Provider Newsletter

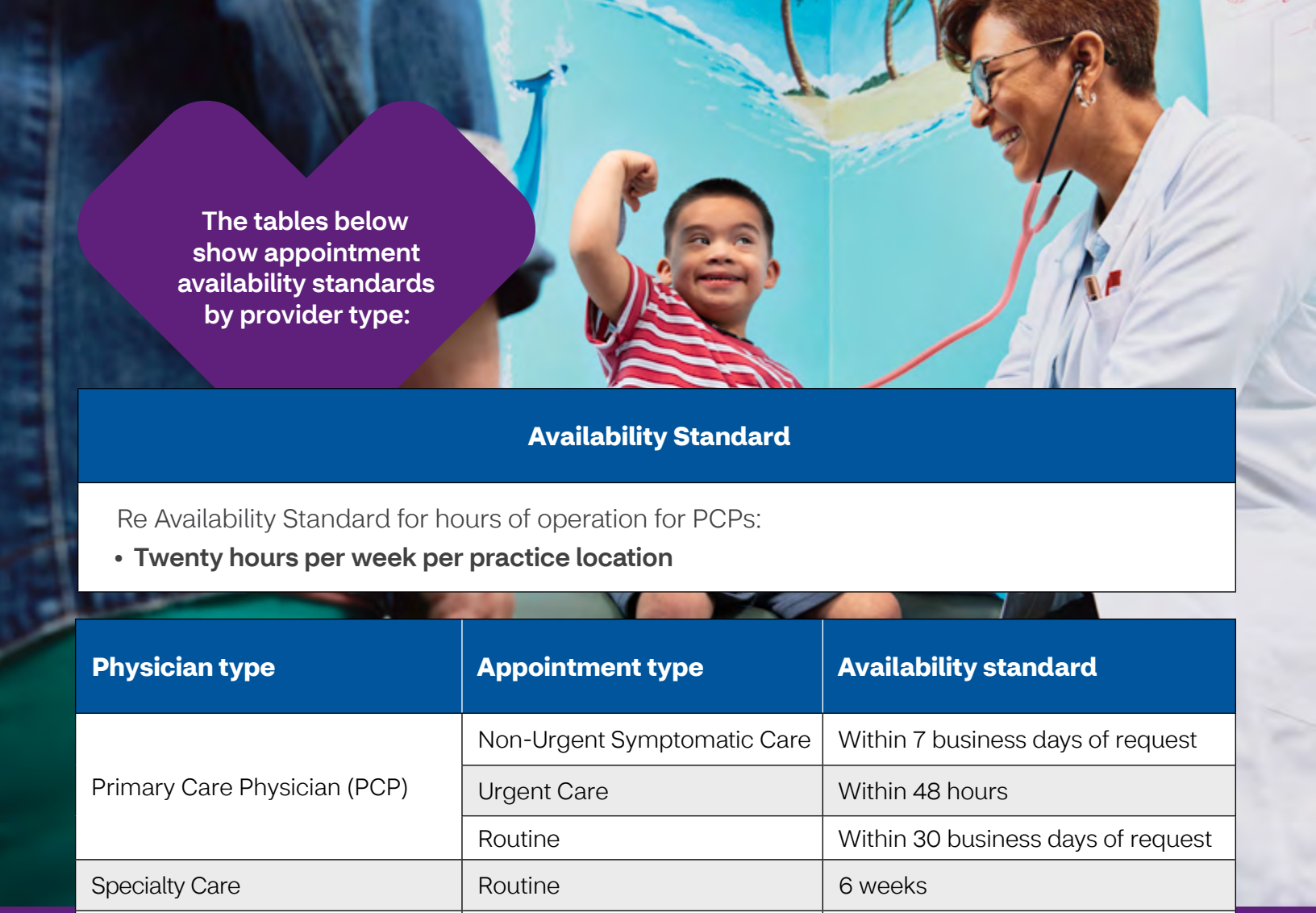
Fall/Winter 2024-2025

Contents

Access and Availability Standards

Our providers must schedule appointments for our members following minimum appointment availability standards and based on the severity of the presenting condition, in conjunction with the member's past and current medical history. Our Provider Experience Department will routinely monitor provider compliance with minimum appointment availability standards and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from those providers not meeting accessibility standards.

Providers are contractually required to adhere to the Michigan Department of Health and Human Services (MDHHS) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of the need for the services.



