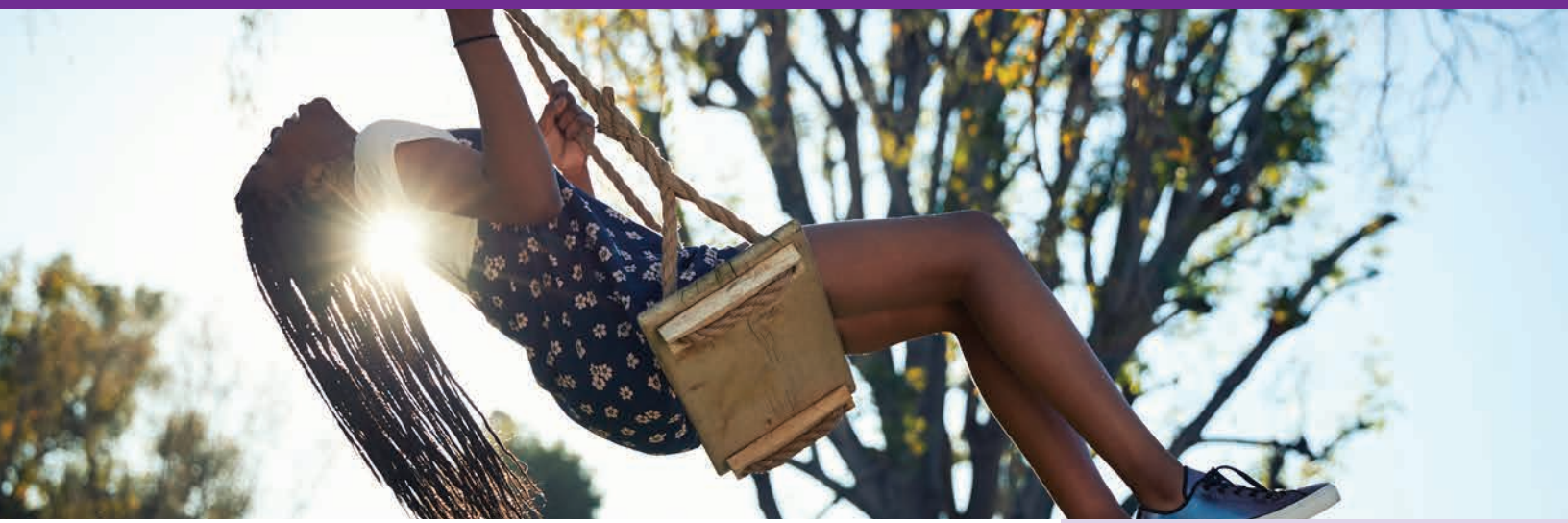
Provider newsletter

Summer 2020



Referrals

The primary care provider (PCP) is responsible for coordinating the provision of specialist services. The specialist and PCP work together to coordinate medical care for the member.

Why are referrals important?

- Support coordination of care between PCP and specialist
- Promote the right care at the right time
- Ensure enrollees receive preventive, primary care services, not just specialty care

No PCP referral is required for the following direct-access services: chiropractic, dermatology (five visits/year), routine podiatric care, optometry, behavioral health, and OB/GYN.

PCP referrals are required for all other specialist services. Referrals can be done electronically via our secure portal at **AetnaBetterHealth.com/Florida/providers/provider-portal**. If a paper version is preferred, it can be downloaded and printed from the Aetna Better Health of Florida website under Authorizations at **AetnaBetterHealth.com/Florida/providers/provider-auth**.

Specialists will coordinate the provision of specialist services with the PCP in a prompt and efficient manner and furnish a written report within 10 business days of the specialist services. Specialists will refer the member back to the PCP if they determine the member needs the services of another specialist.

In this issue

Utilization management (UM) criteria and availability/UM decisions

UM is a system for reviewing eligibility for benefits for the care that has been or will be provided to patients. The UM department is composed of:

- Preauthorization
- Concurrent review
- Case management

Medical necessity is based upon clinical standards and guidelines as well as clinical judgment. All clinical standards and guidelines used in the UM program have been reviewed and approved by practicing, participating physicians in our network. You can receive a copy of our clinical standards and guidelines by calling us at **1-800-441-5501**, 8 AM to 7 PM ET.

The medical director makes all final decisions regarding the denial of coverage for services when the services are reviewed via our UM program. The provider is advised that the decision is a payment decision and not a denial of care. The responsibility for treatment remains with the attending physicians. The medical director is available to discuss denials with attending physicians and other providers during the decision process. Notification includes the criteria used and the clinical reason(s) for the adverse decision. It includes instructions on how to request reconsideration as well as a contact person's name, address and phone number.

