aetna®

Aetna Better Health® of Michigan

Healthy smiles

Provider Newsletter Fall 2018

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. Children through age 20 access dental services through Healthy Kids Dental Coverage. Call **1-800-482-8915** to find a Healthy Kids Dental provider in your area.

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 is 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 can access dental services during their pregnancy and postpartum period directly through their Medicaid Health Plan. Pregnant members can 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 **1-866-314-3784**. Members should also notify their case worker of their pregnancy and due date.

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

Standard
U.S. Postage
PAID
Walla Walla, WA
Permit No. 44

How we make coverage decisions

When making coverage decisions, Aetna Better Health of Michigan follows the health care rules of Milliman Care 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.

Common Formulary

The Michigan Department of Health and Human Services has worked with its health plan partners to create a list of drugs that all Medicaid health plans must cover. This list is called the Michigan Medicaid Managed Care Common Formulary.

Effective June 1, 2016, due to Common Formulary implementation throughout the state of Michigan, Aetna Better Health of Michigan has made some changes to our drug formulary. These changes support our commitment to high-quality, cost-effective health care.

Information relating to the Common Formulary can be found by visiting the department's website at **aetnabetterhealth.com/michigan/providers/medicaid/pharmacy**. Information about the Aetna Better Health of Michigan changes to the formulary that we made to meet Michigan Medicaid Managed Care Common Formulary requirements can be found by visiting **aetnabetterhealth.com/michigan/providers/medicaid/pharmacy**.

Members who have been affected by these changes have been notified and provided a temporary supply to assist transition to a formulary agent.

Updates to our Pharmacy Formulary are posted on our website. Please check our website for Pharmacy Formulary updates frequently.

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 1 or Type 2 diabetes. MQIC also has guidelines for several other conditions, including:

- Asthma
- Attention-deficit/ hyperactivity disorder (ADHD)
- Back pain
- Depression
- Diabetes
- 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***

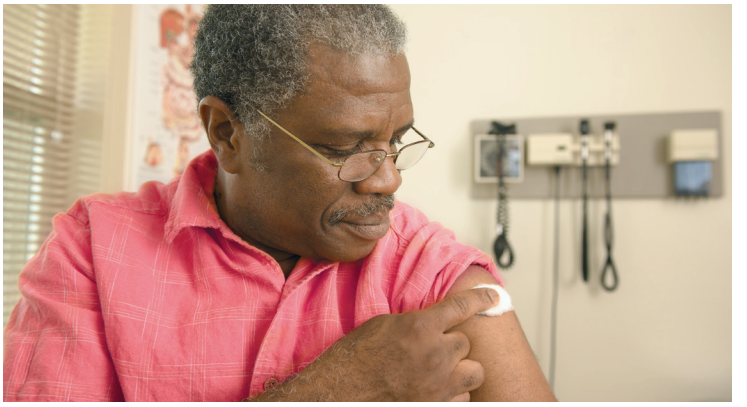
[2]Michigan Quality Improvement Consortium. (2017). MQIC Guidelines. Retrieved Nov. 15, 2017, from Michigan Quality Improvement Consortium: ***mqic.com/guidelines.htm***

Medical records review

All participating primary care practitioners (PCPs), defined as family practice, general or internal medicine, OB/GYN and pediatrics, who provide medical care in ambulatory settings must comply with the Health Plan's Medical Record Documentation standards. The following standards are required:

Medical Record Documentation

1. Past medical history is completed (for members seen three or more times) and is easily identified. It includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
2. History and Physical (H&P) documents have subjective/objective information for presenting problem.
3. For members 14 years and older, there is appropriate notation about cigarettes, alcohol and substance use. (For members seen three or more times, ask about substance abuse history.)



4. Note about follow-up care, calls and visits. Specific time of return is noted in weeks, months or as needed.
5. An immunization record has been initiated for children and history for adults.
6. Preventive screenings and services are offered according to preventive services guidelines.
7. Documentation about advance directives (whether executed or not) is in a prominent place in the member's record (except for under age 18).
8. Treatment plan is documented.
9. Working diagnoses are consistent with findings.
10. Evidence that the member is not at inappropriate risk relevant to particular treatment.
11. Blood pressure, weight, BMI percentile and height measured/recorded at least annually, if member accesses care.
12. Lab and other studies are ordered, as appropriate.
13. Evidence that physician has reviewed lab, X-ray or biopsy results (signed or initialed reports and the member has been notified of results before filing record).
14. Documentation of communications/contact with referred specialist and discharge summaries from hospitals.

The Quality Management (QM) department will audit PCP clinics for compliance with the documentation standards. Written notification of aggregated review results are provided to physician offices after the Medical Record audit has been completed.

The Health Plan will provide routine education to practitioners and their respective clinics. This may include, but is not limited to, articles in our provider newsletter on the medical record review (MRR) process, highlights of low compliance, adaptation of any universal forms by Aetna Better Health of Michigan and updates of any changes within the process and standards. Tools utilized to implement and maintain education may include emails, fax alerts, provider website, provider handbook, provider newsletters and mailings.

Providers understand and agree that members shall not be required to reimburse them for expenses related to providing copies of patient records or documents to any local, state or federal agency (i) pursuant to a request from any local, state or federal agency (including, without limitation, the Centers for Medicare and Medicaid Services [CMS]) or such agencies' subcontractors; (ii) pursuant to administration of Quality Management, Utilization Review and Risk Management programs, including the collection of HEDIS data; or (iii) in order to assist Aetna in making a determination regarding whether a service is a covered service for

which payment is due hereunder.

All records, books and papers of providers pertaining to members, including without limitation records, books and papers relating to professional and ancillary care provided to members and financial, accounting and administrative records, books and papers, shall be open for inspection and copying by Aetna, its designee and/or authorized state or federal authorities during provider's normal business hours. Provider further agrees that it shall release a member's medical records to Aetna upon provider's receipt of a member consent form or as otherwise required by law. Provider acknowledges that member has provided consent to release such records to Aetna when member enrolls in a Product.

In addition, provider shall allow Aetna to audit provider's records for payment and claims review purposes. Provider further agrees to maintain all such members' records for services rendered for a period of time in compliance with state and federal laws.

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.

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 Program Guide” or “See Our Office Manual” under “Need More Information.”

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.

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 January 1, 2019, the 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.

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.

Provider Dispute Form

The Participating Provider Dispute Form mailing address has been updated. Please make sure to use the updated form.

Participating Provider Dispute Form
AETNA BETTER HEALTH® OF MICHIGAN
(Aetna Better Health of Michigan Premier Plan)

Mail:

Aetna Better Health of Michigan
(Aetna Better Health of Michigan Premier Plan)
Attention: Provider Dispute/Reconsiderations
P.O. Box 66215
Phoenix, AZ 85082-6215

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 our members to better understand their conditions, update them with new information and provide them with assistance from our staff to help them manage their disease.

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.

Health Risk Assessments

Aetna Better Health of Michigan is looking for your Health Risk Assessments (HRAs) for Healthy MI members.

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** and submit claims under CPT code **96160**.

Lab results are not mandatory. However, screenings not recommended or screenings 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.

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**.

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.

Access to our clinical staff

If you need access to a nurse during normal business hours, 8 a.m. to 5 p.m., 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**.

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.

MI-18-08-02