Aetna Better Health® of Florida

Maternity Provider Training

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Continuity of Care

The Statewide Medicaid Managed Care Managed Medical Assistance (SMMC MMA) requirements for COC for new members mandate that we pay for COC services rendered to new enrollees transitioning to Aetna Better Health of Florida.

In the event a new Aetna Better Health of Florida member is receiving prior authorized, ongoing treatment with any provider, including services previously authorized under the fee-for service delivery system or by the enrollee's previous managed care plan, Aetna Better Health of Florida is responsible for the costs of continuation of such treatment.

This responsibility stands without any form of authorization and without regard to whether such services are being provided by participating or nonparticipating providers for p to 60 days after the effective date of enrollment.

Timely Filing Requirements

Providers should submit timely, complete, and accurate claims to the Aetna Better Health of Florida.

Untimely claims will be denied when they are submitted past the timely filing deadline.

Unless otherwise stated in the provider agreement, the following guidelines apply.

Provider / Claim Type	Guideline
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 **ninety (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 cross over 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)	A provider must submit any additional information or documentation as specified, within **thirty-five (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)

Grievance & Appeals Summary

Provider Appeals = Request to review the denial of or payment on a claim

- NOTE: When submitting pre-service requests on behalf of a member you must have written consent. These requests are processed as a member appeals and subject to member appeal timeframes and processes.

Complaints/Grievances = Dissatisfaction with anything else not related to a claim

Interfiling vs. Bundling

- **Interfiled** = submitting multiple unrelated claim denials for appeal in one packet.
- **Bundling** = a submission of multiple claims with the same denial reason as one appeal. For example, code XXXX denies every time you submit a claim, or all claims for Jane Doe are denied.

Claim Resubmissions

- Resubmitted claims = claims that are being resubmitted for reprocessing, including but not limited to corrected claims, hard copy claims that were denied due to missing information

Appeals Submissions

As of March 1, 2022, Aetna Better Health will no longer accept Provider mail that is directed to our 261 N. University Dr. Plantation, FL 33324 office.

If you are submitting an interfiled appeal request (multiple unrelated claims) in one mailing you must use physical barriers (elastic, paper clip, binder clip, blank sheet of colored paper etc.) for each claim in the submission.

Appeals, Complaints and Grievances

Whenever possible please submit your appeal, complaint or grievance electronically.

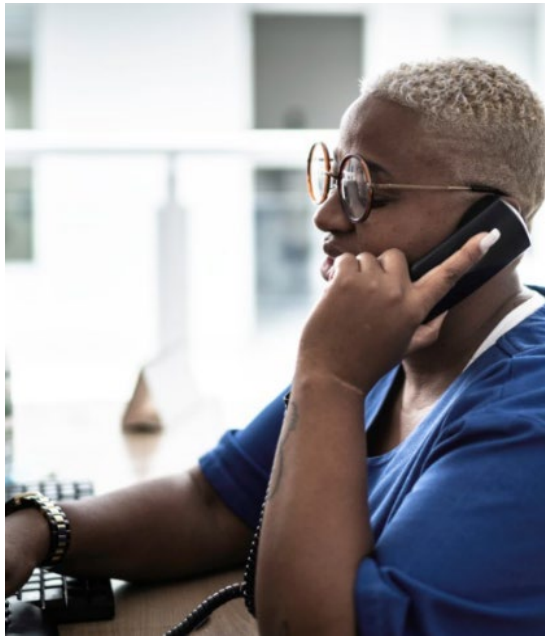
- It is preferred that you submit through the Availity provider portal using the direct application for Appeals, Complaints and Grievances: https://apps.availity.com/availity/web/public.elegant.login
- You may submit by fax to: **1-860-607-7894**

If you prefer to mail hard copy requests for an appeal, complaint or grievance, they must be sent to:

Aetna Better Health of Florida
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Medical necessity claim appeals must be submitted within sixty (60) calendar days from the claim denial or the resubmission denial.

Complaints/Grievances may be submitted at any time.



Managed Medicaid Expanded Benefits- Doulas

Doulas- are trained professionals who provide continuous physical, emotional and informational support to a mother before, during and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible.

- Doula Services are expanded benefits provided to the member fee of charge.

