aetna™

# Aetna Better Health® of Michigan

# Well-being

Provider Newsletter | Fall 2019

## Care management

Aetna Better Health of Michigan (ABHM) 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 optimum health or improved functional capability in the right setting and in a cost-effective manner.

### A variety of programs

It 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. Complex care management is an opt-out program: All eligible members have the right to participate or decline to participate. ABHM offers a variety of programs to its members and does not limit eligibility to one complex condition.

ABHM uses the following sources to identify members for complex care 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

ABHM 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**.

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

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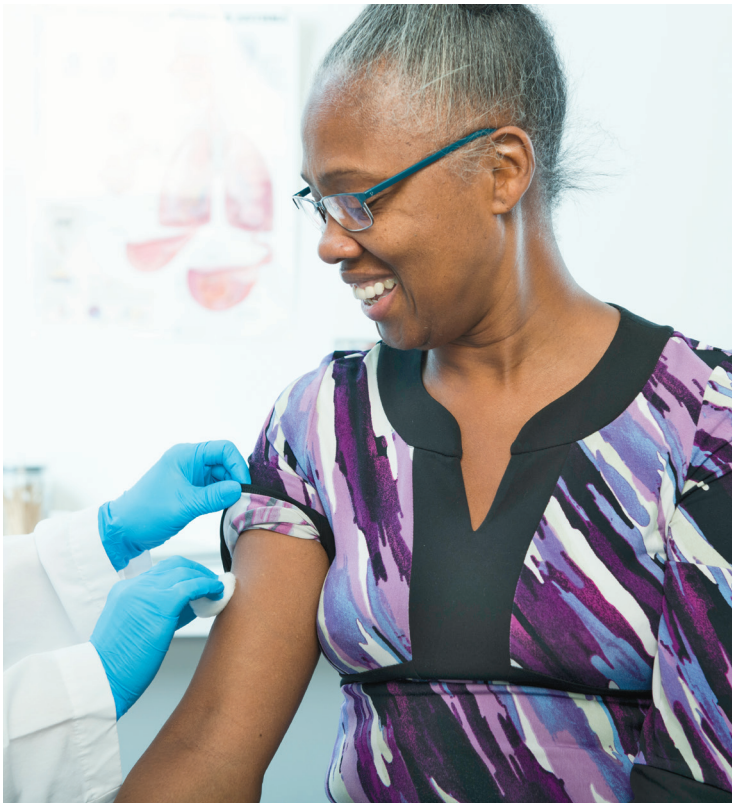
## Aetna Better Health lab services provider

Effective Dec. 4, 2017, we discontinued our contract with Quest, and we are requiring our providers to use our preferred laboratory provider, Joint Venture Hospital Laboratories (JVHL), effective Dec. 4, 2017. We look forward to continuing to work with you in the care of our members. Please contact our Provider Relations Department at **1-866-314-3784** if you have any additional questions.



## The three P's of flu prevention

Even in a relatively mild season, the flu results in numerous hospitalizations, emergency and office visits, and missed school and work. Over the past 35 years, annual flu-related deaths have reached as high as 50,000 in a single season. Healthy kids and adults may be far less likely to suffer the more catastrophic consequences of the flu. However, it poses a risk to the very young, old and chronically ill in our households, schools and workplaces. As health care professionals, we play a pivotal role in lessening the burden of flu-related suffering. With flu season rapidly approaching, it's time to think about the three P's: **Prepare**, **Prod** and **Prevent**.

### Prepare

- Become knowledgeable about current ACIP recommendations for this winter at **cdc.gov/flu/professionals/acip**.
- Order your vaccine stock early.
- If possible, create a separate nurse appointment list for patients only seeking flu and pneumonia vaccines.
- Allow nurses to administer these vaccines without a doctor visit.
- Create a list of alternative sites where flu and pneumonia vaccines are available for your patients (e.g., retail clinics in drug stores, supermarkets and other local options).
- Review current testing and treatment recommendations at **cdc.gov/flu/professionals/diagnosis** and **cdc.gov/flu/professionals/antivirals/summary-clinicians.htm**.

### Prod

- Include a flu prevention statement in every patient contact. You can suggest your office staff end every phone conversation with, "Just a reminder: We have flu shots available and strongly encourage that you protect yourself and your family."
- Display flu prevention material prominently in your office and waiting area.
- Set an example by being the first in your office to be vaccinated. See that your office/practice achieves 100% immunization of staff and family members as soon as possible.
- Identify and actively reach out to high-risk patients.

### Prevent

- Use every patient encounter as an opportunity to immunize (e.g., wellness exams, sports physicals, and acute and chronic illness follow-up visits).
- Emphasize to patients the importance of basic infection-control measures (e.g., thorough and frequent hand-washing).
- Check to be sure children under 5 years old and eligible adults have received their pneumonia shots (pneumonia is the leading cause of flu-related deaths).
- Be sure all your patients in long-term care facilities, as well as their family members, are vaccinated.

