AETNA BETTER HEALTH® of Michigan
Policy

Policy Name:	Prior Authorization	Page:	1 of 22
Department:	Medical Management	Policy Number:	7100.05
Subsection:	Prior Authorization	Effective Date:	03/01/2015
Applies to:	■ Michigan Medicaid ■ Michigan Premier Medicare-Medicaid Plan		

PURPOSE:

The purpose of the prior authorization policy is to define Aetna Better Health business standards for prior authorizations.

STATEMENT OF OBJECTIVE:

Objectives of the prior authorization process are to:

- Accurately document all authorization requests
- Verify that a member is eligible to receive services at the time of the request and on each date of service
- Verify that the service is a covered benefit
- Verify contractual requirements with external vendors
- Assist practitioners and providers in providing appropriate, timely, and cost-effective covered services
- Direct members to the appropriate level of care and place of service
- Verify the practitioner's or provider's network participation
- Evaluate and determine medical necessity and/or need for additional supporting documentation
- Collaborate and communicate as appropriate for the coordination of members' care among the medical and other areas, such as:
  - Integrated Care Management
  - Concurrent Review
  - Provider Services
  - Quality Management
  - Prevention and Wellness
  - Member Services
  - Finance
- Facilitate timely claims payment by issuing prior authorization numbers to practitioners or providers for submission with claims for approved services
- Identify high-cost cases for reinsurance notification
- Determine and report whether a requested service is subject to coordination of benefits or third party liability conditions and, if so, advise the practitioner/provider and the appropriate internal contact
- Research a member's authorization history before approving services to avoid:
  - Duplicating services the member is already receiving
  - Authorizing services that are not in the member's benefit plan

  - Duplicating authorizations already documented in the system
- Not issue arbitrary denial or reductions in the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member
- Determine that services are sufficient in an amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished and are no less than the amount, duration or scope for the same services furnished to members under the Medicaid State Plan
- Place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization management (with the exception of Early and Periodic Screening, Diagnosis and Treatment [EPSDT services]), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.

DEFINITIONS:

Administrative Denial	Denial of request for coverage of services or supplies that are not covered based on a contractual or benefit exclusion, limitation or exhaustion and do not require a clinician to interpret the contractual limitation or apply clinical judgment to the limitation.
Aetna Clinical Policy Bulletins (CPBs)	Aetna CPBs state Aetna's policy regarding the experimental and investigational status and medical necessity of new or evolving use of medical technologies (i.e., drugs, devices, medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided) technologies and other services for the purposes of making coverage decisions under Aetna administered health benefit plans. Aetna CPBs are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of health care practitioners/providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies. Aetna CPBs are available on Aetna.com http://www.aetna.com/healthcare-professionals/policies-guidelines/clinical_policy_bulletins.html

Aetna Clinical Policy Council	Evaluates the safety, effectiveness and appropriateness of medical technologies (i.e., drugs, devices, medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided) that are covered under Aetna medical plans, or that may be eligible for coverage under Aetna medical plans. In making this determination, the Clinical Policy Council will review and evaluate evidence in the peer-reviewed published medical literature, information from the U.S. Food and Drug Administration and other Federal public health agencies, evidence-based guidelines from national medical professional organizations, and evidence-based evaluations by consensus panels and technology evaluation bodies.
Aetna Clinical Policy Review Unit	This is the Aetna policy and procedure unit that reviews and updates Aetna CPBs.
American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition	The ASAM Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed. Carson City, NV: The Change Companies®; 2013.
Child and Adolescent Service Intensity Instrument (CASII)	Developed by the American Academy of Child and Adolescent Psychiatry (AACAP)'s Work Group on Community Systems of Care and is a tool to determine the appropriate level of care placement for a child or adolescent.
Concurrent Review	A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Concurrent reviews are typically associated with inpatient care, residential behavioral care, intensive outpatient behavioral health care and ongoing ambulatory care.
Denial, Reduction, or Termination of Financial Responsibility	The non-authorization of care or service at the level requested based on either medical appropriateness or benefit coverage. Partial approvals (modifications) and decisions to discontinue authorization when the practitioner or member does not agree are also denials.

