AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	Member Appeals	Page:	1 of 23
Department:	Appeal and Grievance	Policy Number:	3100.70
Subsection:		Effective Date:	02/01/2015
Applies to:	■ Medicaid Health Plans		

PURPOSE:

The purpose of this policy is to describe Aetna Better Health's legal and contractual obligations regarding a member's right to file an appeal stemming from an adverse benefit determination for both covered and non-covered item or service[1] issued by the health plan, or any of its providers, and to describe the steps a member may take to file a request for expedited resolution, standard appeal or State fair hearing.

STATEMENT OF OBJECTIVE:

The objectives of this policy are to:

- Facilitate compliance with federal and state laws and rules and state contractual requirements for the member appeals process
- Promote effective management of member appeals
- Provide for accurate maintenance of required documentation
- Maintain compliance with reporting requirements

DEFINITIONS:

Adverse Benefit Determination[2]	Adverse Benefit Determination is defined as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service • The denial, in whole or in part, of payment for a service • The failure to provide services in a timely manner, as defined by the State • The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

[1] NCQA HP 2021/2022 ME7 B

[2] 2020 Louisiana Medicaid Managed Care Organization Statement Of Work, Glossary

	• The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
Appeal and Grievance Application	A highly customizable complaint, grievance and appeal application to capture, process, store, and retrieve detailed information on each complaint, grievance or appeal received.
Clinically Urgent Situation	Any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could result in the following circumstances: • Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, • In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
Deemed Exhaustion of Appeal Process[3]	In the case of an Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) that fails to adhere to the notice and timing requirements for processing an appeal, the member is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The member may initiate a State fair hearing.
Member Appeal	A request by member or their representative for review and reconsideration of a decision with respect to an adverse benefit determination. This includes both coverage and non-coverage determinations.[4] Appeals must be requested within sixty (60) calendar days from the date on the initial adverse adverse benefit determination.[5]

[3] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.3.2 - Standard Resolution of Appeals**
[4] NCQA HP 2021/2022 ME7 B
[5] 42 C.F.R. § 438.402(c)(B)(2)(ii); NCQA HP 2021 UM8 A1/2022 UM8 A2

	****Value Added Benefits (VAB) are not subject to Appeal and State Fair Hearing rights. A denial of these benefits shall not be considered an Adverse Benefit Determination for purposes of member grievances and appeals. Aetna Better Health will send the member a notification letter if a VAB is not approved.****[6]
Member Expedited Appeal	A request by member or their representative for fast review and reconsideration of a decision with respect to an adverse benefit determination, when the time periods for making a non-clinically urgent determination could seriously jeopardize the member's life, health or the ability to attain, maintain or regain maximum function, or in the opinion of the treating provider member's condition cannot be adequately managed without the urgent care or services.[7]
Member Representative	A person who assists with the appeal on the member's behalf, including but not limited to, a family member, friend, guardian, primary care physician (PCP), woman's health care provider (WHCP) or an attorney. The member must designate a representative in writing.
Non Participating Network Provider (also known as non par provider, non contracted provider)	A health care provider, either an individual or facility, who does not have a written provider agreement with Aetna Better Health and is not credentialed by Aetna Better Health.
Notice of Adverse benefit determination Also referred to as a Notice of Action (NOA)	Written notification to a member of a denial, termination, reduction or suspension of a covered service. The Notice of Adverse benefit determination explains the adverse benefit determination Aetna Better Health has taken or intends to take, the reasons for the adverse benefit determination; the right of the member or a representative acting on the member's behalf and with the member's written consent to file an appeal; the right to request a State fair hearing, procedures for exercising the rights to appeal or request a State fair hearing; the member may represent himself or use a family member, friend,

