Aetna Better Health® of Michigan
Policy

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 in order to facilitate accurate and timely reimbursement
- 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 and Integrated Long Term Care Management (inclusive of Disease Management and Behavioral Health as appropriate)
  - Concurrent Review
  - Provider Services
  - Quality Management
  - Prevention and Wellness
  - Member Services
  - Finance
- Expedite 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 to arbitrarily deny or reduce 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 reasonably be expected to achieve the purpose for which the services are furnished and that 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 control (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 | Administrative denials are denials of coverage for services or supplies that are based on reasons other than clinically based rationale and do not require a medical director review. 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. |
Aetna Clinical Policy Bulletins (CPBs)

Aetna CPBs state Aetna’s policy regarding the experimental and investigational status and medical necessity of medical technologies and other services for the purposes of making coverage decisions under Aetna administered health benefit plans. Aetna’s 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 Clinical Policy Council

Aetna Clinical Policy Council is the Aetna policy and procedure unit that reviews and updates Aetna CPBs every other month as scheduled. This unit is represented by the Aetna Medicaid senior vice president of Medical Affairs.


American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders® (ASAM PPC-2R) is a comprehensive national guideline for placement, continued stay and discharge of patients with alcohol and other drug problems.

Child and Adolescent Service Intensity Instrument (CASII)

CASII was 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

Any review for an extension of a previously approved ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care, residential behavioral care, intensive outpatient behavioral health care and ongoing ambulatory care.
# MEDICAL MANAGEMENT: Prior Authorization

Effective: 09/28/2015

## Denial, Reduction, or Termination of Financial Responsibility
A denial, reduction, or termination of financial responsibility is 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)
LOCUS® is 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).

## Medical Necessity Determination
A medical necessity determination is determined on decisions that are (or could be considered to be) covered benefits, including:
- Determinations defined by Aetna Better Health
- Hospitalization and emergency services listed in the certificate of coverage or summary of benefits
- Care or services that could be covered or non-covered, depending on the circumstances

## Medically Necessary
A service, supply or medicine that is appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; They are provided for the diagnosis or direct care and treatment of the medical condition; They meet the standards of good medical practice within the medical community in the service area; They are not primarily for the convenience of the plan member or a plan provider; and they are the most appropriate level or supply of service which can safely be provided.

## MCG (formerly known as Milliman Care Guidelines®)
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.
<table>
<thead>
<tr>
<th>Notice of Action (NOA)</th>
<th>Written notification, using language that is easily understood by the member and provider, of decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer-to-Peer Consultation</td>
<td>A peer-to-peer consultation is a discussion between a requesting practitioner and a medical director concerning a utilization issue. A peer-to-peer consultation may address a potential request for services, requests under review, ongoing patient care, or a denial.</td>
</tr>
<tr>
<td>Post-Service Decision</td>
<td>A post-service decision is any review for care or services that have already been received (i.e., retrospective review).</td>
</tr>
</tbody>
</table>
| Post-Stabilization Care Services | Post-stabilization care services are covered services that are:  
- Related to an emergency medical condition  
- Provided after an enrollee is stabilized and  
- Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the enrollee’s condition |
| Practitioner | A professional who provides health care services (medical or behavioral health). Practitioners are usually licensed as required by law. |
| Pre-Service Decision | A pre-service decision is 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 for health plan members. Examples of providers include hospitals and home health agencies. |
Aetna Better Health® of Michigan
Policy

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:

- DCH Medicaid Contract 1.022 AA (2), 1.022 21, 22
- Contract agreements including those regarding the confidentiality of member information
- 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

FOCUS/DISPOSITION:
Participating and nonparticipating practitioners and providers must obtain prior authorization from Aetna Better Health before providing outpatient referrals, clinical services or procedures, nonemergency or elective hospitalizations, or facility placement (e.g., nursing facility [NF]), which require prior authorization. Any variance from the Aetna Better Health’s prior authorization policies and procedures may result in denial or delay of reimbursement.

Emergency Services
Medical services for the treatment of an emergency medical 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:
• To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
• If an authorized representative, acting for the organization, authorized the provision of emergency services.¹

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 a 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 a 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:

− An Aetna Better Health physician with privileges at the treating hospital assumes responsibility for the member’s care

¹ NCQA HP 2015 UM 12A 1-2
An 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**

- Service authorization for emergency services or post-stabilization services whether provided by an in-network or out-of-network practitioner/provider
- Access to family planning services
- Well-woman services

**Aetna Better Health Responsibility**

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 functions in accordance with state and federal regulations. Other departments approved by the CMO (such as Integrated Care Management, and Concurrent Review) may issue authorizations for