Level Of Care Utilization System (LOCUS)©	A nationally recognized clinical guideline for making decisions regarding medical necessity of behavioral health treatment. LOCUS was developed for adults by the American Association of Community Psychiatrists (AACP).
MCG®	MCG, including Chronic Care Guidelines, are evidence-based clinical guidelines that are updated annually. They support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives.
Medical Necessity Determination	A decision about coverage for a requested service based on whether the service is clinically appropriate and/or needed, based on a member's circumstances. NCQA requires a medical necessity review and appropriate practitioner review of “experimental” or investigational” requests, unless the requested services or procedures are specifically excluded from the benefits plan.
Medically Necessary	A service, supply or medicine that is appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition. Such services are: • Provided for the diagnosis or direct care and treatment of the medical condition; • Meet national clinical standards and the standards of good medical practice within the medical community in the service area; • Not primarily for the convenience of the plan member, caregiver or a plan provider; and • The most appropriate level or supply of service which can safely be provided.
Notice of Action (NOA)	Written notification of decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, specific to the member’s clinical condition, utilizing language that is easily understood by the member and provider. The notification will include a reference to the criterion, rationale for the decision and member appeal rights.

Peer-to-Peer Consultation	A discussion between a requesting practitioner and a practitioner reviewer concerning a utilization issue. A peer-to-peer consultation may address a potential request for services, requests under review, ongoing patient care, a denial or reduction in service.
Post-Service Decision	Any review for care or services that have already been received (i.e., retrospective review).
Post-Stabilization Care Services	Post-stabilization care services are covered services that are: • Related to an emergency medical condition • Provided after a member is stabilized, and • Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member's condition
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
Pre-Service Decision	Any case or service that Aetna Better Health must approve, in whole or in part, in advance of the member obtaining medical care or services. Prior authorization is a pre-service or prospective decision.
Prior Authorization	Prior assessment that proposed services (such as hospitalization) are appropriate for a particular patient and will be covered by an organization. Payment for services depends on whether the patient and the category of service are covered by the member's benefit plan.
Provider	An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility. For Long Term Services And Supports (LTSS) programs, this includes home and community services such as personal care service agencies, home delivered meal providers, and personal emergency response systems.
Urgent Request	A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, ***or*** • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

LEGAL/CONTRACT REFERENCE:

The prior authorization process is governed by:

- MDHHS Contract Applicable federal and state laws, regulations and directives, including the confidentiality of member information (e.g., Health Insurance Portability and Accountability Act [HIPAA])
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans: 2016
- Policy 7000.30 Process for Approving and Applying Medical Necessity Criteria

FOCUS/DISPOSITION:

Participating practitioners and providers must obtain prior authorization from Aetna Better Health before providing those outpatient clinical services or procedures, non-emergent or elective hospitalizations, or facility placement (e.g., nursing facility [NF]), which require prior authorization. In addition, participating practitioners making referrals to non-participating providers may require prior authorization. Any variance from Aetna Better Health's prior authorization policies and procedures may result in denial or delay of reimbursement. Medicaid members may not be billed directly for covered, non-authorized services provided. Dual eligible members who receive a service or item from a contracted plan provider without prior authorization will be held harmless and need not pay more than the plan-allowed cost-sharing (e.g., coinsurance, copays and deductibles). The member will be held harmless independent of whether the service is a covered benefit.1 Plan sponsors may not offer post-enrollment promotional items that in any way compensate members based on their utilization[2]

Emergency Services

Medical services for the treatment of an emergency condition are permitted to be delivered in or out of network without obtaining prior authorization. Aetna Better Health requires coverage of emergency services in the following situations:[3]

- To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency condition existed.

[1] Medicare Chapter 4: 170
[2] 70 Promotional Activities, Events, and Outreach Chapter 3, Page 64
[3] NCQA HP 2016 UM11 A1-2

- If an authorized representative, acting for the organization, authorized the provision of emergency services.

Aetna Better Health will not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Payment will not be withheld from practitioners/providers in or out of network. However, notification is encouraged for appropriate coordination of care and discharge planning. The notification will be documented by the Prior Authorization department or concurrent review clinician.

