Monthly Provider Claims Training

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June 2020

Topics

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Grievance and Appeals

Provider Grievance and Appeals

Providers should submit all grievances and appeals to the address listed below.

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

Aetna Better Health has a form that includes information regarding reconsiderations, claim inquiry, disputes, appeals that can assist with your claim questions and concerns regarding reconsiderations.

The form can also be found on our Aetna Better Health of Florida website at:

https://www.aetnabetterhealth.com/florida/assets/pdf/provider/FL_Provider_Claim_ReconsiderationClaims%20Adjustment%20Request_Form_03.01.2020.pdf

Timely Filing Guidelines

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	Timely Filing 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.
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.
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.
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.
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.
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.

Appeals Filing Guidelines

Appeals	Par/Non-Par	Timely Filing Guideline
Provider Appeals related to Medical Necessity	Par	60 days from Notice of Adverse Benefits Determination (NABD)
	Non-Par	60 days from Notice of Adverse Benefits Determination (NABD)
Provider Appeals related to billing disputes, not related to authorizations The exception to this is underpayment disputes, they all have 365 days to dispute	Par	90 days from Explanation Of Benefits/ Explanation Of Payment/ Remit (EOB/EOP)
	Non-Par	180 days from Explanation Of Benefits/ Explanation Of Payment/ Remit (EOB/EOP)
Provider Appeals- claim appeals (related to authorization) requesting authorization after the claims is filed and EOB went out stating claim was denied for no authorization	Par	90 days from Explanation Of Benefits/ Explanation Of Payment/ Remit (EOB/EOP)
	Non-Par	180 days from Explanation of Benefits (EOB)

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High Dollar Claims Appeal Process

Provider are required to send all “disputes” directly to Equian for review and response of Facility-High Dollar Claims.

Equian will work directly with the Providers to resolve all Outlier Payment disputes and will also review all HP Formal Appeal claim issues.

Providers may contact Equian’s claim resolution team directly to discuss any inquiries regarding documentation and explanation necessary to clarify the charges in questions.

- **Email:** claimsresolution@equian.com
- **Telephone:** (888)-895-2254
- **Mail:** Equian, LLC
  Attention: Reconsiderations Department
  600 12th Street, Suite 300, Golden, CO 80401

Examples of supporting documentation can include, hospital policies, physician orders, and medical records excerpt directly addressing the specific charges at issue.

Durable Medical Equipment (DME)

Durable Medical Equipment and Supplies - Age Requirement

According to Florida Medicaid guidelines, certain durable medical equipment (DME) and supplies are limited to patients less than 21 years of age.

Examples of DME and supplies non-covered for patients 21 years of age or older:

Apnea monitor (E0618, E0619)

Bedside rails (E0305, E0310)

Bilirubin light with photometer (E0202)

Electric heat pad, moist (E0215)

Orthopedic shoes (L3201-L3204, L3206, L3207)

Pneumatic compressor (E0650-E0652)

Splint (A4570)

An exception applies for codes appended with modifier UC (Medicaid level of care 12)

Durable Medical Equipment-Quality of Care

Specific DME and medical supplies are only allowed when billed by a provider with specialized skills and training in dispensing durable medical equipment.