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2 NCQA HP 2015 UM 4A1, UM 4A 2
specific services within their areas of responsibility per contractual requirements. Departments with authority to prior authorize will maintain a postal address, direct telephone, fax number, or electronic interchange (if available) for receiving and responding to notifications and prior authorization requests. Only a health care professional may make determinations regarding the medical necessity of health care services during the course of utilization review.³

Aetna Better Health requires utilization management staff to identify themselves by name, title, and organization name; and upon request, verbally informs member; facility personnel; the attending physician and other ordering practitioners/providers of specific utilization management requirements and procedures.⁴

Nonclinical staff is responsible for:
- Documentation of incoming prior authorization requests and initial screening for members enrollment, member eligibility, and practitioner/provider affiliation
- Forwarding to clinical reviewers any requests that require a medical necessity review

Clinical reviewer’s responsibilities include⁵:
- Identifying service requests that may potentially be denied on the basis of medical necessity
- Forwarding potential denials to the CMO or designated medical director for review
- If services are to be denied:
  - Providing written notification of denials to members who could be held financially responsible for their care
  - Notifying the requesting practitioner/provider and member of the decision to deny 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

³ NCQA HP 2015 UM 4A 2
⁴ NCQA HP 2015 UM 3A 3
⁵ NCQA HP 2015 UM 4A 2
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 is 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 directors’ clinical judgment, a determination is made to approve or deny the service. Only a medical director can reduce or deny a request for service based on a medical necessity review.6

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

When criteria is 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.

Practitioners/providers are notified in the denial letter (i.e., Notice of Action) that they may request a peer-to-peer consultation to discuss denied 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.

6 NCQA HP 2015 UM 4A 2
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.

A prior authorization request must include the following:

- Current, applicable codes may include:
  - International Classification of Diseases, 9th Edition (ICD-9)
  - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth, sex, and identification number of the member
- Primary care provider 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-9 code
- Reason for the referral
- Presentation of supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request

All clinical information must be submitted with the original request.

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
MEDICAL MANAGEMENT: Prior Authorization

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health uses the following medical review criteria. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health’s population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate practitioners in developing, adopting, or reviewing criteria. The criteria are consistently applied, consider the needs of the individual members and allow for consultations with requesting practitioners/providers when appropriate. These are to be consulted in the order listed:

- Criteria required by applicable state or federal regulatory agency
- Applicable MCG as the primary decision support for most medical diagnoses and conditions
- Aetna Clinical Policy Bulletins (CPBs)
- Aetna Clinical Policy Council Review

If MCGs state “current role remains uncertain” for the requested service, the next criteria in the hierarchy, Aetna CPBs, should be consulted and utilized.

For prior authorization of outpatient and inpatient behavioral health services, Aetna Better Health uses:

- Criteria required by applicable state or federal regulatory agency
- LOCUS/CASII Guidelines/American Society of Addiction Medicine (ASAM)
- Aetna Clinical Policy Bulletins (CPB’s)

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7 NCQA HP 2015 UM 2A 1-3
8 NCQA HP 2015 UM 2A 5
9 NCQA HP 2015 UM 2A 4
10 NCQA HP 2015 UM 2A 2
Medical, dental and behavioral health management criteria and practice guidelines are disseminated to all affected practitioners/providers upon request and, upon request, to members and potential members by contacting a Aetna Better Health medical management representative.\textsuperscript{11}

**Administrative Denial**

All denials of service requests require a medical director review with the exception of administrative denials. Administrative denials are denials of coverage for services or supplies that are based on reasons other than clinically based rationale and do not require a medical director review. 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.\textsuperscript{12}

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 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 (DCH), Aetna Better Health adheres to the following decision/notification

\textsuperscript{11} NCQA HP 2015 UM 2B 1, UM 2B 2

\textsuperscript{12} NCQA HP 2015 UM 4A 2
time standards. Departments that handle pre-service authorizations must meet the timeliness standards appropriate to the services required.