# Updates to dispute, appeal and grievance processes

Aetna Better Health of Michigan will be updating our Provider Manual and website to provide clearer understanding and instruction to our providers related to the various dispute/appeal/grievance processes that are available to you. **These updates apply to both our MI HealthLink Duals product and our Medicaid product.** Below is a summary of the updates:

**Claim reconsiderations:** Aetna Better Health of Michigan will **require** providers to use the new PAR and non-PAR forms on our website starting Aug. 1, 2019.

| Reconsideration type | Who uses it | Where to send it | Where to find it | Other required info |
|---|---|---|---|---|
| **Dispute** | Contracted (PAR) providers | Aetna Better Health of MI<br>P.O. Box 66215<br>Phoenix, AZ 85082 | • (Paper form) on website under the "For Providers" section of our site, under the banner "Forms." Click "PAR Provider Dispute Form."<br>• (Provider Portal) User guide available on website. | • (Paper) requirements as outlined on the form.<br>• (Online) complete all fields of information and attach supporting documentation. |
| **Appeal** | Non-contracted (Non-PAR) providers | Aetna Better Health of MI<br>1333 Gratiot, Suite 400<br>Detroit, MI 48207 | • (Paper form) on the website under "For Providers," and under the "Forms" banner. Click "non-PAR Provider Appeals Form." | • For denied claims only, appeal must be submitted with a completed Waiver of Liability form available at same website location. |

## Pre-service authorization member appeals

- **On or before Aug. 1, 2019,** our provider manual will be refreshed to include more information related to this type of pre-claim appeal to help providers better distinguish between the type of member appeal, which can be filed by a provider on a member's behalf, and a claims appeal, which is for non-PAR providers to have a claim reconsidered. Note: Details on what to submit on behalf of a member for a pre-service authorization member appeal is articulated in the authorization denial letter that is sent out by our Utilization Management (UM) staff after the decision is made to deny the claim.

## Provider grievances

- **On or before Aug. 1, 2019,** our provider manual will be refreshed to include updated language related to a provider grievance to help distinguish when this process is used. In general, a provider grievance is used when a provider has a concern related to an overall policy or procedure, unlike a provider dispute or appeal, which are specific to a claim reconsideration.

We hope these reminders and updates allow you and your staff to better navigate the resources that are available. Our goal is to ensure your needs are being addressed appropriately and in a timely fashion. Should you have any questions, please contact us at **1-866-314-3784**.

## 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 (CMS) 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 Attestation page of **aetna.com**. Once on the page, click "See Our Medicare Compliance FDR Program Guide" or "See Our Office Manual" under "Need More Information on the Medicare FDR Program?"

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 Attestation page that corresponds to your contracting status. A single annual attestation meets all your Aetna, Coventry and/or MMP compliance obligations.

## Which medicines help with ADHD?

Every child is unique. And so is every treatment plan for kids with attention-deficit/hyperactivity disorder (ADHD).

But most children take prescribed medications for their ADHD. This helps ease their symptoms so that they can just be regular kids who play and learn.

Medicines for ADHD include:

**Stimulants.** Up to 8 in 10 kids do much better when they take a stimulant — the most common type of ADHD medicine. They don't really stimulate kids though. Rather, they help kids control their behaviors and pay attention. Short-acting stimulants may be taken every four hours. Other types can be taken just once in the morning since they work for several hours.

**Non-stimulant medicines.** Other medicines may be considered if stimulants don't work or cause too many side effects. These other meds can include atomoxetine and guanfacine.

Here are a few more things to know about medicine for ADHD:

- Patients will need checkups. Check to make sure the medicine is working for your patient.
- You may need to adjust the dose or have your patient try another medicine.
- Side effects are usually mild. For instance, some kids have poor appetites or sleep problems.

And take note — adults can have ADHD too. Talk to your patients about ADHD.

*Sources: American Academy of Pediatrics; National Resource Center on ADHD*

## Community Health Automated Processing System (CHAMPS) enrollment

All providers who serve Michigan Medicaid beneficiaries are required to be screened and enrolled in the Community Health Automated Processing System (CHAMPS).

For dates of service on or after Jan. 1, 2019, Michigan Department of Health and Human Services (MDHHS) will prohibit contracted Medicaid health plans and dental health plans from making payments to typical providers not actively enrolled in CHAMPS.

### CHAMPS prescribers

For dates of service on or after July 1, 2019, MDHHS will prohibit Medicaid fee-for-service and Medicaid health plan payment for prescription drug claims written by a prescriber who is not enrolled in CHAMPS.

# Dental benefits for Aetna Better Health members

The State of Michigan Medicaid program is currently the carrier for dental services. Please contact the State of Michigan for further information regarding dental benefits for Aetna Better Health of Michigan and Michigan Medicaid members.

### Medicaid members:

- Benefits are covered through the state — call **1-800-642-3195**.
- Members will use the Green MI Health Card for services.
- Members will need to contact dental providers in the area that accept Medicaid.