[6] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.4.5.8**
[7] NCQA HP 2021/2022 ME7 B4

	guardian, provider, legal counsel or other spokesperson; explain the specific regulations that support or the change in Federal or State law that requires the action; the member's right to request a state agency hearing, or in cases of an adverse benefit determination based on change in law, the circumstances under which a hearing will be granted; the circumstances under which an expedited resolution is available and how to request it; and the member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued and the circumstances under which the member may be required to pay the costs of these services.
Participating Network Provider (also known as Provider, par provider, contracted provider)	A health care provider, either an individual or facility, who has a written provider agreement with and is credentialed by Aetna Better Health and who participates in Aetna Better Health's provider network to serve Aetna Better Health members.
Pre-Service Appeal	A pre-service appeal is a request to change an adverse benefit determination taken by the health plan related to benefit coverage in advance of the member obtaining the care or services.
Post-Service Appeal	A post-service appeal is a request to change an adverse benefit determination for care or services that have already been rendered.
Request for State Fair Hearing	The member and/or the member's representative acting on behalf of the member may request a State fair hearing through the Division of Administrative Law upon exhaustion of the Aetna Better Health appeal process.
Timelines	For non-clinically urgent situations, the organization makes decisions within thirty (30) calendar days of receipt.[8] For post service payment appeals, the organization makes decisions within thirty (30) calendar days of receipt.[9] For clinically urgent situations, the organization

[8] 42 C.F.R. § 438.408(b)(2); NCQA HP 2021/2022 ME7 B4; 2021 UM8 A7/2022 UM8 A8
[9] 42 C.F.R. § 438.408(b)(2); NCQA HP 2021/2022 ME7 B4; 2021 UM8 A8/2022 UM8 A10

	follows an expedited appeal timeline making decisions within seventy-two (72) hours of receipt.[10]

LEGAL/CONTRACT REFERENCE:

- 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 13
- **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15**
- State and federal rules and regulations
- 42 C.F.R. § 438.400 – 438.424
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans: 2021/2022
- Contract agreements

FOCUS/DISPOSITION:

Aetna Better Health has an established, impartial process for resolving member requests to reconsider a decision they are dissatisfied with regarding their care or service.[11]

A member may file an appeal with Aetna Better Health. An authorized member representative, including a provider, may file an appeal on the member's behalf with the written consent of the member.[12]

Responsibility

The Appeal and Grievance department is responsible for the management of member appeals which includes documenting the substance and resolution of individual appeals, coordinating resolutions, tracking data and reviewing appeals for trends in quality of care or other service related issues.[13]

The Appeal and Grievance department staff reports to the chief operating officer (COO). All data collected is reported to the Appeal Committee, Service Improvement Committee (SIC) and

[10] 42 C.F.R. § 438.408(b)(3); NCQA HP 2021/2022 ME7 B4; 2021 UM8 A9/2022 UM8 A11
[11] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.1**
[12] **2023 Louisiana Medicaid Managed Care Oranization Statement of Work, Section 2.15.1.11**
[13] NCQA HP 2021/2022 ME7 B1; 2021 UM8 A2/2022 UM8 A3

Quality Management Oversight Committee (QMOC) at least quarterly (more frequently if appropriate) summarizing the frequency and resolution of all appeals.

Appeal Committee

The Appeal Committee is responsible for reviewing appeal trends and may be responsible for reviewing appeal requests and all supporting documentation. The committee is comprised of two or more staff members, which may include but not limited to:

- Appeal and Grievance manager – chairperson (1 voting member)
- Compliance officer (1 voting member)
- Chief medical officer or designated medical director (1 voting member)
- Representatives from Quality Management and Utilization Management departments
- If clinical issue – staff RN
- If clinical issue – physician with same or similar specialty[14]

As needed the voting members of the committee are assigned prior to each meeting. The voting panel will include individuals who were not involved in the original decision and who are not a subordinate to any person involved in the original decision.[15] When reviewing cases the committee takes into account all documentation received as part of the original denial and with the appeal. Chief medical officer (CMO) or designated medical director takes a vote and renders the final decision.

SCOPE

Appeal Summary

All written documents relating to an appeal, including but not limited to the policies, acknowledgment letter, notice of extension for resolution and appeal resolution letter, will be written in English and available in Spanish and other languages upon request. In addition, oral interpretation services and alternate formats will be available to members at no cost.[16] The health plan advises members of their appeal rights and appeals process in the Member Handbook, the Notice of Adverse benefit determination, and on the website.[17] The member is

[14] NCQA HP 2021 UM8 A6/2022 UM8 A7
[15] NCQA HP 2021 UM8 A5/2022 UM8 A6; 2021/2022 UM9 C
[16] NCQA HP 2021/2022 ME7 B5; 2021 UM8 A15/2022 UM8 A17
[17] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.2

advised of appeal procedures in the written Notice of Adverse benefit determination that advises a member that a service, procedure, equipment or medication was denied, reduced, terminated or suspended.

