AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	Enrollee Appeals	Page:	1 of 26
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 an enrollee'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 an enrollee 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 enrollee appeals process
- Promote effective management of enrollee 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 service 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 2024/2025 ME7 B

[2] 2023 Louisiana Medicaid Managed Care Organization Statement Of Work, Glossary

	• The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee 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 enrollee or the enrollee's ability to regain maximum function, based on a prudent layperson's judgment, • In the opinion of a practitioner with knowledge of the enrollee's medical condition, would subject the enrollee 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 enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.
Enrollee Appeal	A request by enrollee 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]

[3] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.3.2
[4] NCQA HP 2024/2025 ME7 B

	Appeals must be requested within sixty (60) calendar days from the date on the initial adverse benefit determination. This may also be referred to as notice of action.[5] **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 enrollee grievances and appeals. Aetna Better Health will send the enrollee a notification letter if a VAB is not approved.**[6]
Enrollee Expedited Appeal	A request by enrollee 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 enrollee's life, health or the ability to attain, maintain or regain maximum function, or in the opinion of the treating provider enrollee's condition cannot be adequately managed without the urgent care or services.[7]
Enrollee Representative	A person who assists with the appeal on the enrollee'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 enrollee 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	Written notification to an enrollee 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

[5] 42 C.F.R. §438.402(c)(B)(2)(ii); NCQA HP 2024/2025 UM8 A2
[6] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.4.5.8
[7] NCQA HP 2024/2025 ME7 B4

Also referred to as a Notice of Action (NOA)	determination; the right of the enrollee or a representative acting on the enrollee's behalf and with the enrollee'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 enrollee may represent himself or use a family member, friend, guardian, practitioner/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 enrollee'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 enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued and the circumstances under which the enrollee may be required to pay the costs of these services.
Participating Network Practitioner/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 enrollees.
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
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 enrollee 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.
Provider	An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

Request for State Fair Hearing	The enrollee and/or the enrollee's representative acting on behalf of the enrollee may request a State fair hearing through the Division of Administrative Law (DAL) upon exhaustion of the Aetna Better Health appeal process.
Same or Similar Specialty/Specialist[8]	A practitioner whose training and experience meets the following criteria: • Includes treating the condition • Includes treating complications that may result from the service or procedure Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate
Timelines	For non-clinically urgent situations, the organization makes decisions within thirty (30) calendar days of receipt.[9] For post service payment appeals, the organization makes decisions within thirty (30) calendar days of receipt.[10] For clinically urgent situations, the organization follows an expedited appeal timeline making decisions within seventy-two (72) hours of receipt.[11]

LEGAL/CONTRACT REFERENCE:

- 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: 2024/2025
- Contract agreements

[8] NCQA HP 2024/2025 UM8 A7
[9] 42 C.F.R. § 438.408(b)(2); NCQA HP 2024/2025 ME7 B4; 2024/2025 UM8 A8
[10] 42 C.F.R. § 438.408(b)(2); NCQA HP 2024/2025 ME7 B4; 2024/2025 UM8 A10
[11] 42 C.F.R. § 438.408(b)(3); NCQA HP 2024/2025 ME7 B4; 2024/2025 UM8 A11

FOCUS/DISPOSITION:

Aetna Better Health has an established, impartial process for resolving enrollee requests to reconsider a decision they are dissatisfied with regarding their care or service.[12]

An enrollee may file an appeal with Aetna Better Health. An authorized enrollee representative, including a practitioner/provider, may file an appeal on the enrollee's behalf with the written consent of the enrollee.[13]

NOTE: If the enrollee is still inpatient and the appeal is regarding a concurrent review, consent will not be required.[14]

Responsibility

The Appeal and Grievance department is responsible for the management of enrollee 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.[15]

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 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)