Service	Description	Coverage/Limitations	Prior Authorization
Doula Services	Home visits for care before baby is born, care after baby is born, and newborn visit by Doula	No limit for pregnant female members 14 to 55 years of age	Yes

Credentialing

Credentialing is not required if the Doula is not a registered nurse/midwife or has a masters level certification.

- Prior Authorization is required for Doula Services.

Doula Provider Billing Guide:

https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/florida/provider/pdf/doula_provider_billing_guide.pdf

Approved Doula Service Codes and Diagnosis

Codes	Modifier	Description
S9442		Birthing classes, non-physician provider, per session
S9443		Lactation classes, non-physician provider, per session
S9444		Parenting classes, non-physician provider, per session
S9445		Prenatal education (patient education non classified, non-physician)
S9445	TS	Postpartum education (patient education non classified, non-physician)
S9446		Prenatal patient education, not otherwise classified, non-physician provider, group, per session
S9446	TS	Postpartum patient education, not otherwise classified, non-physician provider, group, per session
59400	XU	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	XU	Doula support for vaginal delivery only
59510	XU	Standard doula benefit with support at cesarean delivery; Global code: routine obstetric care including antepartum care, C-section delivery, and postpartum
59514	XU	Doula support during Cesarean delivery only. 1 per delivery
59610	XU	Standard doula benefit with support at VBAC delivery; Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery Codes Used
59612	XU	Doula support for VBAC delivery only, with or without episiotomy and/or forceps
59618	XU	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after failed attempt at vaginal delivery after cesarean.
59620	XU	Doula support for Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Obstetrical (OB) Care Management Program

- An obstetrical nurse works with Obstetricians and Perinatologists to help coordinate services during pregnancy for members with high-risk conditions.
- The care manager also monitors the mother and newborn progress through the sixth week postpartum follow-up visit.
- Call Member Services at 1-800-441-5501 and ask to speak to someone on our Care Management team to enroll a patient.
- Members can choose to join or leave the program at any time.

OB Provider Incentive

How does the OB Provider Incentive work?

ABHFL is offering $50-$100 to providers who submit a completed Obstetrical Form Notification

- $100 incentive for providers that submit a completed Obstetrical Form notification for members that are in their first trimester of pregnancy
- $50 incentive for providers that submit a completed Obstetrical Form notification for members that are in their second or third trimester of pregnancy

How to submit the form

- Visit the ABHFL website https://www.aetnabetterhealth.com/florida
- Select Providers, authorizations and then Obstetrical Notification Form
- Enter the required information
- Fax the completed form to us at 1-860-607-8726