The policy on payment for services helps ensure that the UM decision-making process is based on consistent application of appropriate criteria and policies rather than financial incentives.

- UM decisions are based only on appropriateness of care and service and the existence of coverage
- We do not reward practitioners, providers or other individuals conducting utilization review for issuing denials of coverage or service care.
- The compensation that we pay to practitioners, providers and staff assisting in utilization related decisions does not encourage decisions that result in underutilization or barriers to care or service.

The UM staff is available to discuss specific cases or UM questions by phone by calling **1-800-441-5501** (Medicaid), **1-844-645-7371** (Comprehensive Long-Term Care), or **1-844-528-5815** (Florida Healthy Kids); TTY: **711** from 8 AM to 7 PM ET. UM staff is available on holidays and weekends by voice mail and fax.

Grievance and appeals

Effective March 1, 2020, our Provider/Member grievance and appeals mailing address has changed. We kindly ask you that you update your records accordingly and to address all future grievances and appeals to our new mailing addresses as follows:

Provider Grievance and Appeals NEW address
Aetna Better Health of Florida
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Member Grievance and Appeals NEW address
Aetna Better Health of Florida
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

Claims adjustment requests and provider claim reconsideration form

There are two forms to help you with your claim questions and concerns. These forms also include information regarding reconsiderations, claims inquiry, disputes, appeals and examples for your review.

The forms can be found on our website for your convenience: **Claims Adjustment Request & Provider Claim Reconsideration Form**

You may use the claims adjustment request form for provider claims inquiries and disputes concerning non-clinical denials and rate reimbursement disagreements; or the provider claim reconsideration form for the following reasons:

- Itemized bill
- Duplicate claim
- Corrected claim (note "corrected" on claim)
- Coordination of benefits (note "corrected" on claim)
- Proof of timely filing
- Claim/coding reconsideration
- Other claim reconsideration

Provider claim reconsideration form

Complete the information in its entirety and mail with supporting documentation and a copy of your claim to the address listed at the bottom of this form. Questions regarding a submission should be directed to Claims Inquiry/Claims Research at **1-800-441-5501**. Please use one form per member.

Claims adjustment request form

You may use this form for provider claims inquiries and disputes concerning non-clinical denials and rate reimbursement disagreements. The claims adjustment request form does not initiate a formal claim dispute. It also does not push back the deadline to file a written formal dispute, which is the first step of an official appeal and must be filed within 45 calendar days of original decision shown in the member's EOP/EOB. For more information, see Aetna Better Health of Florida's Provider Manual.

With the claims adjustment request form, include a copy of the EOP/EOB(s) with claim(s) to be reviewed clearly circled. The form may be submitted via:

- Email: **FLAppealsandGrievances@aetna.com**
- Fax: **1-860-607-7894**

Important notice

Aetna Better Health of Florida's Provider Relations department will make reasonable efforts to resolve this request within 30 calendar days of receipt. That resolution may be:

- Reprocessing your claim and issuing a new EOP with new payment information, or
- A determination that a formal dispute is required and issuing you a letter to that effect, or
- A determination that reprocessing is not appropriate and issuing you a letter to that effect.

We appreciate the excellent care you provide to our members. If you have any questions, contact us via e-mail: **FLMedicaidProviderRelations@aetna.com**. You can also fax us at **1-844-235-1340** or call Provider Relations at **1-844-528-5815**.

Pharmacy restrictions and preferences, how to access our drug formularies

You can gain access to the Aetna Better Health of Florida formularies at **AetnaBetterHealth.com/Florida**. The formularies can be found under the "For Providers" tab, "Pharmacy" and "Formulary/Preferred Drug List" areas. This will provide you to access the Florida Medicaid preferred drug list (PDL) and/or the Florida Healthy Kids formulary search tool and formulary document.

Please note, the formulary can change at any time, due to the ever-changing world of medicine. You can find the list of formulary changes on our website under the "For Providers" tab, "Pharmacy" then click on the "Preferred Drug List & Formulary Updates" tab.

If you have any questions regarding the formulary, contact us at the toll-free numbers below or visit our website.

- Medicaid Provider Relations: **1-800-441-5501**
- Florida Healthy Kids Provider Relations: **1-844-528-5815**

Clinical practice guidelines

Aetna Better Health of Florida makes clinical decisions regarding members' health based on the most appropriate care and service available. We make these decisions based on appropriate clinical criteria. The criteria used in the decision-making process will be provided upon request by contacting the Member Services number listed on the back of the member's ID card.