The following applies to all member appeals:

- File content: files include documentation, investigation, including all aspects of clinical care involved and appropriate response to the substance of the appeal.[18]
- Aetna Better Health adheres to specific regulations that support the appeal process or the change in Federal or State law that requires a change to the appeal process
- Aetna Better Health adheres to filing, decision and notification timeliness standards
- Aetna Better Health adheres to reviewer requirements
- Notification: Aetna Better Health provides appeal rights information and adheres to notification requirements for all levels of appeals[19]

Communication of Rights

The health plan advises members of their appeal rights in the Member Handbook, the Notice of Adverse benefit determination, and on the website. The Member Handbook will include information on appeal procedures and timeframes, including:

- The requirement and timeframes for filing an appeal
- The availability of assistance in the filing process
- The toll-free numbers that the member can use to file an appeal by phone
- The procedures for exercising the rights to appeal in the event of a denial, termination, suspension or reduction of services, inclusive of non covered items or services[20]
- The procedures for exercising the rights to request a State fair hearing
- That the member may represent himself or designate a legal counsel, a relative, a friend, a provider or other spokesperson to represent them
- The specific regulations that support the appeal process or the change in Federal or State law that requires a change to the appeal process
- The fact that, when requested by the member[21]

[18] NCQA HP 2021/2022 ME7 B1, B2; 2021 UM8 A2, A3/2022 UM8 A3, A4; 2021/2022 UM9 A
[19] NCQA HP 2021/2022 ME7 B3
[20] NCQA HP 2021/2022 ME7 B
[21] NCQA HP 2021 UM8 A16/2022 UM8 A18

  - Benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing has requested continuation of services; and
  - The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member
- Any appeal rights that the state chooses to make available to providers to challenge the failure of the organization to cover a service

The Member Handbook will include the following information about the member's right to request a State fair hearing, or in cases of an adverse benefit determination based on change in law, the circumstances under which a hearing will be granted:

- A member or a representative acting on their behalf may request a State fair hearing within one hundred twenty (120) calendar days from the health plan's appeal decision letter.[22]
- That the state agency must reach its decisions within the specified timeframes:
  - For standard resolution: within ninety (90) calendar days
  - For expedited resolution: within seventy-two (72) hours

Regulatory Complaints

At any time throughout the appeal or grievance process, or instead of the appeal and grievance process, the member may file a complaint with a regulatory body for any reason including dissatisfaction with the outcome of an appeal or grievance. Regulatory complaints may be received from any area of the State though primarily through the Ombudsman's office.

Processing of all regulatory complaints will follow the grievance or appeal process timeframes depending on complaint classification unless the regulatory body stipulates a different timeframe for the complaint.

All regulatory complaints related to the denial, reduction, termination or suspension of coverage will be identified as a regulatory appeal and will be processed and tracked in the Appeal and Grievance Application as an appeal to allow for comprehensive trending of all received complaints regardless of origination.

[22] 42 C.F.R. § 438.408(f)(2)

Notice of Adverse Benefit Determination; or Notice of Action (NOA)

Aetna Better Health mails the Notice of Adverse benefit determination[23] to the member within the following timeframes:

- In cases of verified member fraud, or when LDH has facts indicating that action should be taken because fo probable member fraud at least five (5) days before the date of action.[24]
- At least ten (10) calendar days before the date of adverse benefit determination for termination, suspension, or reduction of previously authorized covered services.[25] Under the following circumstances, the notices may be mailed not later than the date of the adverse benefit determination:
  - The health plan has factual information confirming the death of the member
  - The health plan receives a clear, written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information
  - The member's whereabouts are unknown and the post office returns health plan mail directed to the member indicating no forwarding address (refer to 42 C.F.R. § 431.231(d) for procedures if the member's whereabouts become known)
  - The member's physician prescribes a change in the level of medical care
  - The member's admission to an institution where he is ineligible for further services
  - The member has been accepted for Medicaid services by another local jurisdiction
- At the time of any adverse benefit determination affecting the claim for denial of payment decisions that result in member liability
- Within the timeframes required by the service accessibility standards for prior authorization specified herein for service authorization decisions that deny or limit services