Receiving payment

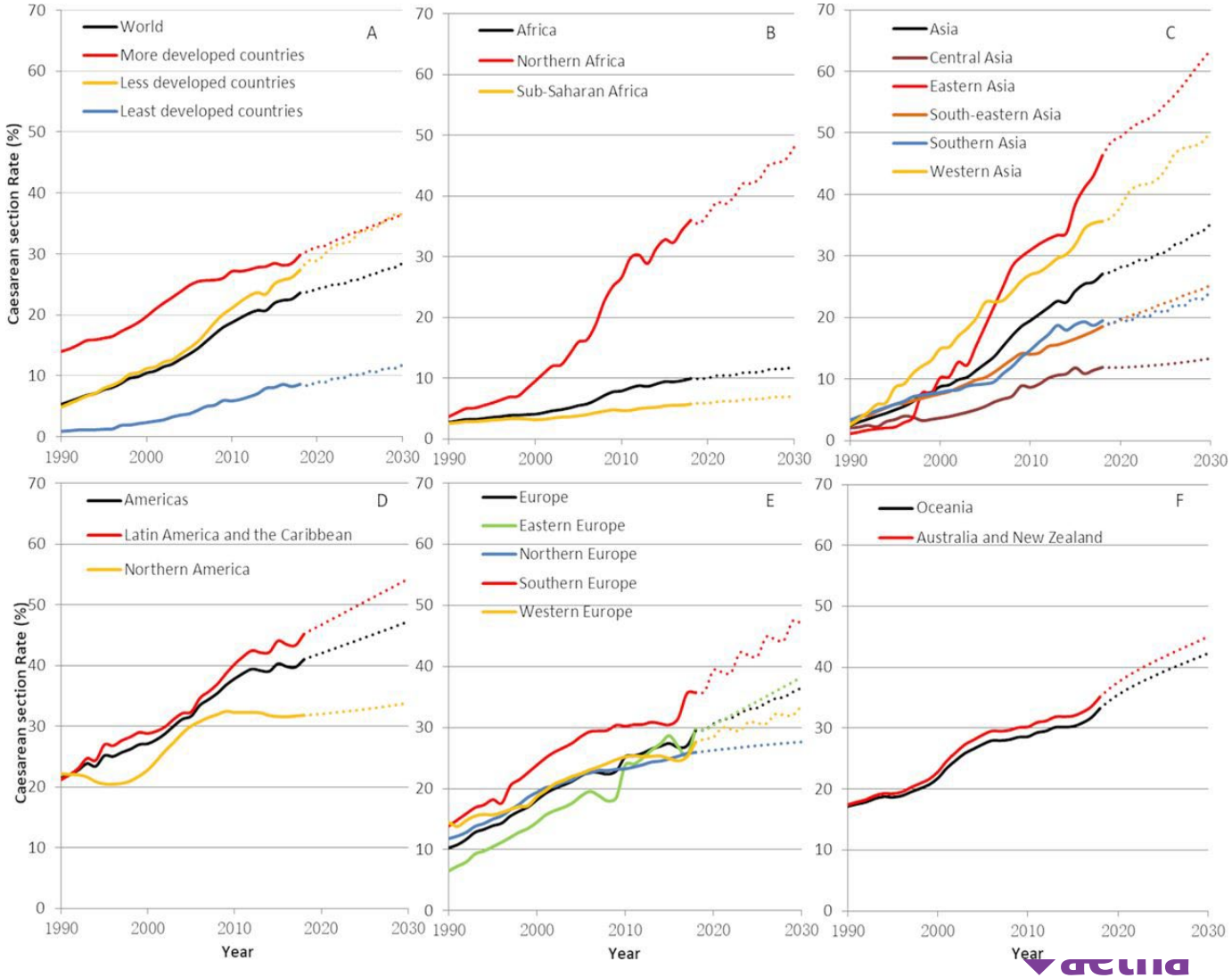
- OB forms received will be reviewed and paid on a quaterly basis through our Accounts Payable systems

Member Benefits

- Helps ABHFL to outreach members timely to offer care management services
- Ensures timely prenatal and postpartum care

Cesarean Section Rates Increasing Worldwide

- The optimal caesarean section rate is unknown, but it varies between facilities because of differences in the obstetric populations attended.
- Over the last decades birth by caesarean section has increased in a sustainable and continuous manner to unprecedented levels worldwide
- Governments and clinicians have expressed concern about the rise in the numbers of caesarean section births and the potential negative consequences for maternal and infant health.
- Target Goal <23.6% (Healthy people 2030 goal)



Reducing Cesarean Deliveries

- More than half of cesarean deliveries are founded on abnormal labor and abnormal or indeterminate fetal heart rate (FHR) tracings.
- The variation in rates of nulliparous, term, singleton and vertex cesarean births suggest that clinical practice patterns influence the number of cesarean deliveries done.

Below are the most common indications in order of occurrence are:

- ✓ Labor dystocia
- ✓ Abnormal or indeterminate (formerly non-reassuring) FHR tracing
- ✓ Fetal malpresentation
- ✓ Multiple gestations
- ✓ Suspected fetal macrosomia

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Prior Authorization

Prior authorization (PA) is required for some out-of-network providers, outpatient care and planned hospital admissions. We don't require PA for emergency care. You can find a current list of the services that need PA on the Provider Portal. You can also find out if a service needs PA by using ProPAT, our online prior authorization search tool.