The tables below show appointment availability standards by provider type:

Availability Standard
Re Availability Standard for hours of operation for PCPs: • **Twenty hours per week per practice location**

Physician type	Appointment type	Availability standard
Primary Care Physician (PCP)	Non-Urgent Symptomatic Care	Within 7 business days of request
	Urgent Care	Within 48 hours
	Routine	Within 30 business days of request
Specialty Care	Routine	6 weeks
Acute Specialty Care	Routine	5 business days
Mental Health	Non-Life-Threatening Emergency	Within six (6) hours
	Urgent Care	Within 48 hours
	Routine Care	Within ten (10) business days
Prenatal	First (1st) Trimester	Within 7 business days of enrollee being identified as pregnant.
	Initial Second (2nd) Trimester	Within 7 business days of enrollee being identified as pregnant.
	High Risk/Initial Visit Third (3rd) Trimester	Three (3) business days from the date of referral
Dental	Initial Appointment	Within 8 weeks of Request
	Routine Care	Within 21 business days of request
	Preventive Services	Within 6 weeks of request
	Urgent Care	Within 48 hours
	Emergency	24 hours/day seven days per week

Fraud, waste and abuse

Know the signs — and how to report an incident

Health care fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person.

Abuse means provider practices are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Healthcare program 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 duty to report suspected fraud, waste and abuse.

Penalties

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

1. Criminal fines up to $250,000
2. Prison for up to 20 years
3. 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.

Doulas are a covered Medicaid benefit

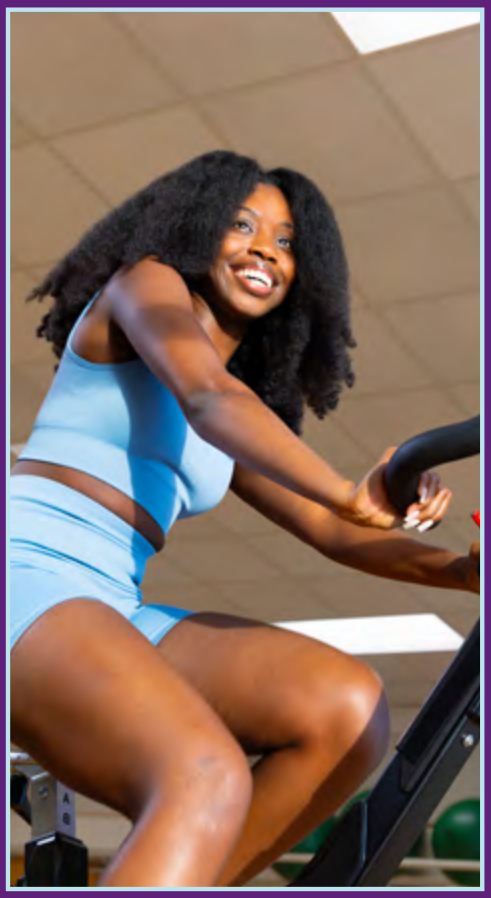
If you support a pregnant member, please be sure to shareinformation on doula services. We cover different types of doula services, including community-based doulas, prenatal doulas, labor and birth doulas, and postpartum doulas.

For a full list of covered services please see MDHHS Policy Bulletin: MMP 22-47.

A doula is a trained birth professional who helps families have safe, healthy and positive birth experiences. Doulas provide non-clinical emotional, physical, and informational support to pregnant people and their families before, during, and after birth.

Doula services have been shown to positively impact the social determinants of health, support birth equity, and decrease existing health and racial disparities. With your support, we can work to reduce infant and maternal mortality and birth inequities. You can also refer members to Mae, a digital health platform that can assist in matching members with a doula specializing in culturally specific pregnancy care.

For more information on Doulas, just go to **AetnaBetterHealth.com/Michigan/Find-Provider** and scroll to middle of the page and look for "**Doula**."



Active and Fit benefit

The new year is here! It's a great time to set new health goals and create plans to achieve them. If you are caring for one of our members, please remind them of their access to the Active&Fit Enterprise™ program. With the Active&Fit Enterprise program, members can enjoy:

- Membership at a participating fitness center
- Workout plans to help start an exercise routine
- A variety of on-demand workout videos on the website
- The Active&Fit Connected!™ tool for tracking activity

Members can either go to **ActiveAndFit.com** or call **1-866-316-3784** to learn more. The Active&Fit Enterprise program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit Enterprise and Active&Fit Connected! are trademarks of ASH and used with permission herein. Fitness center participation may vary by location and is subject to change.

Dental Coverage

Dental benefits for adult Medicaid beneficiaries were expanded and redesigned in the spring of 2023. We are asking all providers to remind our members to ensure they know about the benefit and the importance of oral health and how it directly impacts overall wellbeing. The following services are covered:

- X-rays
- Teeth cleanings
- Fillings
- Extractions
- Dentures

Members can call our member services line at **1-866-316-3784** to be connected with a dental provider.

Claims and claims submission

Filing a claim:

- First, you'll need to fill out a claim form.
- New claims must be filed within 365 days from the date you provide services, unless there's a contractual exception. For hospital inpatient claims, the date of service refers to the date that the member was discharged.

