Teamwork

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AetnaBetterHealth.com/Michigan

Aetna Better Health® of Michigan

Care management.

Aetna Better Health of Michigan offers an integrated care management program that includes disease management and complex case management. The goal of complex case management is to help members regain optimal health or improved functional capability in the right setting and in a cost-effective manner.

A variety of programs

Complex case management involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up. It is an opt-out program: All eligible members have the right to participate or decline to participate. Aetna Better Health of Michigan offers a variety of programs to its members and does not limit eligibility to one complex condition.

Aetna Better Health of Michigan uses the following sources to identify members for complex case management: claims data, hospital discharge data, pharmacy data, utilization management (UM) data and data supplied by the state. We also use data supplied by our members or their caregivers (such as health appraisals) and data supplied by practitioners (such as electronic health records, if available).

By referral

Aetna Better Health of Michigan accepts referrals to our case/care management program from members, caregivers, the UM department, practitioners, the 24/7 health information line and discharge planners.

If you want to refer your patient for case/care management, please call Member Services at **1-866-314-3784**.

Fall 2020
72.22.801.0-FA

Aetna Better Health® of Michigan
1333 Gratiot Ave.
Suite 400
Detroit, MI 48207

Provider experience team contact information and coverage area.

Aetna Better Health of Michigan takes great pride in our network of physicians and related professionals who serve our members with the highest level of quality care and service. We are committed to making sure our providers receive the best and latest information, technology and tools available to ensure their success and their ability to provide for our members. We focus on operational excellence, constantly striving to eliminate redundancy and streamline processes for the benefit and value of all of our partners. Our provider experience team members are assigned to designated areas throughout the state and are located within the counties in which they serve.

- Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Hillsdale, Jackson, Lenawee, Livingston, Macomb, Monroe, Oakland, Van Buren and Washtenaw

Aetna Better Health of Michigan also offers a provider services line, which can be reached by calling **1-855-676-5772**, Monday through Friday, 8 AM to 5 PM.

Nehya Ahmed, Network Relations Consultant **AhmedN2@Aetna.com** Direct: **248-318-4400**	Beaumont, Oakwood, Botsford, Doctors Hospital, Trinity Health System, Select Specialty hospitals
Kristen Chase, Network Relations Consultant **ChaseK@Aetna.com** Direct: **269-243-0024**	Allegan, Ascension Borgess, Oaklawn
Stacey Cruse, Network Relations Consultant **CruseS@Aetna.com** Direct: **248-450-8653**	Garden City, Karmanos, Kindred, ProMedica, Tenet hospitals
Kayla Hurst, Network Relations Consultant **HurstK@Aetna.com** Direct: **734-280-0436**	Ascension, Oakland Regional, Southeast Michigan Surgical Hospital, Straith Hospital
Dawnielle May, Network Relations Consultant **MayD@Aetna.com** Direct: **313-268-8419**	Allegiance Health, Henry Ford Health System, Mid-Michigan, University of Michigan
Patricia Pogodzinski, Network Relations Representative **PogodzinskiP@Aetna.com** Direct: **616-265-9609**	Hillsdale, Lakeland Health Services, Spectrum, Sturgis, Three Rivers Health System

Member rights and responsibilities.

Our member rights and responsibilities are listed in our provider manual, located on the Aetna Better Health website at **AetnaBetterHealth.com/Michigan/medicaid/rights**, and in the Member Handbook, also located on our website. A printed copy of the provider manual can be provided as well. If you would like to receive one, please call us at **1-866-314-3784** and ask to speak to your provider experience representative.

How to contact the Utilization Management department.

Fax request forms to **1-866-603-5535** (forms are available on the health plan website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing. Call directly at **1-866-874-2567**.

Medicaid provider manual.

Aetna Better Health is pleased to announce the new updated version of the Medicaid provider manual, which has been developed for your use.

Key features:
- Contact information
- Provider responsibilities and important information
- Covered services
- Eligibility and enrollment
- Encounters, billing and claims

The 2020 provider manual is available at **AetnaBetterHealth.com/Michigan**. The provider manual is intended to provide Aetna Better Health contracted providers with guidance in understanding our programs, processes and policies. Manuals may be revised as Aetna Better Health's policies, programs or regulatory requirements change. All changes and revisions will be updated and posted to the Aetna Better Health website located at **AetnaBetterHealth.com/Michigan**.