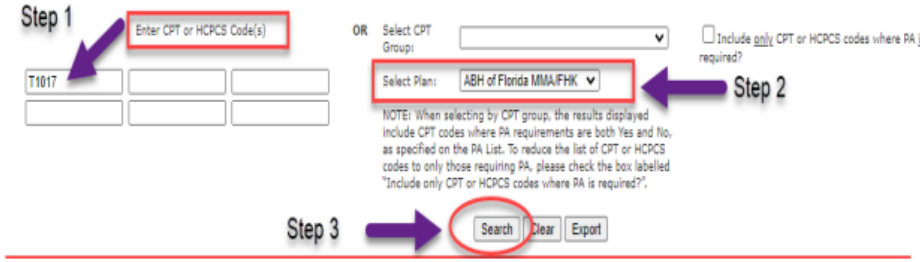
Propat Link: https://medicaidportal.aetna.com/propat/Default.aspx

- **ABHFL Obstetrical Notification Form PDF Opens In New Window**
- **Florida Medicaid Pregnancy Notification Form**

ProPat Examples on next slide

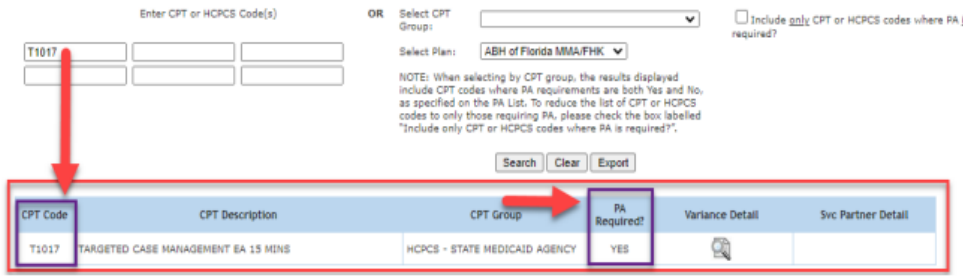
How to Search a CPT or HCPCS Code(s) in Propat & determine if PA Authorization is required?

- **Step 1** – Enter CPT or HCPCS Code (s). You can enter up to six Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes or a CPT group to search and determine if a PA is required for rendering services.
- **Step 2** – Select Plan option (Required). The tool is the same for all lines of business, however, it's important to note that you must indicate the line of business you are searching for in the tool to make sure accurate information is pulled for that line of business.
- **Step 3** – Click on "Search" to obtain the results



Results – PA Required YES/NO

Once step 3 (Search) is completed, the below results will appear and confirm if a PA is required for the CPT or HCPS code entered.



Search result definitions:

- YES - Prior authorization request is required for this service.
- NO - Health plan does not require a prior authorization request for this service.
- NON-COV - CPT or HCPCS code entered is not a covered benefit by health plan.
- INVALID - CPT or HCPCS code entered was invalid, not found.
- EXPIRED - CPT or HCPCS code entered is no longer valid for use by health plan providers.

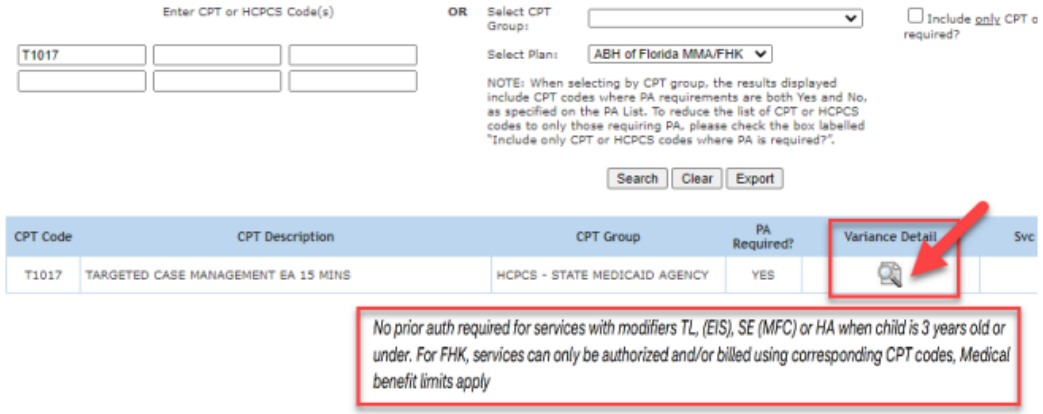
Variance Detail

The "Variance Detail" is a very important and informational feature. You can simply hover over the icon, and it will provide detailed information about the requirements of the PA.