Appeal Request

The following apply to appeal requests:

[23] NCQA HP 2021/2022 ME7 B3
[24] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 13.5.3.2
[25] 2020 Louisiana Medicaid Managed Care Organization Statement or Work, Section 13.5.3.1

- Filing an appeal or State fair hearing will not negatively affect or impact the Aetna Better Health member or providers who treat the member.
- A member may authorize anyone including but not limited to legal counsel, a relative, a friend, a provider or other spokesperson to represent them to file an appeal on their behalf.[26] Member assignment of an authorized representative must be in writing and on file with the health plan.
- The member and/or the member's representative may present supporting documentation or evidence in person or in writing on or before the date of the appeal meeting date.[27] The member and/or their representative may request to review the member's file or clinical records that will be presented to the appropriate person, persons or department before and or during the appeals process by contacting the Appeal and Grievance department.**[28]**
- Member, or a member's representative acting on behalf of the member with written consent of the member, must file an appeal no later than sixty (60) calendar days from the adverse benefit determination[29] from the postmark on the Aetna Better Health *Notice of Adverse benefit determination.* The expiration date to file an appeal is included in the *Notice of Adverse benefit determination*.
- Members or their representative may file an appeal either verbally by contacting Aetna Better Health's Member Service department at 1-855-242-0802 or by submitting a request in writing.
- All written requests are submitted to the health plan at the following mailing address or faxed to the following fax number:

Aetna Better Health
Appeal and Grievance Department
PO Box 81139, 5801 Postal Rd
Cleveland, OH 44181
Fax: 1-860-607-7657

[26] NCQA HP 2021 UM8 A14/2022 UM8 A16
[27] NCQA HP 2021 UM8 A4/2022 UM8 A5
[28] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.6
[29] 42 C.F.R. § 438.402(c)(2)(ii); NCQA HP 2021 UM8 A1/2022 UM8 A2**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.1.1**

- Aetna Better Health's Member Service department will provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate Teletypewriting Device for the Deaf/Teletypewriter (TTY/TTD) and interpreter capability.[30]
- Aetna Better Health will acknowledge the receipt of expedited appeals verbally at the time of receipt
- Aetna Better Health will acknowledge the receipt of standard appeals in writing within five (5) business days after receiving an appeal request.[31]
- Oral inquiries seeking to appeal are treated as appeals. (to establish the earliest possible filing date for the appeal).
- Upon receipt, each appeal request is assigned a tracking number, which is used by the Appeal and Grievance department to monitor each appeal throughout the research and resolution process. Aetna Better Health logs and tracks all appeals, expedited appeals, grievances and requests for fair hearings in the Appeal and Grievance Application. The content will be available to the Department in electronic format upon request.
- Within five (5) business days[32] of receipt of the written appeal, the Appeal and Grievance department will send an acknowledgement letter to the member or authorized member representative and the member's practitioner. The letter will provide information about their appeal rights and will include a request for any additional clinical documentation that could support the services requested.

Request for Continued Benefits During Appeals Process[33]

A member may continue to receive services for an ongoing course of treatment that were previously approved during the appeals process under the following circumstances:[34]

- The appeal is filed timely[35]

[30] NCQA HP 2021/2022 ME7 B5; 2021 UM8 A15/2022 UM8 A17
[31] **2023 Louisiana Medicaid Managed Care Organization Statement of Work Section 2.15.3.1.3**
[32] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 13.4.1.1
[33] NCQA HP 2021 UM8 A16/2022 UM8 A18**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2**
[34] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1**
[35] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.1**

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment[36]
- The member or their designed representative request continuation of benefits[37]
- The services were ordered by an authorized provider; and[38]
- The original period covered by the original authorization has not expired.[39]

NOTE: As used here, "timely" filing means filing on or before the later of the following:

- Within ten (10) calendar days of the health plan mailing the notice of adverse benefit determination[40]
- The intended effective date of the health plan's proposed adverse benefit determination[41]

The health plan will continue the member's benefits until one of the following occurs:[42]

- The member withdraws the appeal[43]
- Ten (10) calendar days pass after Aetna Better Health mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) calendar day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached[44]
- A State fair hearing officer issues a hearing decision adverse to the member.[45]
- The time period or service limits of a previously authorized service has been met[46]

If the final resolution of the appeal is adverse to the member, that is, upholds Aetna Better Health's adverse benefit determination, Aetna Better Health may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished

[36] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.2**
[37] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.5**
[38] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.3**
[39] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.4**
[40] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.1**
[41] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.1**
[42] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.2 / 2.15.4.8**
[43] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.2.1 / 2.15.4.8.1**
[44] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.2.2 / 2.15.4.6**
[45] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.2.3 / 2.15.4.8.2**
[46] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.2.4**

solely because of the requirements of this section. The member is informed that he/she can be financial liable for the services that were rendered during this process.[47]

Appeal Review - Same or Similar Specialty

Aetna Better Health will confirm that the individual(s) who make decisions on appeals either individually or through appeal committee are individual(s) who were not involved in any previous level of review or decision-making and if deciding an appeal of a denial, reduction, termination or suspension that is based on lack of medical necessity or an appeal that involves other clinical issues are health care professionals who have the appropriate training and clinical expertise, as determined by NCQA and the state agency, in the field of medicine treating the member's condition or disease or who has experience treating the member's condition or disease or treating similar complications related to the member's condition or disease.[48]

- Clinical appeal considerations are conducted by health professionals who:
  - Are clinical peers
  - Would typically manage the medical, procedure, or treatment in their practice that is the subject of the appeal
  - Hold an active, unrestricted license to practice medicine or a health profession;
  - Are board-certified (if applicable) by:
    - A specialty board approved by the American Board of Medical Specialties (doctors of medicine)
    - The Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine)
  - Chiropractic appeals will be reviewed by a chiropractor
- Aetna Better Health will appoint at least one person to review the appeal who is a practitioner in the same or a similar specialty as typically manages the medical, procedure, or treatment in question in the appeal.[49] All same specialty review recommendations are presented to the appropriate person, persons or department as part of the appeal investigation**.**

[47] 42 C.F.R. § 438.420(d); 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 13.6.4.2
[48] NCQA HP 2021 UM8 A5/2022 UM8 A6
[49] NCQA HP 2021 UM8 A6/2022 UM8 A7

Appeal Process

The appeal process is executed with utmost regard given to protecting the confidentiality of any protected health information gathered through the process. The appeals process follows Aetna Better Health's Privacy Policies, which comply with Health Insurance Portability and Accountability Act (HIPAA) requirements.

- The member and his or her representative are provided a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing.[50] Aetna Better Health will inform the member of the limited time available for presenting evidence and allegations of fact or law, in person as well as in writing in the case of expedited resolution.**[51]** Aetna Better Health takes all information into account during the appeals process without regard to whether the information was submitted or considered in the initial consideration of the case; and implements the decision of appeal if it overturns the initial denial.
- The member and his or her representative are provided with an opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process free of charge.[52]
- The appeals process will include, as parties to the appeal, the member and his or her representative or the legal representative of a deceased member's estate.**[53]**
- An investigation of the appeal will take place and will be documented in the appeal file. The documentation will include but is not limited to:[54]
  - Type of appeal, standard or expedited, the substance of the appeal request, including a short, dated summary of the issues, name of the appellant, name of the provider or facility, date of appeal, date of decision, the resolution and any other actions taken
  - Electronic images of written documentation
  - The initial adverse benefit determination notes and records

[50] NCQA HP 2021 UM8 A4/2022 UM8 A5**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.1.4**
[51] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.4.3
[52] NCQA HP 2021 UM8 A12/2022 UM8 A14**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.1.5**
[53] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.1.6.1 / 2.15.3.1.6.2
[54] NCQA HP 2021/2022 ME7 B1, B2; 2021 UM8 A2, A3, A6/2022 UM8 A3, A4, A7