### Healthy Michigan plan members, ages 19 to 64:

- Benefits are covered through DentaQuest Dental.
- Members call: **1-844-870-3976**.
- Providers call: **1-844-870-3977**.
- Dental ID card will be required for dental services.
- There is a copayment of $3 per visit.

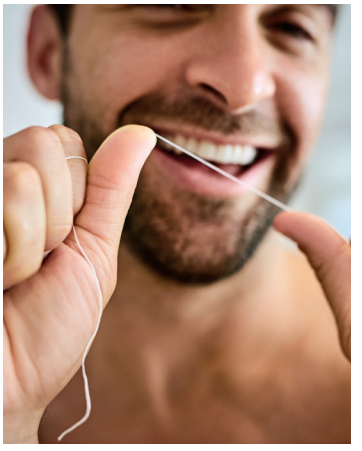
Benefits include:

- Cleaning and exam every six months

### Pregnant women dental benefit

Effective July 1, 2018, members who are or become pregnant are able to access dental services during their pregnancy and postpartum period directly through their Medicaid Health Plan. Pregnant members will be able to see dentists that are contracted as part of the Aetna Better Health network. Members may also receive transportation to and from scheduled dental appointments.

To receive dental services, the member must notify Aetna Better Health of their pregnancy and due date by calling Member Services at **1-866-316-3784**. Members should also notify their caseworker of their pregnancy and due date.



# 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, find out what services require authorization or 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: 3 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.

## Health Risk Assessments

Aetna Better Health of Michigan is looking for your Health Risk Assessments (HRA).

HRAs completed within 150 days of the member's enrollment date are eligible to receive the provider incentive of $50. For each completed and returned HRA, you have the opportunity to earn the incentive for up to one year of the member's enrollment anniversary date.

Please fax all completed HRAs to Healthy Michigan department at **1-866-889-7572**. Submit claims under CPT code 96160.

- Lab results are not mandatory. However, "Screening not recommended" or "Screening ordered" must be checked for cholesterol, diabetes, and flu sections on HRAs prior to April 2018.

If you have any questions, please contact the Healthy Michigan hotline at: **1-866-782-8507**.

Thank you for your ongoing care of our members.

## Where to find clinical practice guidelines

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., U.S. Preventive Services Task Force and 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 I or type II 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
- 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*

## Aunt Bertha: A resource for your patients

Do you have a patient who requires assistance beyond medical care? Are social issues impacting your patient's health? A list of available resources by ZIP code can be found on the Aetna Better Health of Michigan website under the tab "Resources/Services for Aunt Bertha."

There you can search for local resources for a wide range of issues, including: food, housing, goods, transit, health, money, care, education, work and legal assistance. For example, if you have a pregnant patient who could benefit from parenting education, counseling, food delivery or baby supplies, a search will provide the available programs. You can make a referral by phoning the listed number to schedule an appointment for your patient. Check out this site the next time you identify social issues impacting your patient's health.

## Member Rights and Responsibilities

We work with our members to make sure they receive the best care available. They have certain rights and responsibilities. These help them receive the best service.

Members of Aetna Better Health of Michigan have the right to:

- Get information about their health, their primary care provider (PCP), our providers, Aetna Better Health and its services, and members' rights and responsibilities
- Request information on the plan's structure, operations and services
- Be treated with respect and dignity
- Be assured their personal information is kept private and confidential
- Seek advice and help
- Discuss all treatment options for their condition, regardless of cost or benefit coverage
- Voice grievances, complaints, appeals, and offer suggestions about Aetna Better Health and/or the services we provide
- Make recommendations about our members' rights and responsibilities policy
- Choose a PCP as their personal medical provider
- Work with doctors in making decisions about their health
- Know about diagnosis, treatment and prognosis
- Get prompt and proper treatment for physical and emotional problems
- Receive discharge planning
- Receive guidance and suggestions for more medical care if health care coverage is ended
- Access their medical records in accordance with state and federal law
- Get information about how their PCP is paid (further information available through Member Services at **1-866-316-3784**)
- Request an emergency PCP transfer if their health or safety is threatened
- Receive culturally and language appropriate services
- Request and get a copy of their medical records and request for records to be amended or corrected
- Participate in decisions regarding their health care, including the right to refuse treatment and express their desires about treatment options
- Be free to exercise their rights without adversely affecting the way Aetna Better Health and its providers or the state treats them
- Be free from any form of restraint or seclusion used as a means of force, discipline, convenience or retaliation
- Be provided health care services consistent with the contract and state and federal regulations
- Be free from other discrimination prohibited by state and federal regulations

Members of Aetna Better Health of Michigan also have responsibilities.

These responsibilities include:

- Giving information to the plan, its practitioners and providers needed for our staff to take care of the member
- Following the instructions given to the member by doctors
- Understanding their health condition and sharing in the decisions for their health care
- Treating Aetna Better Health staff and doctors with respect and dignity
- Keeping all appointments and calling to cancel them when unable to make them
- Understanding what medicine to take
- Giving us feedback about their health rights and responsibilities
- Letting us know of any changes in member's name, address or telephone number

# 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/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.

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.

People 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 person 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).

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.



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