Example

When you hover over the "Variance Detail" for code T1017, it will provide you with the following message:

"No prior auth required for services with modifiers TL, (EIS), SE (MFC) or HA when child is 3 years old or under. For FHK, services can only be authorized and/or billed using corresponding CPT codes, Medical benefit limits apply".



To request a prior authorization, be sure to:

- Always verify member eligibility prior to providing services.
- Complete the appropriate authorization form (medical or pharmacy).
- Attach supporting documentation when submitting. This could include:
  - Recent progress notes documenting the need for the service
  - Lab results
  - Imaging results (x-rays, etc.)
  - Procedure/Surgery reports
  - Notes showing previous treatment tried and failed
  - Specialty notes

Important to Note: When checking whether a service requires an authorization under Aetna Better Health of Florida, please keep in mind that a listed service does not guarantee that the service is covered under the plan's benefits. Always check plan benefits first to determine whether the service is covered or not.

Availity Provider Portal

Current Functionalities

- **Claim Status Inquiry**
- **Eligibility and Benefits**
- **Payer Space**
  - Claim Submission Link (Through Connect Center)
  - Contact Us Messaging for
    - Changing Provider Demographics
    - Claim Issues
    - Prior Auth/Auth Issues
    - Member Eligibility Issues
    - HEDIS Record Submissions
    - Credentialing Inquiries
  - **Appeals and Grievances**
    - **Grievance Submission**
    - **Appeal Submission**
    - **Grievance and Appeal Status Check**
  - Panel Roster- Panel Look Up
  - Reports
    - PDM/ProReports (Provider Deliverables Manager)
    - Ambient (Business Intelligence Reporting)
  - EFT/ERA Registration/Change Forms
  - Prior Authorization Requirements Look Up
- **Prior Authorization**
  - Submission
  - Status

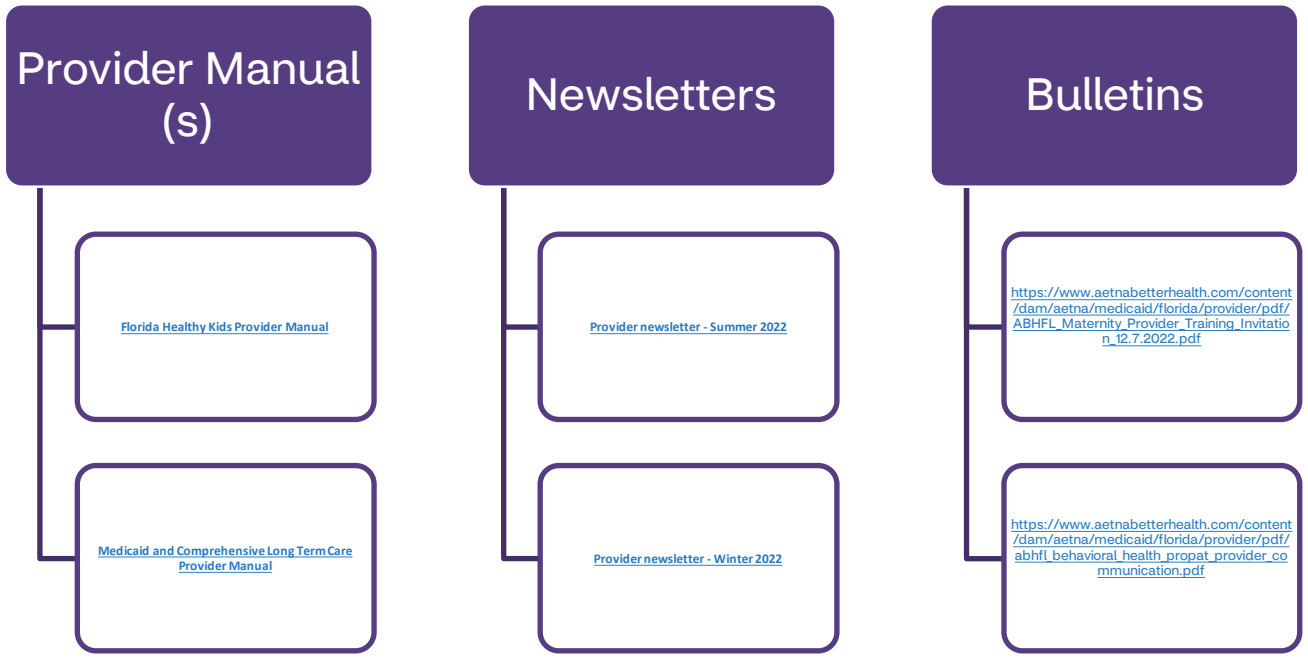
Note- For Registration/Login/or Technical Issues, please contact Availity Client Services at 1-800-282-4548
M-F 8am to 8pm eastern (except holidays).