[12] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.1
[13] 2023 Louisiana Medicaid Managed Care Oranization Statement of Work, Section 2.15.1.11
[14] Managed Care Organizational Manual, Provider Issue Resolution Section
[15] NCQA HP 2024/2025 ME7 B1; 2024/2025 UM8 A3

- 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[16]

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.[17] 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

Appeal notices are based on enrollee cultural and linguistic needs. 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 enrollees at no cost.[18] The health plan advises enrollees of their appeal rights and appeals process in the Enrollee Handbook, the Notice of Adverse benefit determination, and on the website. The enrollee is advised of appeal procedures in the written Notice of Adverse benefit determination that advises an enrollee that a service, procedure, equipment or medication was denied, reduced, terminated or suspended.

The following applies to all enrollee appeals:

- File content: files include documentation, investigation, including all aspects of clinical care involved and appropriate response to the substance of the appeal.[19]
- 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

[16] NCQA HP 2024/2025 UM8 A7
[17] NCQA HP 2024/2025 UM8 A6; 2024/2025 UM9 C
[18] NCQA HP 2024/2025 ME7 B5; 2024/2025 UM8 A17
[19] NCQA HP 2024/2025 ME7 B1, B2; 2024/2025 UM8 A3, A4; 2024/2025 UM9 A

- 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[20]

Communication of Rights

The health plan advises enrollees of their appeal rights in the Enrollee Handbook, the Notice of Adverse benefit determination, and on the website. The Enrollee 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 enrollee 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[21]
- The procedures for exercising the rights to request a State fair hearing
- That the enrollee may represent himself or designate a legal counsel, a relative, a friend, a practitioner/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 enrollee[22]
  - Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing has requested continuation of services; and
  - The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee
- Any appeal rights that the state chooses to make available to practitioners/providers to challenge the failure of the organization to cover a service

[20] NCQA HP 2024/2025 ME7 B3
[21] NCQA HP 2024/2025 ME7 B
[22] NCQA HP 2024/2025 UM8 A18

The Enrollee Handbook will include the following information about the enrollee'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:

- An enrollee 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.[23]
- 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 enrollee 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.

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

Aetna Better Health mails the Notice of Adverse benefit determination[24] to the enrollee within the following timeframes:

[23] 42 C.F.R. § 438.408(f)(2)
[24] NCQA HP 2024/2025 ME7 B3

- In cases of verified enrollee fraud, or when LDH has facts indicating that action should be taken because of probable enrollee fraud at least five (5) days before the date of action. [25]
- At least ten (10) calendar days before the date of adverse benefit determination for termination, suspension, or reduction of previously authorized covered services. 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 enrollee
  - The health plan receives a clear, written statement signed by the enrollee 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 enrollee's whereabouts are unknown and the post office returns health plan mail directed to the enrollee indicating no forwarding address (refer to 42 C.F.R. § 431.231(d) for procedures if the enrollee's whereabouts become known)
  - The enrollee's physician prescribes a change in the level of medical care
  - The enrollee's admission to an institution where he is ineligible for further services
  - The enrollee 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 enrollee liability
- Within the timeframes required by the service accessibility standards for prior authorization specified herein for service authorization decisions that deny or limit services

Aetna Better Health will offer the informal reconsideration at a mutually agreed upon time, which shall occur within one (1) Business Day of the receipt of the request and shall be conducted between the provider rendering the service and Aetna Better Health's physician authorized to make adverse determinations or a clinical peer designated by the

[25] 2023 Louisiana Medicaid Managed Care Organization Statement or Work, Section 2.12.1.2.3: 42 CFR §455.1(a)(1)

medical director if the physician who made the adverse determination cannot be available within one (1) Business Day.[26]

Appeal Request

The following apply to appeal requests:

- Filing an appeal or State fair hearing will not negatively affect or impact the Aetna Better Health enrollee or practitioners/providers who treat the enrollee.
- An enrollee may authorize anyone including but not limited to legal counsel, a relative, a friend, a practitioner/provider or other spokesperson to represent them to file an appeal on their behalf.[27] Enrollee assignment of an authorized representative must be in writing and on file with the health plan.[28]
- If Aetna Better Health receives an appeal from the provider, the date received is still the date Aetna Better Health received; however, if there is no written consent from the member, the appeal is to be immediately closed (due to no member written consent). Once the member's written consent is received, the appeal should be logged using the date the written consent was received as the received date and a new tracking number assigned.
- The enrollee and/or the enrollee's representative may present supporting documentation or evidence in person or in writing on or before the date of the appeal meeting date.[29] The enrollee and/or their representative may request to review the enrollee'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.
- Enrollee, or an enrollee's representative acting on behalf of the enrollee with written consent of the enrollee, must file an appeal no later than sixty (60) calendar days from the date on the *Notice of Adverse benefit determination.*[30] The expiration date to file an appeal is included in the *Notice of Adverse benefit determination*.

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[26] 2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract, Section 2.12.6.4.3.3
[27] NCQA HP 2024/2025 UM8 A16
[28] CFR §438.408(c)(1)(ii)
[29] NCQA HP 2024/2025 UM8 A5
[30] 42 C.F.R. § 438.402(c)(2)(ii); NCQA HP 2024/2025 UM8 A2: 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.1.1

- Enrollees or their representative may file an appeal either verbally by contacting Aetna Better Health's Enrollee 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

- Aetna Better Health's Enrollee Service department will provide enrollees 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.[31]
- 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~~ **each** appeal~~s~~ in writing within five (5) business days **of receipt unless the member requests an expedited resolution** ~~after receiving an appeal request~~.[32]
- Oral inquiries seeking to appeal are treated as appeals. (to establish the earliest possible filing date for the appeal). **Once an oral Appeal is received, Aetna Better Health will inform the member they will receive a notice or written confirmation of the Appeal. The date of the oral filing will consititute date of receipt.[33]**
- 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 state fair hearings in the Appeal and Grievance Application. The content will be available to the Department in electronic format upon request.

[31] NCQA HP 2024/2025 ME7 B5; 2024/2025 UM8 A17
[32] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.1.3
[33] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.1.2

- Within five (5) business days [34] of receipt of the written appeal, the Appeal and Grievance department will send an acknowledgement letter to the enrollee or authorized enrollee representative and the enrollee'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[35]

An enrollee may continue to receive services for an ongoing course of treatment that were previously approved during the appeals process under the following circumstances:[36]

- The appeal is filed timely[37]
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment[38]
- The enrollee or their designed representative request continuation of benefits[39]
- The services were ordered by an authorized practitioner/provider; and[40]
- The original period covered by the original authorization has not expired.[41]

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[42]
- The intended effective date of the health plan's proposed adverse benefit determination[43]

The health plan will continue the enrollee's benefits until one of the following occurs:

[34] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.1.3
[35] NCQA HP 2024/2025 UM8 A18: 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2
[36] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1
[37] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.1
[38] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.2
[39] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.5
[40] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.3
[41] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.4
[42] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.1
[43] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.1.1

- The enrollee withdraws the appeal[44]
- Ten (10) calendar days pass after Aetna Better Health mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, 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[45]
- A State fair hearing officer issues a hearing decision adverse to the enrollee.[46]
- The time period or service limits of a previously authorized service has been met[47]

If the final resolution of the appeal is adverse to the enrollee, that is, upholds Aetna Better Health's adverse benefit determination, Aetna Better Health may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. The enrollee is informed that he/she can be financial liable for the services that were rendered during this process.[48]

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, breach of contract, benefit limitation or exhaustion and do not require a clinician to interpret the contractual limitation or apply clinical judgment to the limitation. Service code requests that fall under EPSDT are excluded from administrative denials.