Don't let your network status change — complete your FDR attestation today.

If you are a participating provider in our Medicare plans and/or our Medicare-Medicaid plans (MMPs), you must meet the Centers for Medicare & Medicaid Services' compliance program requirements for first-tier, downstream and related (FDR) entities. You also have to confirm your compliance with these requirements through an annual attestation.

How to complete your attestation

You'll find the resources you need to ensure your compliance on the "Medicare Compliance FDR Attestation" page at **Aetna.com/health-care-professionals/medicare.html**. Once on the page, under "Need more information on the compliance requirements?" heading, click on "Medicare compliance FDR program guide" or "Office Manual."

Once you review the information and ensure that you've met the requirements, you're ready to complete your attestation. Simply click the link on the "Medicare Compliance FDR Attestation" page that corresponds to your contracting status. A single annual attestation meets all your Aetna, Coventry and/or MMP compliance obligations.

OB-GYNs: LARC reimbursement.

Effective since Oct. 1, 2018, separate reimbursement is available for long-acting reversible contraception (LARC) devices when the device is provided immediately postpartum in an inpatient hospital setting prior to discharge. Individual practitioners will continue to receive payment for their professional services related to the immediate postpartum LARC insertion procedure if billed separately from the professional global obstetric procedure codes and the hospital facility. Payment for the LARC will be made in accordance with the Practitioner Medicaid fee schedule in effect on the date of service for the procedure code billed. IUD procedures 58300-58301; IUD device S4989, J7300; LARC procedures S4981, 11976, 11980, S4989; LARC device J7296-J7298, J7306, J7307.

Medicaid Preferred Drug List.

Due to a policy change by the Michigan Department of Health and Human Services, all Medicaid health plans in Michigan will have a new drug formulary starting on Oct. 1, 2020. This new formulary is known as the single Medicaid Preferred Drug List (PDL).

The PDL will require many changes; some changes are small, such as moving to a brand-name inhaler over the equivalent generic inhaler, and other changes are large, in which members are required to be on certain specialty medications over others.

Here at Aetna Better Health of Michigan, we are committed to our members and would like this transition to the PDL to be as smooth as possible. We will be sending out letters to affected members and to their prescribers. If a change is not possible, a prior authorization will be needed.

Clinical practice guidelines (CPGs) define the role of diagnostic and treatment methods in the diagnosis and management of patients. The guidelines contain recommendations developed from scientific review and the synthesis of published medical literature. While these guidelines are not a mandatory set of rules, they do provide a recommended course of action for diagnosis and treatment for diseases and conditions.[1]

Aetna Better Health of Michigan is proud to participate in the Michigan Quality Improvement Consortium (MQIC), a collaborative effort whose participants include physicians and other personnel representing the Michigan medical community. According to their website, MQIC's mission is to "establish and implement a core set of clinical practice guidelines and performance measures. The interventions designed and implemented by each plan to improve consistent delivery of services will be at the discretion of individual plans, but guidelines, performance goals, measurement methodology and performance reporting will be standardized."[2]

The group includes representation from nearly all Michigan managed care organizations, as well as the Michigan State Medical Society, the Michigan Osteopathic Association, the Michigan Association of Health Plans, the Michigan Peer Review Organization and practicing physicians. The guidelines are developed based on current medical evidence and information from nationally recognized organizations (e.g., the U.S. Preventive Services Task Force and the American Cancer Society).

The MQIC website provides an overview of several CPGs for treatment of diseases and conditions. For instance, the CPGs for diabetes include guidance for providers about periodic assessments; laboratory tests; education, counseling and risk factor modification; and medical recommendations for patients ages 18 to 75 with type 1 or type 2 diabetes. MQIC also has guidelines for several other conditions, including attention-deficit/hyperactivity disorder (ADHD), diabetes, asthma, back pain, depression, heart failure, hypertension, substance use and tobacco control.

You can access the MQIC guidelines at **MQIC.com/guidelines.htm**.