Post-stabilization Services

Aetna Better Health will cover post-stabilization services under the following circumstances, without prior authorization, whether or not the services are provided by an Aetna Better Health network provider if:

- The post-stabilization services were approved by Aetna Better Health
- The practitioner/provider requested prior approval for the post-stabilization services, but Aetna Better Health did not respond within one (1) hour of the request
- The practitioner/provider could not reach Aetna Better Health to request prior approval for the services
- The Aetna Better Health representative and the treating practitioner could not reach an agreement concerning the member's care, and a Aetna Better Health medical director was not available for consultation

  Note: In such cases, the treating practitioner must be allowed an opportunity to consult with an Aetna Better Health medical director; therefore, the treating practitioner may continue with the member's care until a medical director is reached or any of the following criteria are met:

  - A Aetna Better Health physician with privileges at the treating hospital assumes responsibility for the member's care
  - A Aetna Better Health physician assumes responsibility for the member's care through transfer
  - Aetna Better Health and the treating physician reach an agreement concerning the member's care or
  - The member is discharged

Services Requiring Authorization

The Aetna Better Health Provider Manual, and, if applicable, the Aetna Better Health website lists the services that require prior authorization, consistent with Aetna Better Health's policies and governing regulations. The list is updated at least annually and revised periodically as appropriate. It is available to members, practitioners, providers, and internal staff either in the Member Handbook, Provider Manual, on the website, or by request from the Provider Services or Member Services departments.

Exceptions to Service Authorizations

The following services do not require authorization, whether furnished by a network or non-network provider or practitioner:

- Family planning services
- Well-woman services

Aetna Better Health Responsibility[4]

The chief medical officer (CMO) is responsible for directing and overseeing the Aetna Better Health prior authorization function. The Prior Authorization department is principally responsible for carrying out the day-to-day operations (e.g., evaluating requests, documenting requests and decisions, and issuing authorization numbers for approved requests) under the supervision of a medical director or designated licensed clinical professional qualified by training, experience and certification/licensure to conduct the utilization management (UM) functions in accordance with state and federal regulations. Other departments approved by the CMO (such as Care Management and Concurrent Review) may issue authorizations for specific services within their areas of responsibility per contractual requirements. Departments with authority to authorize services will maintain a postal address, direct telephone, fax number, or electronic interchange (if available) for receiving and responding to notifications and service authorization requests. Only a health care professional may make determinations regarding the medical necessity of health care services during the course of utilization review.

When initiating or returning calls regarding UM issues, Aetna Better Health requires UM staff to identify themselves by name, title, and organization name;[5] and upon request, verbally inform

[4] NCQA HP 2016 UM4 A1-2
[5] NCQA HP 2016 UM3 A3

member, facility personnel, the attending physician and other ordering practitioners/providers of specific UM requirements and procedures. [6]Aetna Better Health must triage incoming standard and expedited requests for services based upon the need for urgency due to the member's health condition.[7]

Nonclinical staff is responsible for:

- Documenting incoming prior authorization requests and screening for member's enrollment, member eligibility, and practitioner/provider affiliation
- Forwarding to clinical reviewers any requests that require a medical necessity review

Clinical reviewer's responsibilities include:

- Identifying service requests that may potentially be denied or reduced on the basis of medical necessity
- Forwarding potential denials or reductions to the CMO or designated medical director for review
- If services are to be denied or reduced:
  - Providing written notification of denials/reductions to members
  - Notifying the requesting practitioner/provider and member of the decision to deny, reduce or terminate reimbursement within the applicable time frame (see the table Decision/Notification Requirements, below)
  - Documenting, or informing data entry staff to document the denial decision in the business application system prior authorization module

Medical Director Reviewer Responsibilities

Authorization requests that do not meet criteria for the requested service, or for which there are no established medical necessity criteria will be presented to a medical director for review. The medical director conducting the review must have clinical expertise in treating the member's condition or disease and be qualified by training, experience and certification/licensure to conduct the prior authorization functions in accordance with state and federal regulations. The medical director will review the service request, the member's need, and the clinical information presented. Using the approved criteria and medical director's clinical judgment, a