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/code
- Failure to obtain a prior authorization

[44] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.2.1 / 2.15.4.8.1
[45] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.2.2 / 2.15.4.6
[46] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.2.3 / 2.15.4.8.2
[47] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.2.2.4
[48] 42 C.F.R. § 438.420(d) / 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.3.2

- Breach of Contract, (e.g., when Aetna Better Health's contract requires notification of an admission within a specified timeframe and no notification is received)

Appeal Rights for an Administrative Denial

An appeal may be filed for the administrative denial. The appeal must specifically state the factual basis for the administrative appeal and the relief requested. You may attach any documents that you believe will assist us in reviewing your administrative appeal. Members or their designated representative can file a standard appeal with Aetna Better Health orally or in writing within sixty (60) calendar days from the postmark on the Aetna Better Health Notice of Adverse benefit determination, also called the Notice of Action (NOA). We will review your request and let you know our decision within the standard appeal timeframes.

Appeals of administrative denials are limited to appeals for classification of the decision as administrative.

Appeal Review - Same or Similar Specialty Review[49]

The decision to uphold a medical necessity denial requires review by a same-or-similar specialist. The same-or-similar specialist may be the same individual designated to make the appeal decision, or a separate reviewer who provides a recommendation to the individual making the decision as part of the appeal investigation. All practitioner types listed below can serve as a same-or-similar specialist. To be considered a same-or-similar specialist, the reviewing specialist's clinical training and experience, in relation to the subject of appeal, must:

- Include treating the condition
- Include treating complications that may result from the service or procedure
- Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate

The below requirements refer to clinical training and experience and therefore, experience that is limited to UM decision making is not considered sufficient experience and does not supersede the requirement for same-or-similar specialist review. Board certification in a specialty may be used as a proxy for clinical training and experience.

[49] NCQA HP 2024/2025 UM8 A7

Medical Necessity Appeals[50]

For appeals that require medical necessity review, the final decision to uphold an appeal must be made by an appropriate practitioner who was not involved in the initial denial decision and is not subordinate to the practitioner who made the initial denial decision. The following practitioner types are considered appropriate for review of UM denial decisions for Aetna Better Health:

- Physicians, all types: Medical, BH, pharmaceutical, dental, chiropractic and vision denials
- Dentists: Dental denials

These practitioners:

- Are clinical peers as defined above
- 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)
- Are chiropractors when reviewing chiropractic appeals

Non Clinical Appeals

For appeals that no not require medical necessity review, the final decision to uphold an appeal must be made by an individual who was not involved in the initial denial decision and is not subordinate to the individual who were not involved in any previous level of review or decision making.

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

[50] NCQA HP 2024/2025 UM8 A6

Better Health's Privacy Policies, which comply with Health Insurance Portability and Accountability Act (HIPAA) requirements.

- The enrollee 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.[51] Aetna Better Health will inform the enrollee 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.[52] Aetna Better Health documents when enrollees fail to submit relevant information by the specified deadline.[53]
- 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 appeal review does not give deference to the denial decision.[54]
- The enrollee and his or her representative are provided with an opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process free of charge.[55]
- The appeals process will include, as parties to the appeal, the enrollee and his or her representative or the legal representative of a deceased enrollee's estate.[56]
- 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: [57]
  - Previous denial or appeal history, follow-up activities associated with the denial and conducted before the current appeal.[58]
  - 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

[51] NCQA HP 2024/2025 UM8 A5: 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.1.4
[52] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.4.3
[53] NCQA HP 2024/2025 UM8 A5
[54] NCQA HP 2024/2025 UM8 A4
[55] NCQA HP 2024/2025 UM8 A14; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.1.5
[56] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.1.6.1 / 2.15.3.1.6.2
[57] NCQA HP 2024/2025 ME7 B1, B2; 2024/2025 UM8 A3, A4, A7
[58] NCQA HP 2024/2025 UM8 A3

practitioner/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
  - Additional clinical information and documentation submitted by the enrollee enrollee's representative, enrollee's practitioner and/or enrollee'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.[59]
- The health plan reports appeals to the state agency in the format and frequency specified by the state agency.[60]
- 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 enrollee.