For example: Orthopedic Specialty

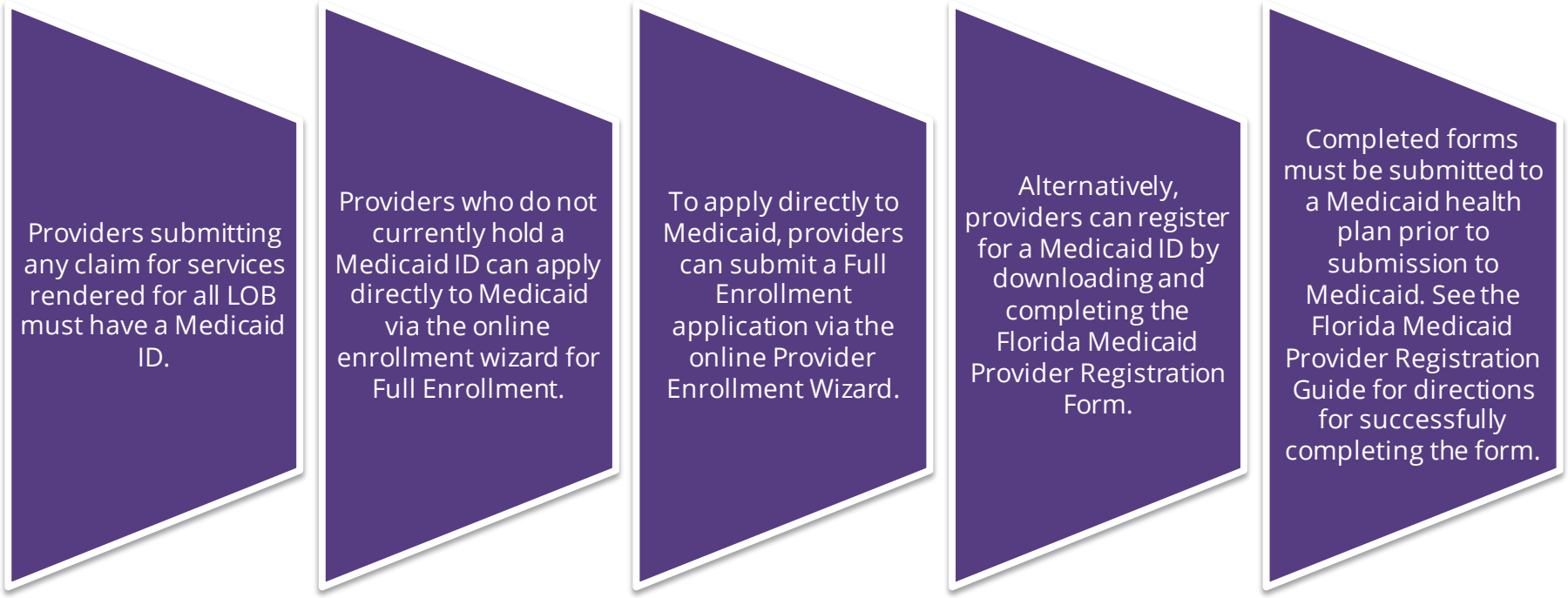
Category	Code	Age	Orthopedic Specialty
Orthotic and Prosthetic	L1810	0 - 999	OS
Orthotic and Prosthetic	L1820	0 - 999	OS
Orthotic and Prosthetic	L1830	0 - 999	OS
Orthotic and Prosthetic	L1832	0 - 999	OS
Orthotic and Prosthetic	L1836	0 - 999	OS
Orthotic and Prosthetic	L1843	0 - 999	OS
Orthotic and Prosthetic	L1845	0 - 999	OS
Orthotic and Prosthetic	L1847	0 - 999	OS
Orthotic and Prosthetic	L1850	0 - 999	OS
Orthotic and Prosthetic	L1902	0 - 999	OS
Orthotic and Prosthetic	L1906	0 - 999	OS
Orthotic and Prosthetic	L1910	0 - 999	OS
Orthotic and Prosthetic	L1930	0 - 999	OS

For a complete list of codes, visit
https://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

Durable Medical Equipment and Medical Supply Services Provider Fee Schedule for All Medicaid Recipients

Provider Record/Common Denials

Provider Medicaid IDs



For more information and applications, you can visit http://portal.flmmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCare_Registration/tabId/77/Default.aspx?linkid=pml

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Common Claim Denials

- **Billing or Rendering NPI is not found or is listed as inactive on the PML.**
  - **The claim(s) denied because either the billing or rendering National Provider Identifier (NPI) is not active or does not exist in the Florida Medicaid system.**
- **Billing or Rendering NPI has an NPI beginning date before the claim date of service.**
  - **The claim(s) denied because the Medicaid ID linked to the NPI was not active for the claim date of service.**
- **For example, NPI 1234567890 maps to Florida MCD ID 000000000, which has an NPI beginning date of 12/10/19. The date of service billed on the claim is 12/5/19. The claim will deny because 12/5/19 is before the NPI beginning date of 12/10/19.**
- **In some instances, the state will allow the NPI crosswalk to be back dated 1 year. Providers will need to reach out to Florida Medicaid and request they back date the NPI providers panel and the Medicaid claims eligibility panel 1 year.**
- **To verify the information listed on the Provider Master List (PML) visit http://portal.flmmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCare_Registration/tabId/77/Default.aspx?linkid=pml**

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For more information please contact your Network Relations Consultant or a Provider Services Representative.

Thank you.

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