You can access Aetna Better Health's Clinical Practice Guidelines website at **AetnaBetterHealth.com/Michigan/providers/practice-guidelines** or call Provider Services at **1-855-676-5772**.

[1]Michigan Quality Improvement Consortium (2017). MQIC Guidelines. Retrieved Nov. 15, 2017, from Michigan Quality Improvement Consortium: MQIC.com/guidelines.htm

National Center for Complementary and Integrative Health (2017). Clinical Practice Guidelines. Retrieved Nov. 15, 2017, from National Institutes of Health: NCCIH.NIH.gov/Health/Providers/ClinicalPractice.htm

[2]Michigan Quality Improvement Consortium (2017). MQIC Guidelines. Retrieved Nov. 15, 2017, from Michigan Quality Improvement Consortium: MQIC.com/guidelines.htm

Pharmacy benefits.

Prescription drugs are often an important part of your patients' health care. Aetna Better Health of Michigan's members have the right to certain prescription drug benefits.

Aetna Better Health of Michigan covers prescription drugs and certain over-the-counter drugs when presented with a prescription at a pharmacy.

To find out if a drug is covered, you can check our formulary. A formulary is a list of drugs that Aetna Better Health covers. The formulary is available on our website at **AetnaBetterHealth.com/Michigan**. You can use the prescription drug search tool to find out if a drug is covered. You may also request a printed copy of this formulary by calling Provider Services. If you have any questions about a drug that is not listed, please call the Pharmacy Helpdesk toll-free at **1-866-314-3784 (TTY: 711)**, 24 hours a day, 7 days a week.

If a drug is not listed on the formulary, a pharmacy prior authorization (PA) request form must be completed. You or your staff can complete this form. You must demonstrate why a formulary drug will not work for your patient. Please include any medical records needed for the request.

The pharmacy PA form is available on our website, or you can make a request by telephone at **1-866-314-3784** or via fax at **1-855-799-2551**.

Aetna Better Health of Michigan members must have their prescriptions filled at a network pharmacy.

Pharmacy prior authorization process

Aetna Better Health of Michigan's pharmacy PA process is designed to approve drugs that are medically needed. We require doctors to obtain a PA before prescribing or giving out the following:

- Injectable drugs provided by a pharmacy
- Nonformulary drugs that are not excluded under a state's Medicaid program
- Prescriptions that do not follow our guidelines (like quantity limits, age limits or step therapy)
- Brand-name drugs, when a generic is available

Aetna Better Health of Michigan's medical director decides if a drug is denied or approved by using our guidelines. The medical director may need additional information before making a decision. This information may include the following:

- Drugs on the formulary have been tried and do not work (step therapy).
- No other drugs on the formulary would work as well as the drug requested.
- The request is acceptable by the U.S. Food and Drug Administration (FDA) or is accepted by nationally noted experts.
- For brand-name drug requests, a completed FDA MedWatch form documenting failure or issues with the generic equal is required.

Electronic remittance advice (ERA).

We encourage our providers to take advantage of EDI, EFT and ERA, as it shortens the turnaround time for providers to receive payment and reconcile outstanding accounts. In order to qualify for an ERA, a provider must currently submit claims through EDI and receive payment for claims by EFT. Providers must also be able to receive ERAs through an 835 file. For assistance with this process, please contact our CICR at:

- Medicaid: **1-866-316-3784** or **1-866-314-3784**
- Duals: **1-855-676-5772**

How to utilize chronic condition management programs.

Aetna Better Health of Michigan has chronic condition management programs for the following diseases:

- Asthma
- Coronary artery disease
- Congestive heart failure
- Chronic kidney disease
- COPD
- Depression
- Diabetes
- Sickle cell disease

The purpose of these programs is to guide our members and their providers in accordance with clinical practice guidelines adopted by Aetna Better Health. Our goal is to help members to better understand their conditions, update them with new information and provide them with assistance to help manage their diseases. Our disease management programs are designed to reinforce your treatment plans. Providers can contact the Plan at **1-866-314-3784** and follow the prompts to enroll a member in our case/disease management program.

Prior authorizations.

Aetna Better Health℠ Premier Plan requires prior authorization for select services. However, prior authorization is not required for emergency services.