Any changes to the appeal process are submitted to Louisiana Department of Health for approval prior to implementation. Enrollees 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.[61]

Timeframe for Resolving – Expedited Appeals[62]

An enrollee or an enrollee'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

[59] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.7
[60] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.8
[61] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.12.1
[62] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.4.1

to attain, maintain or regain maximum function. Expedited appeals may be submitted orally or in writing and do need written consent for the practitioner to file on behalf of the enrollee.[63]

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 enrollee'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 an enrollee's request meets expedited urgency or a practitioner supports the enrollee's request, Aetna Better Health's medical director renders a decision as expeditiously as the enrollee's health requires, within seventy-two (72) hours from the receipt of request.[64] Aetna Better Health grants an expedited review for all requests concerning admissions, continued stay or other health care services for an enrollee 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 [65] of an initial oral notification and within the original seventy-two (72) hours.[66]

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 an enrollee who requests an appeal or a practitioner/provider who requests an expedited resolution or supports a enrollee's appeal.[67]

If an enrollee or enrollee'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

[63] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.11
[64] 42 C.F.R. § 438.408(b)(3); NCQA HP 2024/2025 ME7 B3, B4; 2024/2025 UM8 A11
[65] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.4.5
[66] 42 C.F.R. § 438.408(b)(3); NCQA HP 2024/2025 ME7 B3, B4; 2024/2025 UM8 A11; 2024/2025 UM9 B4
[67] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.10; 2.15.4.11

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 enrollee and/or practitioner prompt oral notice of the denial and follow up within two (2) calendar days of receipt of request[68] with a written notice that the appeal will be handled through the non-expedited standard process.[69]

Timeframe for Resolving – Pre-service and Post-service Standard Appeals[70]

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

- Pre-service standard appeal: thirty (30) calendar days from the date the appeal is received [71]
- Post-service standard appeal: thirty (30) calendar days from the date the appeal is received [72]

Appeal Extension[73]

- Aetna Better Health may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days if the enrollee 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 enrollee's interest
- Aetna Better Health will confirm the enrollee's request for an extension in writing
- If the enrollee 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.[74]

[68] 42 C.F.R. § 438.408(c)(2)(ii)
[69] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.4.5
[70] NCQA HP 2024/2025 ME7 B4, 2024/2025 UM9 B
[71] 42 C.F.R. § 438.408(b)(2); NCQA HP 2024/2025 ME7 B4; 2024/2025 UM8 A8; 2024/2025 UM9 B1; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.3.1
[72] 42 C.F.R. § 438.408(b)(2); NCQA HP 2024/2025 ME7 B4, 2024/2025 UM8 A10; 2024/2025 UM9 B3: 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.3.1
[73] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.2.4
[74] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.4.4

- If the resolution timeframe is being extended and was not requested by the enrollee, Aetna Better Health must make reasonable attempts to give oral notification of delay[75] and must give written notice of the delay within two (2) calendar days of the decision to delay[76] and within the original standard or expedited timeframe to the affected parties. The written notice of delay will include the enrollee'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 or non coverage and/or medical necessity, a decision is reached. Medical Necessity appeals are then approved and signed by Aetna Better Health's Medical Director or a physician designee. Non-clinical appeals are then decided by the Appeal and Grievance staff member. A written *Appeal Decision Letter* is sent to the enrollee, their representative if designated and their treating practitioner as expeditiously as the enrollee's health requires but not to exceed two (2) calendar days [77] 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.[78] State fair hearings are available through the State Agency at Louisiana Division of Administrative Law at 1-225-342-1800.[79]

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 enrollee's health condition requires within seventy-two (72) hours of the decision to overturn.[80]