  - Additional clinical information and documentation submitted by the member member's representative, member's practitioner and/or member's provider
  - All aspects of clinical care involved
  - Same specialty reviewer's comments
  - Appeal committee minutes
- The appeal request and all supporting documentation are presented to the appropriate person/persons or department and a Medical Director or the Appeal Committee, as appropriate will consider the additional information and will decide the appeal.
- Aetna Better Health will maintain the privacy of all appeals records at all times, including the transmittal of medical records, if applicable.
- Aetna Better Health will retain all appeals files in a secure, designated area for a period of at least ten (10) years following the final decision.[55]
- The health plan reports appeals to the state agency in the format and frequency specified by the state agency.[56]
- Aetna Better Health will promptly forward any adverse benefit determinations to Division of Administrative Law for further review/action upon request by Division of Administrative Law or the Aetna Better Health member.

Any changes to the appeal process are submitted to Louisiana Department of Health for approval prior to implementation. Members are then notified at least thirty (30) calendar days in advance of any changes in Aetna Better Health's grievance or appeal policies, when possible.[57]

Timeframe for Resolving – Expedited Appeals[58]

A member or a member's representative may request an expedited appeal if they feel the timeframe required for a standard appeal could seriously jeopardize life or health, or the ability to attain, maintain or regain maximum function. Expedited appeals may be submitted orally or in writing and do ~~not~~ need written consent for the practitioner to file on behalf of the member.[59]

[55] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.7**
[56] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.8**
[57] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Chapter 13
[58] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.4.1**
[59] **2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 13.4.2.1**

For expedited appeal request, Aetna Better Health notifies the party filing the appeal, as soon as possible of all information that the plan requires to evaluate the appeal. Post-service appeals are not eligible for expedited processing.

Aetna Better Health's medical director reviews the expedited appeal request, together with any supporting documentation submitted, as expeditiously as the member's health requires upon receipt of the request to determine if the case meets expedited urgency or need. In cases where the health plan determines a member's request meets expedited urgency or a practitioner supports the member's request, Aetna Better Health's medical director renders a decision as expeditiously as the member's health requires, within seventy-two (72) hours from the receipt of request.[60] Aetna Better Health grants an expedited review for all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility. Aetna Better Health will make reasonable effort to communicate expedited decisions orally, followed by an electronic or written notification within two (2) calendar days[61] of an initial oral notification and within the original seventy-two (72) hours.[62]

Aetna Better Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. All allegations of discrimination will be processed as part of Policy 3100.90. In addition, Aetna Better Health will make sure that punitive action is not taken in retaliation against a member who requests an appeal or a provider who requests an expedited resolution or supports a member's appeal.**[63]**

If a member or member's representative requests an expedited appeal and Aetna Better Health denies the request because it does not meet the expedited urgency or need, the appeal will be transferred processed and resolved in accordance with a non-expedited standard appeals process maintaining the original received date. The Appeal and Grievance coordinator will give the member and/or practitioner prompt oral notice of the denial and follow up within two (2)

[60] 42 C.F.R. § 438.408(b)(3); NCQA HP 2021/2022 ME7 B3, B4; 2021 UM8 A9/2022 UM8 A11
[61] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 13.7.2.2**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.4.2**
[62] 42 C.F.R. § 438.408(b)(3); NCQA HP 2021/2022 ME7 B3, B4; 2021 UM8 A9/2022 UM8 A11; 2022 UM9 B4
[63] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.10 / 2.15.4.11

calendar days of receipt of request[64] with a written notice that the appeal will be handled through the non-expedited standard process.**[65]**

Timeframe for Resolving – Pre-service and Post-service Standard Appeals[66]

Aetna Better Health will resolve each appeal and provide an electronic or written notice of the appeal resolution, as expeditiously as the member's health condition requires but will not exceed:

- Pre-service standard appeal: thirty (30) calendar days from the date the appeal is received [67]
- Post-service standard appeal: thirty (30) calendar days from the date the appeal is received [68]