[7] Medicare Chapter 13 Section 50.4
[7] Medicare Chapter 13 Section 50.4

determination is made to approve, deny or reduce the service. Only a medical director can reduce or deny a request for service based on a medical necessity review.[8]

If all applicable medical necessity criteria are not clear enough to make a determination or the requested service is not addressed by the standard criteria, or Aetna CPBs, the medical director may submit a request for a position determination to the Aetna Clinical Policy Review Unit, using the Emerging Technology Review/Medical Review Request form. The Aetna Clinical Policy Review Unit will research literature applicable to the specific request and, when a determination is reached, will respond to the CMO/designated medical director.

When criteria are present but unclear in relation to the situation, the reviewing medical director may contact the requester to discuss the case or may consult with a board-certified physician from an appropriate specialty area before making a determination of medical necessity.[9]

Practitioners/providers are notified in the denial letter (i.e., NOA) that they may request a peer-to-peer consultation to discuss denied or reduced service, non-behavioral or behavioral healthcare, authorizations with the medical director reviewer by calling Aetna Better Health. All medical director discussions and actions, including discussions between medical directors and treating practitioners/providers are to be documented in the Aetna Better Health authorization system.[10]

Practitioner and Provider Requirements

Generally, a member's primary care practitioner (PCP), or treating practitioner/provider is responsible for initiating and coordinating a request for authorization. However, specialists and other practitioners/providers may need to contact the Prior Authorization department directly to obtain or confirm a prior authorization.

The requesting practitioner or provider is responsible for complying with Aetna Better Health's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health will not prohibit or otherwise restrict practitioner, acting within the lawful scope of practice, from advising, or

[8] NCQA HP 2016 UM4 A2
[9] NCQA HP 2016 UM4 F1
[10] NCQA HP 2016 UM7 A, UM7 D

advocating on behalf of, an individual who is a patient and member of Aetna Better Health about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.[11]

Information Required for a Review

A prior authorization request must include the following:

- Current, applicable codes may include:
  - Current Procedural Terminology (CPT)
  - International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)
  - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth, and identification number of the member
- PCP or treating practitioner
- Name, address, phone and fax number and signature, if applicable, of the referring practitioner or provider
- Name, address, phone and fax number of the consulting practitioner or provider
- Problem/diagnosis, including the ICD-10
- Reason for the referral
- Presentation of supporting objective clinical information, such as clinical notes, clinical notes, comorbidities, complications, progress of treatment, psychosocial situation, home environment, laboratory and imaging studies, and treatment dates, as applicable for the request [12]

All clinical information must be submitted with the original request.

[11] Medicare Chapter 6: 40
[12] NCQA HP 2016 UM2 A2, UM6 A, UM6 B

Medical Necessity Criteria

To support prior authorization decisions, Aetna Better Health uses 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.[13] Service authorization staff that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to Aetna Better Health policies and procedures.

A listing of medical review criteria as well as the process for review and application of criteria is described in policy *7000.30 Process for Approving and Applying Medical Necessity Criteria*

Criteria for long term services and supports (LTSS) and state plan only services are based on the Michigan program benefits. Authorization for LTSS will be referred to the member's assigned case manager/case management coordinator and approval based on the member's needs as aligned with the LTSS benefits.

Case managers may discuss service requests and plans of care with a plan medical director for guidance or benefit determinations at any time.

Medical, dental, and behavioral health management criteria and practice guidelines are available to practitioners/providers, members, and potential members upon request by contacting a Aetna Better Health medical management representative. Guidelines are distributed by mail, e-mail or fax by Aetna Better Health. Clinical Practice Bulletins CPBs are available through the Aetna website www.Aetna.com.[14]

Administrative Denial

All denials of service requests require a medical director review with the exception of administrative denials. Administrative denials are decisions that result from coverage requests for services that are not covered based on a contractual or benefit exclusion, limitation or exhaustion and do not require a clinician to interpret the contractual limitation or apply clinical judgment to the limitation.[15]

[13] NCQA HP 2016 UM2 A1-3
[14] NCQA HP 2016 UM2 B1-2
[15] NCQA HP 2016 UM4 A2

Examples of administrative denials include:

- The individual is not a member at the time the service or supply is provided
- A limited benefit that is exhausted
- An excluded benefit
- Breach of Contract, e.g., when the Aetna Better Health contract requires notification of an admission within a specified timeframe and no notification is received

Timeliness of Decisions and Notifications to Practitioners, Providers, and/or Members

Aetna Better Health makes prior authorization decisions and notifies practitioners and/or providers and applicable members in a timely manner. Unless otherwise required by Department of Community Health, Medical Services Administration, Aetna Better Health adheres to the following decision/notification time standards. Departments that handle pre-service authorizations must meet the timeliness standards appropriate to the services required.

Decision/Notification Requirements[16,17]

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	Seventy-two (72) hours from receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent pre-service denial	Seventy-two (72) hours from receipt of request	Practitioner/Provider and Member	Oral and Electronic/Written
Non-urgent pre-service approval	Fourteen (14) calendar days from receipt of the request	Practitioner/Provider and Member	Oral or Electronic/Written
Non-urgent pre-service denial	Fourteen (14) calendar days from receipt of the request	Practitioner/Provider and Member	Electronic/Written
Urgent concurrent approval	Twenty-four (24) hours of receipt of request	Practitioner/Provider	Oral or Electronic/Written

[16] Medicare Chapter 13 Section 50.2
[17] NCQA HP 2016 UM5 A-D, UM5 H1-4

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent concurrent denial	Twenty-four (24) hours of receipt of request	Practitioner/Provider	Oral and Electronic/Written
Post-service approval	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider	Oral or Electronic/Written
Post-service denial	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider and Member	Electronic/Written
Termination, Suspension Reduction of Prior Authorization	At least ten (10) calendar days before the date of the action.	Practitioner/Provider and Member	Electronic/Written

Electronic notifications are provided to members and providers via a secure electronic portal. Members and providers who are unable to access the portal are provided with notification orally and/or in writing upon request. Information on how members and providers can access the portal or request alternate notifications is located in both the Member and Provider Handbooks.
If Aetna Better Health approves a request for expedited determination Aetna Better Health must notify the member and the physician involved, as appropriate, of its determination as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receiving the request.[18]

If Aetna Better Health denies a request for an expedited determination, the time for determination will automatically transfer to the standard time frame. Aetna Better Health will promptly provide the member oral notice, notify the denial for an expedited review and include the member's rights. The Aetna Better Health will subsequently deliver to the member, within three (3) calendar days, a written letter of the member's rights.[19]

[18] Medicare Chapter 13 Section 50.4
[19] Medicare Chapter 13 Section 50.3

Members may initiate a coverage or organization determination. When Aetna Better Health staff receives the request, the member is offered a warm-transfer to the prior authorization team for authorization initiation. If the member declines the transfer, the staff will obtain as much information as possible including the name of physician/provider performing or recommending the service. The information is then provided to the prior authorization team for initiation of the authorization. The prior authorization team will obtain any additional clinical information necessary to complete the request**.** Under no circumstances will the member be instructed to contact the provider to initiate or complete the request. All requests for authorization will follow applicable CMS/State turnaround times.[20]

Extension of Decision Times for Non-urgent Pre-service Decisions[21]

The timeframe for non-urgent prior authorization decisions may be extended up to fourteen (14) additional calendar days, if:

- The member or requesting practitioner requests the extension, or
- Aetna Better Health needs the extension to obtain additional information to make the decision and the extension is in the member's best interest

If the request lacks clinical information, the organization may extend the non-urgent pre-service or post-service timeframe up to fifteen (15) calendar days, under the following conditions:

- The organization asks the member (or the member's representative) for the specific information necessary to make the decision within the decision timeframe.
- The organization gives the member (or the member's authorized representative) at least forty-five (45) calendar days to provide the information

The extension period, within which a decision must be made by the organization, begins:

- On the date when the organization receives the member's response (even if not all of the information is provided), or
- At the end of the time period given to the member to supply the information, if no response is received from the member or the member's authorized representative

[20] Part C: 42 CFR Part 422, Subpart M Medicare Managed Care Manual, Chapter 13, Part D: 42 CFR Part 423, Subpart M Medicare Prescription Drug Benefit Manual, Chapter 18, sections 10.3, 20.2
[21] NCQA HP 2016 UM5 A (see Explanation section)

The organization may deny the request if it does not receive the information within the timeframe, and the member may appeal the denial.