To request a prior authorization, be sure to:

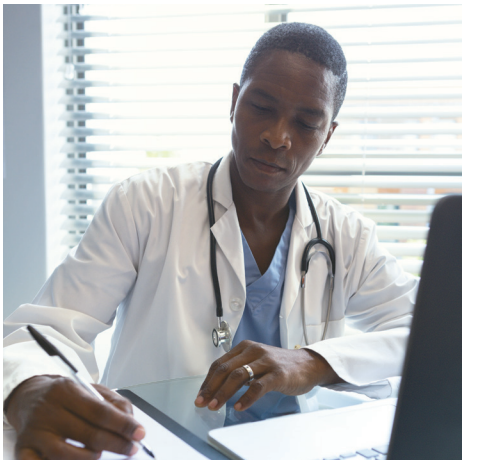
- Always verify member eligibility prior to providing services
- Complete the appropriate authorization form (medical or prescription)
- Attach supporting documentation

If covered services and those requiring prior authorization change, we will notify you at least 60 days in advance via the provider newsletter, email, website, mail, telephone or office visit.

Remember: We don't reimburse for unauthorized services. Also, prior authorization is not a guarantee of payment.

To request an authorization, to find out what services require authorization or to check on the status of a request, just visit our secure provider website. See your provider manual for more information about prior authorization.

For assistance in registering for or accessing the secure provider website, please contact your provider relations representative at **1-855-676-5772 (TTY: 711)**. You can also fax your authorization request to **1-844-241-2495**.



When you request prior authorization for a member, we'll review it and get back to you according to the following time frames:

- Routine: 14 calendar days upon receipt of request
- Urgent: Three business days upon receipt of request. An urgent request is appropriate for a non-life-threatening condition, which, if not treated promptly, will result in a worsened or more complicated patient condition. We encourage you to call the Prior Authorization department at **1-855-676-5772** for all urgent requests.

Subcontractors

We work with certain subcontractors to coordinate services such as transportation, vision or dental services. If you have a member who needs one or more of these services, please contact Member Services at **1-855-676-5772** for more information.

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 (ER) 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
1333 Gratiot Ave., Suite 400
Detroit, MI 48207

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.

How we make coverage decisions.

When making coverage decisions, Aetna Better Health of Michigan follows the health care rules of MCG® Guidelines. Aetna Better Health of Michigan uses these rules to determine the type of treatments that will be covered for members. Providers can obtain the criteria to make coverage decisions by calling Provider Services at **1-866-314-3784 (option 4)**. Specific criteria will be made available upon your request.

Aetna Better Health of Michigan's staff and its providers must make health care decisions based on the proper care and service rules, including member eligibility. There are no rewards or financial incentives for providers or staff for the denial or reduction of services.

Access to our clinical staff.

If you need access to a nurse during normal business hours, 8 AM to 5 PM, call Member Services at **1-866-314-3784** and ask to be connected to a nurse. If you need a nurse after business hours, call **1-866-711-6664**. You will be connected to our 24-hour nurse line. Members/providers with hearing impairment, please use our TTY line at **711**. Language translation is also provided for free by calling **1-866-314-3784**.

Provider portal.

Our enhanced, secure and user-friendly web portal is now available. This HIPAA-compliant portal is available 24 hours a day. And it supports the functions and access to information that you need to take care of your patients. Popular features include:

- **Single sign-on.** One login and password allows you to move smoothly through various systems.
- **Mobile interface.** Enjoy the additional convenience of access through your mobile device.
- **Personalized content and services.** After login, you will find a landing page customized for you.
- **Real-time data access.** View updates as soon as they are posted.
- **Better tracking.** Know immediately the status of each claim submission and medical prior authorization (PA) request.
- **eReferrals.** Go paperless. Refer patients to registered specialists electronically and communicate securely with the provider.
- **Auto-authorizations.** Depending on the authorization type and service location, it is possible to receive an auto-approval on your request.
- **Detailed summaries.** Find easy access to details about denied PA requests or claims.
- **Enhanced information.** Analyze, track and improve services and processes.

Please go to **AetnaBetterHealth.com/Michigan/providers/portal** to access the provider portal.

This newsletter is published as a community service for the providers of Aetna Better Health® of Michigan. Models may be used in photos and illustrations.