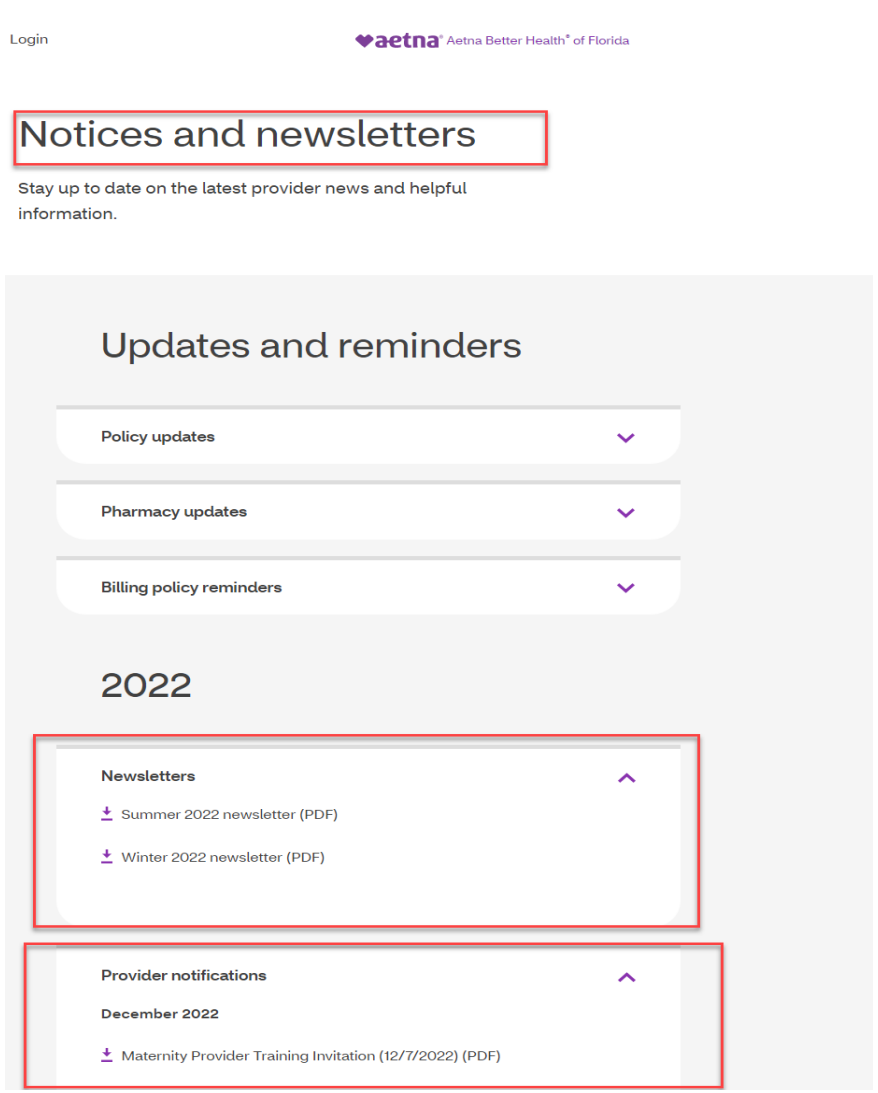
https://apps.availity.com/availity/web/public.elegant.login

Stay Informed

ABHFL regularly updates and uploads Provider Bulletins, Provider Manual and Provider Newsletters on our ABHFL website for easy access.

To stay informed with the most updated information please visit our ABHFL under the provider tab: https://www.aetnabetterhealth.com/florida/providers/





Note: Provider Newsletters are issued 2 times a year. (Summer & Winter).

Questions? We have answers!

Call our Provider Services Department at 1-844-528-5815.

Thank you all!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