The notice must include the specific information needed to make the decision, the time period given to provide the information, and must inform the member of the right to file a grievance if he/ she disagrees with the decision to extend. Aetna Better Health may deny the request if the needed information is not received within the decision timeframe. The member may appeal the denial.
Aetna Better Health must give notice on the date that timeframe expires if the authorization decision has not been reached. Untimely service authorizations constitute a denial and are considered adverse actions.

Extension of Timeframes for Urgent Pre-Service Decisions

The timeframe for urgent prior authorization decisions may be extended once for up to forty-eight (48) hours, or regulatory requirements, if:

- The member or requesting practitioner requests the extension, or
- Aetna Better Health needs the extension to obtain additional information to make the decision and the extension is in the member's best interest

The organization may extend the urgent pre-service timeframe due to a lack of information, once, for forty-eight (48) hours, under the following conditions:

- Within twenty-four (24) hours of receipt of the urgent pre-service request, the organization asks the member (or the member's representative) for the specific information necessary to make the decision
- The organization gives the member at least forty-eight (48) hours to provide the information
- The extension period, within which a decision must be made by the organization, begins:
  - On the date when the organization receives the member's response (even if not all of the information is provided), ***or***
  - At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative

Aetna Better Health must inform the member of the right to file a grievance if he/she disagrees with the decision to extend. Aetna Better Health may deny the request if the needed information is not received within this timeframe. The member may file an appeal.

Aetna Better Health must give notice on the date that timeframes expire if the authorization decision has not been reached. Untimely service authorizations constitute a denial and are considered adverse actions.

Extension of Timeframes for Urgent Concurrent Decisions

The timeframe for making an urgent ongoing care decision may be extended if:

- The request to extend the urgent ongoing care is not made at least twenty-four (24) hours prior to the expiration date of the prescribed period of authorization or number of treatments. Such requests that are received late will be handled as urgent pre-service decisions and the decision will be made within seventy-two (72) hours
- The request to approve additional days is related to care not previously approved by Aetna Better Health documents that it made at least one (1) attempt to obtain needed clinical information within the initial twenty-four (24) hours after the request for coverage of additional days. In this case, the decision must be made within seventy-two (72) hours
- The member voluntarily agrees to extend the decision-making timeframe

If a request to continue ongoing care does not meet the definition of urgent care, the request may be handled as a new request and decided within the timeframe for non-urgent prior authorization requests.

Termination, Suspension, or Reduction of Services

Aetna Better Health is required to give at least ten (10) days' notice before the date of action whenever the action is termination, suspension, or reduction of previously authorized services, except under conditions specified in federal or state regulations.

Prior Authorization Period of Validation

Unless a member's benefit plan, a practitioner or provider's contract or Aetna Better Health requirements specify differently, a prior authorization number is valid for the date of service authorized or for a period not to exceed sixty (60) days after the date of service authorized. The member must be enrolled and eligible on each date of service.

Post Service (Retrospective) Review

When making post-service reviews, Aetna Better Health bases reviews solely on the medical information available to the attending physician or ordering practitioner/provider at the time the

health care services were provided. Post-service determinations are reviewed against the same criteria used for pre-service determinations for the same service. Aetna Better Health communicates decisions to the requesting practitioner/provider and the member, if applicable, within thirty (30) calendar days of receipt of the request.

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, Aetna Better Health will assign a prior authorization number, which refers to and documents the approval. Aetna Better Health sends written documentation of the approval or denial to the out-of-network provider within the timeframes appropriate to the type of request.

Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health makes decisions regarding use of an out-of-network provider on a case-by-case basis in consultation with Aetna Better Health's medical director.

Notice of Action Requirements

Aetna Better Health provides the practitioner/provider and the member with written notification (i.e., NOA) of any non-behavioral or behavioral healthcare decision to deny, reduce, suspend or terminate a service authorization request, limits, or to authorize a service in the amount, duration or scope that is less than requested or denies payment, in whole or part, for a service.

