **1-866-889-7517**. Expedited review requests that meet the above criteria will have determinations made within 72 hours or earlier as the member's physical or mental health requires.

Process definitions and determination time frames

Process	Definition	Determination
Inquiry	Inquiries are handled daily and are generally resolved during the initial contact. Questions received from a member or provider regarding issues from an Aetna Better Health Member Service Representative, such as benefits information, claim status or eligibility, are classified as an inquiry. To avoid delay in processing an inquiry, do not label an Inquiry as a Grievance or Appeal. Written Inquiries should be mailed to the address listed below.	Fifteen (15) working days from receipt of the Inquiry
Grievance	Any written or oral expression of dissatisfaction with any aspect of care other than the Appeal of actions is considered an Appeal expressed by a member or provider. This dissatisfaction refers to any reason other than dissatisfaction due to the Health Plan's adverse benefit determination or action. A complaint is a Grievance. Most Grievances are categorized as Quality of Care, Quality of Service, or Service Center Specific.	Member: 90 days and Provider: 45 days
Appeal	An Appeal is a written or oral request by the member or provider to review an Adverse Determination or payment/reimbursement denial related to a health service request or benefit that the member or provider believes he or she is entitled to receive. Denial or limited authorization of a requested service includes a type or level of service that is determined to be experimental, investigational, cosmetic, not medically necessary, or inappropriate. A failure to provide services in a timely manner is defined by the State as a failure of the Health Plan to act within specified time frames. The Appeals must be received by the Health Plan within ninety (90) calendar days of the date of the Health Plan's Notice of Action for it to be considered an Appeal.	Seventy-two (72) hours from receipt of the Expedited Appeal request for each level of internal Appeal 30 calendar days for members and 45 days for providers from receipt of the Standard Appeal request for each level of internal Appeal

Address for written inquiries and grievances	Address for written appeals
Aetna Better Health of Michigan Attn: Inquiries P.O. Box 81040 5801 Postal Road Cleveland, OH 44181	Aetna Better Health of Michigan Attn: Grievance & Appeals P.O. Box 81040 5801 Postal Road Cleveland, OH 44181

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Grievances and appeals

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State Fair Hearing

Aetna Better Health members have 120 days from the date of Aetna Better Health's Notice of Action or appeal decision letter to initiate a State Fair Hearing. The member must complete the Health Plan appeal process before starting the State Fair Hearing. If the member is dissatisfied with the state agency determination denying a member's request to transfer plans or disenroll, they may also access the State Fair Hearing process. To arrange for a State Fair Hearing, members should call or write to:

Michigan Department of Health and Human Services Legal Services-Hearing Section
P.O. Box 30763
Lansing, MI 48909
1-877-833-0870

A member's provider may request a State Fair Hearing if the provider is acting as the member's authorized representative. In addition, the provider can request a State Fair Hearing without representing the member for claims issue resolution, as allowable per state law.

Evidence-based guidelines

Aetna Better Health uses valid and reliable evidence-based Clinical Practice Guidelines and preventive health guidelines. The guidelines consider the needs of enrollees, opportunities for improvement identified through our quality management program, and feedback from participating practitioners and providers. Guidelines are updated as appropriate, but at least every two years.

The Clinical Practice Guidelines and preventive health guidelines are located on our website. Click on "For Providers," then "Clinical Practice Guidelines."

Fraud, waste and abuse

Know the signs — and how to report an incident

Health care fraud means getting benefits or services that are not approved. Fraud can be committed by a provider, member or employee.

Abuse is doing something that results in needless costs.

Waste goes beyond fraud and abuse. Most waste does not involve a violation of law. It relates primarily to mismanagement, inappropriate actions and inadequate oversight. Some examples are:

- Inefficient claims processing and health care administration
- Preventable hospital readmissions
- Medical errors
- Unnecessary emergency room visits
- Hospital-acquired infections or conditions

Everyone has a right and duty to report suspected fraud, waste and abuse. An example of provider fraud is billing for services, procedures and/or supplies that were not provided. Abuse is treatment or services that do not agree with the diagnosis. Hostile or abusive behavior in a doctor's office or hospital is also abuse. Suspected use of altered or stolen prescription pads is an example of member fraud. An example of abuse would be a member asking the transportation driver to take him or her to an unapproved location.