Criteria may be viewed on **AetnaBetterHealth.com/Florida** or a hard copy may be requested. We adopt evidence-based clinical practice guidelines (CPG) from national recognized sources. These guidelines have been adopted to promote consistent application of evidence-based treatment methodologies and made available to practitioners to facilitate improvement of health care and reduce unnecessary variations in care.

Aetna Better Health reviews the CPGs every two years or more frequently if national guidelines change within the two-year period. CPGs that have been formally adopted can be found on the Aetna Better Health website at **AetnaBetterHealth.com/Florida**. The CPGs are provided for informational purposes only and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider's clinical judgment regarding the appropriate treatment of a patient in any given case.

Our provider portal

Aetna Better Health of Florida offers easy access to a variety of functions, web-based tools, and resources at **AetnaBetterHealth-Florida.com**. All participating providers may use this resource to access business activity information such as:

- Claim inquiries
- Authorization requirements and information
- Remittance advices
- Member eligibility
- Business forms
- Provider manual
- Member benefit information
- Other business information or documentation
- Member health alerts

Our secure web portal can be accessed at **AetnaBetterHealth-Florida.com**. The Provider Relations team is available to address questions regarding the website and services. You may contact a representative at **1-800-441-5501** or **1-800-645-7371**, Monday – Friday, 8 AM – 7 PM ET. Signing up is quick and easy. Have your federal tax identification number available.

Member rights and responsibilities

We have adopted the Florida Member's Bill of Rights and Responsibilities. Members can request a copy of it from their doctor or from Member Services.

Rights:

- You have the right to be treated with courtesy and respect
- You have the right to have your privacy protected
- You have the right to a response to questions and requests
- You have the right to know who is providing services to you
- You have the right to know the services that are available, including an interpreter if you don't speak English
- You have the right to know the rules and regulations about your conduct
- You have the right to be given information about your health
- You have the right to refuse any treatment, except as otherwise provided by law
- You have the right to get service from out-of-network providers
- You have the right to get family planning services without prior authorization
- You have the right to be given information and counseling on the financial resources for your care
- You have the right to know if the provider or facility accepts the assignment rate
- You have the right to receive an estimate of charges for your care
- You have the right to receive a bill and to have the charges explained
- You have the right to be treated regardless of race, national origin, religion, handicap, or source of payment
- You have the right to be treated in an emergency
- You have the right to participate in experimental research
- You have the right to file a grievance if you think your rights have been violated
- You have the right to information about our doctors
- You have the right to be treated with respect and with due consideration for your dignity and privacy
- You have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand
- You have the right to participate in decisions regarding your health care, including the right to refuse treatment
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- You have the right to request and receive a copy of your medical records and request that they be amended or corrected
- You have the right to be furnished health care services in accordance with federal and state regulations
- You are free to exercise your rights, and the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat you

Responsibilities

- You should provide accurate and complete information about your health
- You should report unexpected changes in your condition
- You should report that you understand your care and what is expected of you
- You should follow the treatment plan recommended
- You should keep appointments
- You should follow your doctor's instructions
- You should make sure your health care bills are paid
- You should follow health care facility rules and regulations

Early intervention services (EIS) prior authorization and modifier requirement

Effective April 1, 2020, Aetna Better Health of Florida implemented changes in the way that early intervention services (EIS) therapy claims are billed. The TL modifier is required to ensure that claims are paid with the correct reimbursement fee when billing physical therapy (PT), occupational therapy (OT) and speech-language therapy (ST) treatment and assistance claims.

Please review the table below with details about the codes that require the TL modifier when billing Aetna Better Health of Florida. Prior authorization for these services is NOT required.

If you have any questions please contact us via e-mail at **FLMedicaidProviderRelations@aetna.com**, fax at **1-844-235-1340** or call Provider Relations at **1-844-528-5815**.

Early intervention services (EIS) – billing therapy with TL modifier

Therapy service	Code	Modifier	NEW Aetna required modifier	Description	Maximum allowable units
Physical therapy	97110		TL	Physical therapy treatment visit	4 per day, 14 per week
Physical therapy	97110	HM	TL	Physical therapy visit provided by a physical therapy assistant	4 per day, 14 per week
Occupational therapy	97530		TL	Occupational therapy treatment visit	4 per day, 14 per week
Occupational therapy	97530	HM	TL	Occupational therapy visit provided by an occupational therapy assistant	4 per day, 14 per week
Speech-language therapy	92507		TL	Speech therapy visit	4 per day, 14 per week
Speech-language therapy	92508	HA	TL	Group speech therapy per child in the group per 15 minutes	4 per day, 14 per week
Speech-language therapy	92507	HM	TL	Speech therapy visit provided by a speech therapy assistant	4 per day, 14 per week

Effective 04/01/2020, the TL modifier is required when billing Aetna Better Health of Florida.