A NOA must be in writing and at a sixth grade reading level or below using language that is easily understood. The notice must include:

- The action that Aetna Better Health has or intends to take and the effective date of that action
- The specific reason for the action, customized to the member circumstances, and in easily understandable language[22]
- A reference to the benefit provision, guideline, or protocol or other similar criterion on which the denial decision was based[23]

[22] NCQA HP 2016 UM7 B1, UM7 E1
[23] NCQA HP 2016 UM7 B2, UM7 E2

- Notification that, upon request, the practitioner or member, if applicable, may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based[24]
- Notification that practitioners have the opportunity to discuss medical and behavioral healthcare UM denial decisions with a physician or other appropriate reviewer[25]
- A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal[26]
- An explanation of the appeals process, including the right to member representation (with the member's permission) and the timeframes for deciding appeals[27]
- A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures
- The right of the member or practitioner/provider (with written permission of the member) to request a Medicaid Fair Hearing and instructions about how to request a Medicaid Fair Hearing
- A description of the expedited appeals process for urgent pre-service or urgent concurrent denials[28]
- Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.
- The circumstances under which expedited resolution is available and how to request it
- The member's right to request continued benefits pending the resolution of the appeal or pending a Medicaid Fair Hearing, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these services
- Translation service information
- The procedures for exercising the rights specified in this section

Monitoring

Monthly the CMO, in conjunction with the director of Medical Management, is responsible for analyzing utilization data, identifying areas of concern in the plan's performance and identifying

[24] NCQA HP 2016 UM7 B3, UM7 E3
[25] NCQA HP 2016 UM7 A, UM7 D
[26] NCQA HP 2016 UM7 C1, UM7 F1
[27] NCQA HP 2016 UM7 C2, UM7 F2
[28] NCQA HP 2016 UM7 C3, UM7 F3

recommendations for action. At a minimum, the CMO presents quarterly summaries of this information to the Quality Management/Utilization Management Committee (QM/UM). The QM/UM committee is responsible to provide feedback to the CMO and approve action plans including adjustments to the Quality Assessment Performance Improvement (QAPI) program.

OPERATING PROTOCOL:

Systems

The business application system has the capacity to electronically store and report all service authorization requests, decisions made by Aetna Better Health regarding the service requests, clinical data to support the decision, and timeframes for notification to practitioners/providers and members of decisions.

Prior authorization requests, decisions and status are documented in the business application system prior authorization module.

Measurement

The Prior Authorization department measures:

- Volume of requests received by telephone, facsimile, mail, and website, respectively
- Service level
- Timeliness of decisions and notifications
- Process performance rates for the following, using established standards:
  - Telephone abandonment rate: under five percent (5%)
  - Average telephone answer time: within thirty (30) seconds
  - Consistency in the use of criteria in the decision making process among Prior Authorization staff measured by annual inter-rater reliability audits
  - Consistency in documentation by department file audits at least quarterly
- Percentage of prior authorization requests approved
- Trend analysis of prior authorization requests approved
- Percentage of prior authorization requests denied
- Trend analysis of prior authorization requests denied

Reporting

- Monthly report to the CMO of the following:
  - Number of incoming calls

  - Call abandonment rate
  - Trend analysis of incoming calls
  - Average telephone answer time
  - Total authorization requests by source – mail, fax, phone, web
  - Number of denials by type (administrative/medical necessity)
- Utilization tracking and trending is reviewed by the CMO on a monthly basis and is reported at a minimum of quarterly to the QM/UM Committee
- Annual report of inter-rater reliability assessment results

INTER-/INTRA-DEPENDENCIES:

Internal

- Claims
- Chief medical officer/medical directors
- Finance
- Information Technology
- Medical Management
- Member Services
- Provider Services
- Quality Management
- Quality Management/Utilization Management Committee

External

- Members
- Practitioners and providers
- Regulatory bodies

Beverly Allen
Chief Executive Officer

Jacqueline R Simmons, MD
Chief Medical Officer

Reviewed and revised: 01/2017