Penalties

Criminal health care fraud. Persons who knowingly make false claims may be subject to:

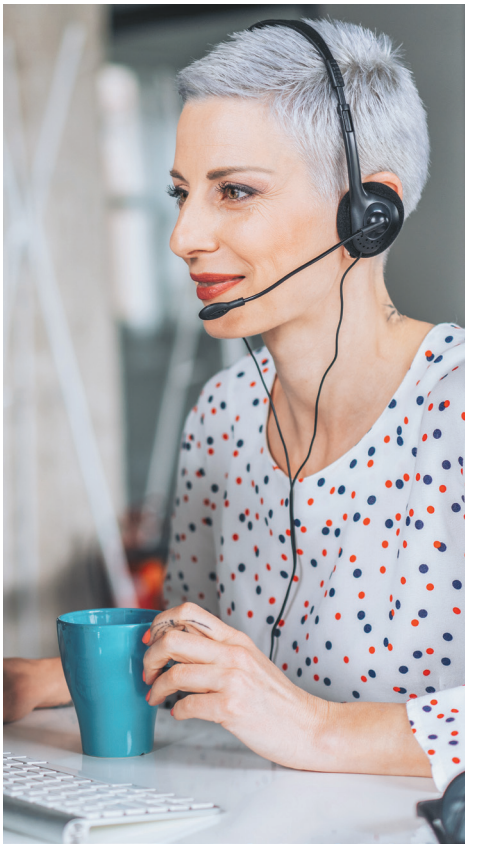
- Criminal fines up to $250,000
- Prison for up to 20 years
- Being suspended from Michigan Medicaid

If the violations resulted in death, the individual may go to prison for years or for life. For more information, refer to 18 U.S.C. Section 1347.

Anti-Kickback Statute. The Anti-Kickback Statute bans knowingly and willingly asking for, getting, offering or making payments (including any kickback, bribe or rebate) for referrals for services that are paid, in whole or in part, under a federal health care program (including the Medicare program). For more information, refer to 42 U.S.C. Section 1320a-7b(b).

How to report fraud, waste and abuse

If you suspect a colleague, member or other individual of fraud, waste or abuse, report it. You can report anonymously on the Aetna Better Health of Michigan Fraud, Waste and Abuse Hotline at **1-855-421-2082**. You may also write to:



Aetna Better Health of Michigan
28588 Northwestern Highway,
Suite 380B
Southfield, MI 48034

You may also anonymously report fraud, waste and abuse to the Michigan Department of Health and Human Services' Office of the Inspector General by calling **1-855-643-7283**, going online at **Michigan.gov/Fraud** or writing to:

Office of the Inspector General
P.O. Box 30062
Lansing, MI 48909

You do not have to leave your name when you report fraud, waste or abuse.

Second and third opinions

Members have the right to a second opinion from a qualified health care professional any time the member wants to confirm a recommended treatment. A member may request a second opinion from a provider within our network. If a member requests, you must refer the member to another network provider within an applicable specialty for a second opinion.

The member has a right to a third opinion when the recommendation of the second opinion fails to confirm the primary diagnosis, there is a medical need for a specific treatment and the member desires the third opinion.

Members will incur no expenses other than standard co-pays, if applicable, for a second or third opinion given by a participating provider, as appropriate under the Member Handbook. Out-of-network services must receive prior authorization and are approved only when an in-network provider cannot perform the service.

If our member has questions about second or third opinions, please have them call our Member Services department at **1-866-316-3784 (TTY: 711)**.

Please share this reminder with members

Has your personal information changed?

Any changes in phone number, email or address should be reported to the Michigan Department of Health and Human Services. You can do this by going to the MIBridges website at **Michigan.gov/MIBridges**. If you do not have an account, you will need to create an account by selecting "Register." Once in your account, when reporting changes, please make sure you do so in both the Profile section and the Report Changes area. The Report Changes area is what the local office will use to update the address for your case.

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