[75] 42 C.F.R. § 438.408(c)(2)(i); 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.5.2.1
[76] 42 C.F.R. § 438.408(c)(2)(ii); 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.5.2.2
[77] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.4.5
[78] NCQA HP 2024/2025 ME7 B3
[79] NCQA HP 2024/2025 UM8 A12
[80] 42 C.F.R. § 438.424(a)

If Aetna Better Health reverses the decision to deny authorization of services, and the enrollee 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:[81]

- Unique appeal number[82]
- The results of the resolution process and the date it was completed
- The specific reasons for the decision, in easily understandable language, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. If abbreviations are used, they are to be clearly explained in lay language.[83]
- For appeals not resolved wholly in the favor of the enrollees, the right to request a State fair hearing and how to do so[84]
- The right to request a continuation of benefits while the hearing is pending and how to make the request[85]
- Notification that the enrollee may be held liable for the cost of those benefits if the hearing decision upholds Aetna Better Health's adverse benefit determination[86]
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based[87]
- Notification that the enrollee 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 enrollee is entitled to receive, free of charge and, upon request, reasonable access to and copies of all documents relevant to the appeal. Relevant

[81] NCQA HP 2024/2025 UM9 D
[82] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.3.5.2
[83] NCQA HP 2024/2025 UM8 A8-11
[84] NCQA HP 2024/2025 ME7 B3; 2024/2025 UM8 A12
[85] 42 C.F.R. § 438.420(b)-(c); NCQA HP 2024/2025 UM8 A18
[86] 42 C.F.R. § 438.420(d)
[87] NCQA HP 2024/2025 UM8 A13

documents include documents or record relied upon and document and records submitted in the course of making the appeal decision[88]

- For clinical (medical necessity) appeal reviews, a list of the titles, qualifications and specialties of each practioner participating in the appeal review, including the same-or-similar specialist reviewer, when applicable.[89]
- For non-clinical (benefit) appeal reviews, a list of the titles and qualifications of each individual participating in the appeal review.[90]
- Participant names need not be include in the written notification to the enrollees, but must be provided to enrollees, 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 enrollee may be held financially liable for such services if the state upholds the denial decision[91]

Request for State fair hearing[92]

- The enrollee 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.[93] The enrollee 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 enrollee has met the timeline of within one hundred twenty (120) calendar days of the Appeal Decision letter to request a State fair hearing.

[88] NCQA HP 2024/2025 UM8 A14
[89] NCQA HP 2024/2025 UM8 A15
[90] NCQA HP 2024/2025 UM8 A15
[91] NCQA HP 2024/2025 UM8 A18
[92] NCQA HP 2024/2025 ME7 B3; 2024/2025 UM8 A12
[93] 42 C.F.R. § 438.408(f)(2) : 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.1

- Aetna Better Health will notify Division of Administrative Law within two (2) business days if the enrollee 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.[94] 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[95]
- 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.[96]
- For expedited fair hearing requests Aetna Better Health will forward a copy of the enrollee'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 enrollee appeals at the hearing level.[97]
- 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.[98]
- The parties to the State Fair Hearing include Aetna Better Health, the enrollee and his or her representative or the representative of a deceased enrollee's estate.[99]
- 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

[94] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.3
[95] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.3
[96] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.4
[97] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.2
[98] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.5
[99] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4

provide the disputed services promptly and as expeditiously as the enrollee's health condition requires within seventy-two (72) hours of the notification of the overturn.[100]

- If the State fair hearing officer reverses the decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, Aetna Better Health will pay for those services.[101]

OPERATING PROTOCOL:

Systems

- All appeals are entered and tracked in the Appeal and Grievance Application.
- Enrollee, 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

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

[100] 42 C.F.R. § 438.424(a) ; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.9
[101] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.7

- Chief medical officer (CMO) or designated medical director
- Chief operating officer (COO)
- Enrollee Services
- Medical Services
- Provider Relations
- Quality Management

External

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

Aetna Better Health

Bridget L Galatas
Chief Executive Officer

Brian Knobloch
Chief Operating Officer