### Decision/Notification Requirements

<table>
<thead>
<tr>
<th>Decision</th>
<th>Decision/notification timeframe</th>
<th>Notification to</th>
<th>Notification method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent pre-service approval</td>
<td>72 hours from receipt of request</td>
<td>Practitioner/Provider</td>
<td>Oral or Electronic/Written</td>
</tr>
<tr>
<td>Urgent pre-service denial</td>
<td>72 hours from receipt of request</td>
<td>Practitioner/Provider</td>
<td>Oral and Electronic/Written</td>
</tr>
<tr>
<td>Non-urgent pre-service approval</td>
<td>14 calendar days from receipt of the request</td>
<td>Practitioner/Provider</td>
<td>Oral or Electronic/Written</td>
</tr>
<tr>
<td>Non-urgent pre-service denial</td>
<td>14 calendar days from receipt of the request</td>
<td>Practitioner/Provider</td>
<td>Electronic/Written</td>
</tr>
<tr>
<td>Urgent concurrent approval</td>
<td>24 hours of receipt of request</td>
<td>Practitioner/Provider</td>
<td>Oral or Electronic/Written</td>
</tr>
<tr>
<td>Urgent concurrent denial</td>
<td>24 hours of receipt of request</td>
<td>Practitioner/Provider</td>
<td>Oral and Electronic/Written</td>
</tr>
<tr>
<td>Post-service approval</td>
<td>30 calendar days from receipt of the request</td>
<td>Practitioner/Provider</td>
<td>Oral or Electronic/Written</td>
</tr>
<tr>
<td>Post-service denial</td>
<td>30 calendar days from receipt of the request</td>
<td>Practitioner/Provider</td>
<td>Electronic/Written</td>
</tr>
</tbody>
</table>

14 NCQA HP 2015 UM5A-B
Extension of Decision Times for Non-urgent Pre-service Decisions\textsuperscript{15}

The time frame 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 time frame 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 time frame.
- 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.

\textsuperscript{15} NCQA HP 2015 UM 5A (see Explanation section)
The organization may deny the request if it does not receive the information within the time frame, 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 or she disagrees with the decision to extend. Aetna Better Health may deny the request if the needed information is not received within the decision time frame. The member may appeal the denial.

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

*Extension of Time Frames for Urgent Pre-Service Decisions*

The time frame 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

Aetna Better Health must notify the member and requesting practitioner in writing of the need for the extension within twenty-four (24) hours of receipt of the request. 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 or she disagrees with the decision to extend. Aetna Better Health may deny the request if the needed information is not received within this time frame. 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 Time Frames for Urgent Concurrent Decisions

The time frame 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 and 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 time frame.

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 time frame for non-urgent prior authorization requests.

Termination, Suspension, or Reduction of Services

Aetna Better Health is required to give at least ten (10) day 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 Reviews of Authorization

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 time frames 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 such decisions 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., Notice of Action) of any 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 notice of action must be in writing and at a sixth\(^{16}\) 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
- The specific reason for the action, customized to the member circumstances, and in easily understandable language\(^{17}\)
- A reference to the benefit provision, guideline, or protocol or other similar criterion on which the denial decision was based\(^{18}\)

\(^{16}\) DCH 1.022 H (1)
\(^{17}\) NCQA HP 2015 UM7B 1, UM7E 1
\(^{18}\) NCQA HP 2015 UM7B 2, UM7E 2
MEDICAL MANAGEMENT: Prior Authorization

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.

Notification that practitioners have the opportunity to discuss medical and behavioral healthcare utilization management (UM) denial decisions with a physician or other appropriate reviewer.

A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal.

An explanation of the appeals process, including the right to member representation (with the member’s permission) and the time frames for deciding appeals.

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 member’s or practitioner/provider’s (with written permission of the member) right 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 preservice or urgent concurrent denials.

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 benefits.

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19 NCQA HP 2015 UM7B 3, UM7E 3
20 NCQA HP 2015 UM7A, UM7D
21 NCQA HP 2015 UM7C 1, UM7F 1
22 NCQA HP 2015 UM7C 2, UM7F 2
23 NCQA HP 2015 UM7C 3, UM7F 3
24 NCQA HP 2015 UM7C 4, UM7F 4
Translation service information

The procedures for exercising the rights specified in this section

**Prior Authorization Period of Validation**

Unless a member’s benefit plan or 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.

**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 recommendations for action planning. 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 time frames for notification of practitioners/providers and members of decisions.

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

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25 NCQA HP 2015 UM7
Measurement

The Prior Authorization department measures:
- Volume of requests received by telephone, facsimile, and website, respectively
- Service level
- Timeliness of decisions and notifications
- Process performance rates for the following, using established standards:
  - Telephone abandonment rate: under five (5) percent
  - 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

- Weekly the Prior Authorization department reports to the CMO, including:
  - Number of incoming calls
  - Trend analysis of incoming calls
  - Call abandonment rate
  - Average telephone answering time
- Monthly report to the CMO medical officer of the following:
  - Number of incoming calls
  - Telephone abandonment rate
  - 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
Aetna Better Health® of Michigan
Policy

Policy Name: Prior Authorization
Department: Medical Management
Subsection: Prior Authorization
Applies to: Medicaid Health Plans

- Annual report of inter-rater reliability assessment results

**INTER-/INTRADEPENDENCIES:**

**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

Aetna Better Health

Beverly Allen
Chief Executive Officer

Joseph Blount, MD
Chief Medical Officer