Appeal Extension

- Aetna Better Health may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days if the member requests the extension; or
- Aetna Better Health demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's interest
- Aetna Better Health will confirm the member's request for an extension in writing
- **If the member requested an extension on an expedited appeal, Aetna will send the denial of expedited processing and transfer the case to standard processing maintaining the original received date.[69]**
- If the resolution timeframe is being extended and was not requested by the member, Aetna Better Health must make reasonable attempts to give oral notification of delay[70] and must give written notice of the delay within two (2) calendar days of the decision to delay[71] and within the original standard or expedited timeframe to the affected parties. The written

[64] 42 C.F.R. § 438.408(c)(2)(ii)
[65] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.4.5
[66] NCQA HP 2021/2022 ME7 B4, 2021/2022 UM9 B
[67] 42 C.F.R. § 438.408(b)(2); NCQA HP 2021/2022 ME7 B4; 2021 UM8 A7/2022 UM8 A8; 2022 UM9 B1**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.3.1**
[68] 42 C.F.R. § 438.408(b)(2); NCQA HP 2021/2022 ME7 B4, 2021 UM8 A8/2022 UM8 A10; 2022 UM9 B3**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.3.1**
[69] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.4.4
[70] 42 C.F.R. § 438.408(c)(2)(i)
[71] 42 C.F.R. § 438.408(c)(2)(ii)

notice of delay will include the member's right to file a grievance if they disagree with Aetna Better Health taking an extension.

Appeal Decision

The appeal is reviewed, and based on coverage and/or medical necessity, a decision is reached. It is then approved and signed by Aetna Better Health's Medical Director or a physician designee and a written *Appeal Decision Letter* is sent to the member, their representative if designated and their treating practitioner as expeditiously as the member's health requires but not to exceed two (2) calendar days[72] of the decision. If the decision is upheld, the *Appeal Decision Letter* explains the next level of appeal, which is the State fair hearing option.[73] State fair hearings are available through the State Agency at Louisiana Division of Administrative Law at 1-225-342-1800.[74]

If Aetna Better Health reverses the decision to deny, limit or delay services that were not furnished while the appeal was pending, Aetna Better Health will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires within seventy-two (72) hours of the decision to overturn.[75]

If Aetna Better Health reverses the decision to deny authorization of services, and the member received the disputed services while the appeal was pending, Aetna Better Health will pay for those services.

Written Appeal Decision Letter (Pre-Service, Expedited, Post-Service)

The written notice of the appeal resolution will **be on the LDH approved template and** include:[76]

- **Unique appeal number**[77]
- The results of the resolution process and the date it was completed
- The specific reasons for the decision, in easily understandable language

[72] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 13.6.2.2
[73] NCQA HP 2021/2022 ME7 B3
[74] NCQA HP 2021 UM8 A10/2022 UM8 A12
[75] 42 C.F.R. § 438.424(a)
[76] NCQA HP 2021/2022 UM9 D
[77] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.5.2**

- For appeals not resolved wholly in the favor of the members, the right to request a State fair hearing and how to do so[78]
- The right to request a continuation of benefits while the hearing is pending and how to make the request[79]
- Notification that the member may be held liable for the cost of those benefits if the hearing decision upholds Aetna Better Health's adverse benefit determination[80]
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.[81]
- Notification that the member can obtain, free of charge and, upon request, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based
- Notification that the member is entitled to receive, free of charge and, upon request, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or record relied upon and document and records submitted in the course of making the appeal decision[82]
- A list of the titles and qualifications of each individual participating in the appeal review, including specialty, as appropriate.[83] Participant names need not be include in the written notification to the members, but must be provided to members, upon request
- A description of the State fair hearing process along with any relevant written procedures; and
- A description of the process to request that services continue while a State fair hearing is being processed, including that the member may be held financially liable for such services if the state upholds the denial decision[84]

[78] NCQA HP 2021/2022 ME7 B3; 2021 UM8 A10/2022 UM8 A12**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.5.3**
[79] 42 C.F.R. § 438.420(b)-(c); NCQA HP 2021 UM8 A16/2022 UM8 A18
[80] 42 C.F.R. § 438.420(d)
[81] NCQA HP 2021 UM8 A11/2022 UM8 A13
[82] NCQA HP 2021 UM8 A12/2022 UM8 A14
[83] NCQA HP 2021 UM8 A13/2022 UM8 A15
[84] NCQA HP 2021 UM8 A16/2022 UM8 A18