PCP toolkit – behavioral health trainings

Aetna Better Health of Florida, along with our behavioral health partner, Beacon, takes great pride in our network of physicians and related professionals who serve our members with the highest level of quality care and service. We're absolutely committed to making sure our providers receive the best possible and latest information, technology and tools available to ensure their success and their ability to provide for clients.

We are happy to announce that behavioral health trainings will be available every month on our website.

Visit our Aetna Better Health of Florida website by clicking on Provider Education followed by Behavioral Health Trainings **AetnaBetterHealth.com/Florida/providers/education**.

Should you have questions or require additional information, contact Provider Relations at **1-844-528-5815**, email **FLMedicaidProviderRelations@aetna.com**, or fax **1-844-235-1340**.

Aetna Better Health's timely filing guidelines

To avoid payments delays or untimely denials, follow Aetna Better Health's timely filing standards listed below.

Plan participating providers	Provider shall mail or electronically transfer (submit) the claim within **180 days** after the date of service or discharge from an inpatient admission. (F.S. 641.3155)
Non participating providers	Provider shall mail or electronically transfer (submit) the claim within **365 days** after the date of service or discharge from an inpatient admission. (SMMC Contract) (Section VIII.D)(E)(2)
Plan as secondary payor	When the managed care plan is the secondary payer, the provider must submit the claim within **90 calendar days** after the final determination of the primary payer. (SMMC Contract) (Section VIII)(E)(1)(h)
Medicare crossover	When the managed care plan is the secondary payer to Medicare, and the claim is a Medicare crossover claim, these must be submitted within **36 months** of the original submission to Medicare. (SMMC Contract) (Section VIII)(E)(2)(d)(2)
Corrected claims	Provider shall mail or electronically transfer (submit) the corrected claim within 180 days from the date of service or discharge from an inpatient admission. (F.S. 641.3155)
Return of requested additional information (itemized bill, ER records, med records, attachments)	Provider must submit any additional information or documentation as specified, within **35 days** after receipt of the notification. Additional information is considered received on the date it is electronically transferred or mailed. Aetna Better Health cannot request duplicate documents. (F.S. 641.3155(2)(c)(2)

Access to care and service standards

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history. Our Provider Relations Department will routinely monitor compliance and seek corrective action plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standard. Providers are contractually required to meet standards for timely access to care and services, considering the urgency of and the need for the services.

Providers shall offer appointments and access to members within the specified guidelines. Review your provider manual for details online at **AetnaBetterHealth.com/Florida/provider-manual**.

Hours of operation/quick reference guide

Health plan main office	Provider & member services phone numbers
261 N University Drive Plantation, FL 33324	MMA **1-800-441-5501** LTC **1-844-645-7371** FHK **1-844-528-5815**
Hours of operation	**Provider & member services fax numbers**
Monday through Friday 7:30 AM to 7:30 PM ET	Provider services fax: **1-844-235-1340** Member services fax: **1-877-542-6958**
Claims/billing address	**To file a provider appeal**
Aetna Better Health of Florida P.O. Box 63578 Phoenix, AZ 85082-1925	Aetna Better Health of Florida PO Box 81040, 5801 Postal Road Cleveland, OH 44181
Claims payer ID for EDI	**Real time payer ID**
128FL	ABHFL
Claim timely filing – initial & corrected claims	**Claims inquiry / claims research (CICR)**
180 days from date of service or date of discharge	MMA **1-800-441-5501** option 5, 5, 3 FHK **1-844-528-5815** option 5, 4, 3
Fraud & abuse hotline	**Nurse line**
1-888-891-8910	MMA **1-800-441-5501** FHK **1-844-528-5815**
Provider services email address	**CVS mail order phone number**
FLMedicaidProviderRelations@aetna.com	**1-855-271-6603**
Pharmacy helpdesk number	**Web portal**
1-866-693-4445	**AetnaBetterHealth.com/Florida/login**
Prior authorization phone numbers	**Prior authorization fax numbers**
MMA **1-800-441-5501** LTC **1-844-645-7371** FHK **1-844-528-5815**	MMA, LTC, FHK (general services) Fax: **1-860-607-8056** Obstetrics fax: **1-860-607-8726** Pharmacy fax: **1-855-799-2554**
Vendor phone numbers	
Beacon/PsychCare Behavioral Health **1-844-513-4954** eviCore (radiology, pain management, cardio) **1-888-693-3211**	HearUSA Hearing **1-800-442-8231** (option 2) iCare Vision **1-866-770-8170**