Some timeframes to note:

- Medicaid: You have 180 days from the paid date to resubmit a revised version of a processed claim.
- Medicare-Medicaid (Aetna Better Health Premier Plan): You have one year from the date of service or discharge to resubmit a revised version of a processed claim.

Online

Availity is our provider portal, which provides functionally for the management of patients, claims, authorizations and referrals. To submit claims online via Availity, choose the button labeled "Medicaid Claim Submission- Office Ally." This link will take you directly to the Office Ally website where you can submit claims using their online claim entry feature or by uploading a claim file.

Providers must have an Office Ally account to submit claims online. Submission of your ABH claims using Office Ally is free of charge. The status of claims submitted online should be managed through your Office Ally Account.

By mail

Hard copy: Medicaid: Aetna Better Health of Michigan, Po Box 982863 El Paso, TX 79998-2963

Claim reconsideration

You can submit a claim reconsideration through Availity or by mail. If you submit by mail, you'll need to include these documents.

- Claim reconsideration and dispute form
- An updated copy of claim –all lines must be rebilled.
- A copy of the original claim (reprint or copy is acceptable)
- A copy of the remittance advise on which we denied or incorrectly paid the claim.
- A brief note describing the requested correction
- Any other required documents

*Mark resubmitted claims clearly with "resubmission" to avoid denial as a duplicate.

Echo Health

Echo Health processes and distributes Sooner Select claims payments to providers. To enroll in EERS, visit the **Aetna Better Health Echo portal**.

Sign up for EFT:

To sign up you'll need to provide an ECHO payment draft number and payment amount for security reasons as part of the enrollment authentication. Find the ECHO draft number on all provider Explanation of Provider Payments (EPP), typically above your first claim on the EPP. Haven't received a payment from ECHO before ? You'll receive a paper check with a draft number you can use to register after receiving your first payment.

You can also update your preferences on the dedicated **Aetna Better Health Echo portal**.

Fees apply when you choose to enroll in ECHO's ACH all payer program. Be sure to use the portal for no fee processing. You can confirm you're on our portal when you see "Aetna Better Health" at the top left of the page.

There could be a 48-hour delay between the time you receive a payment, and an ERA is available.

If you need assistance, contact ECHO Health **atallpayer@echohealthinc.com** or **1-888-834-3511**.

Claim submission resources

Claim submission assistance/links

Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary. How to fill out a CMS 1500 Form: **CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf**

Sample CMS 1500 Form: **CMS.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms1500805.pdf**

How to fill out a CMS UB-04/1450 Form: **CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf**

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 when the period covered by the original authorization has not expired, and the Member files for continuation of benefits, on or before the later of the following:

1. Within 10 Days of the Contractor's mailing the Adverse Benefit determination notice

2. The effective date of the proposed Adverse Benefit determination notice. 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. **See PDF Table for Reconsiderations vs. appeals**.

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.

See PDF table for Process definitions and determinations time frames.

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.

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."*

Improving mental health outcomes with Pyx Health

Aetna Better Health is excited to introduce a new behavioral health resource for our members. Pyx Health is a platform that is focused on reducing loneliness through member engagement and social determinants of health (SDOH) screening tools for our most vulnerable members. There are two main components to the digital Pyx Health platform.

The first component is a mobile app. The app has a chatbot personality that builds a trusted and loyal relationship with the end users. The chatbot is compassionate, full of humor and companionship, and focuses on self-management for the end users.

The mobile platform can screen members for loneliness, depression, anxiety, SDOH, health risk assessment questions, and additional screenings. Pyx Health can push SDOH resources to members and connect them with Aetna Better Health's 24/7 Nurse Line. The menu offering within the tool also can link to other online resources, including our member portal, our provider directory, the suicide hotline, and more.

The next component is a compassionate call center. Non-clinical Pyx Health employees call and onboard members to the platform over the phone. They can also make outbound companionship calls when members have low sentiment scores, where they reach out within one business day to follow up on an urgent SDOH need.

Increase your efficiency with Availity

Have you joined our Provider Portal, Availity? With Availity, you will be more easily able to support your patients, our members.

Some areas of increased functionality include:

- Appeals and grievance submissions.
- Prior authorization submission and status lookup.
- Claims submissions and status inquiry.
- Panel roster lookup.

More importantly, Aetna Better Health of Michigan will continue implementing new and improved functions throughout the year.

If you are already registered in Availity, you will simply select Aetna Better Health from your list of payers to begin accessing the portal and all of the above features.

If you are not registered, we recommend that you do so immediately.

Click here to learn more about **Availity Portal Registration**.

Go here to register

Need help? For registration assistance, call Availity Client Services at **1-800-282-4548** between 8 AM and 8 PM ET, Monday through Friday.