Request for State fair hearing[85]

- The member may request a State fair hearing through Division of Administrative Law upon exhaustion of the Aetna Better Health appeal process. This request must be completed within one hundred twenty (120) calendar days.[86] The member may contact Division of Administrative Law at 1-225-342-1800 for further assistance during the State fair hearing process. Information on how to contact Division of Administrative Law will be included in the Appeal Decision Letter.
- Upon receipt of the notice that Division of Administrative Law has received a request for a State fair hearing Aetna Better Health will verify that the member has met the timeline of within one hundred twenty (120) calendar days of the Appeal Decision letter to request a State fair hearing.
- Aetna Better Health will notify Division of Administrative Law within two (2) business days if the member has not met the timeline for the request.
- **Aetna Better Health will submit an evidence packet to LDH and to the Enrollee, free of charge, within seven (7) business days from the time Aetna Better Health receives notification of the hearing.[87] The evidence packet shall be submitted to LDH in accordance with any prehearing instructions. The evidence packet shall include all necessary documents including the statement of matters (or, alternatively, the denial letter) and any medical records or other documents and/or records considered or relied upon by Aetna Better Health and supporting the Adverse Benefit Determination and Appeal resolution[88]**
- **Within two (2) business days of notification of the State Fair Hearing request, Aetna Better health will provide the corresponding Notice of Adverse Benefit Determination and the Notice of Appeal Resolution that relate to the State Fair Hearing request to LDH.[89]**
- ~~For standard fair hearing requests Aetna Better Health will forward a copy of the member's file with a summary to Division of Administrative Law at least ten (10) calendar days prior to the hearing date sooner if specified by the State.~~

[85] NCQA HP 2021/2022 ME7 B3; 2021 UM8 A10/2022 UM8 A12
[86] 42 C.F.R. § 438.408(f)(2); **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.1**
[87] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.3**
[88] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.3**
[89] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.4**

- For expedited fair hearing requests Aetna Better Health will forward a copy of the member's file with a summary to Division of Administrative Law within four (4) business hours.
- Aetna Better Health will devote the necessary staffing resources necessary to address member appeals at the hearing level.[90]
- **Aetna Better Health will designate an email address for all State Fair Hearing-related communications from LDH and any party to the State Fair Hearing.**[91]
- The parties to the State Fair Hearing include Aetna Better Health, the member and his or her representative or the representative of a deceased member's estate.[92]
- If the State fair hearing officer reverses the decision to deny, limit or delay services that were not furnished while the appeal was pending, Aetna Better Health will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires within seventy-two (72) hours of the notification of the overturn.[93]
- If the State fair hearing officer reverses the decision to deny authorization of services, and the member received the disputed services while the appeal was pending, Aetna Better Health will pay for those services.[94]

OPERATING PROTOCOL:

Systems

- All appeals are entered and tracked in the Appeal and Grievance Application.
- Member, claims, and call information is available from the Aetna Better Health business application system

Measurement

- Total volume of appeals by type and reason
- Total volume of appeals adjudicated within regulatory time frames
- Appeal turn-over rates by volume and type

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[90] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.2**
[91] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.5**
[92] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 13.6.5.2
[93] 42 C.F.R. § 438.424(a)**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.9**
[94] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.7**

Reporting

- Appeals Report(s) to LDH in the format specified by LDH
- Appeals Report(s) to Medical Management and Quality Management Oversight Committee
- Management reports monthly and quarterly, more often as directed
- Annual reports as applicable

INTER-/INTRADEPENDENCIES:

Internal

- Appeal and Grievance
- Claims
- Chief medical officer (CMO) or designated medical director
- Chief operating officer (COO)
- Member Services
- Medical Services
- Provider Relations
- Quality Management

External

- Members or their authorized representative
- National Committee for Quality Assurance (NCQA)
- Practitioners
- Providers
- State regulatory agency

Aetna Better Health

Richard C. Born
Chief Executive Officer

Andre Greenwood~~Roger Gunter~~
Interim Chief Operating Officer