



# Aetna Better Health® of Florida

Long Term Care Provider Training



June 28, 2024

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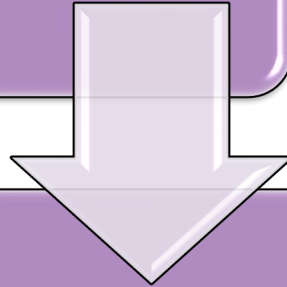
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Monthly Provider Trainings Information

## **Long Term Care (LTC) General Information**

# What is LTC/LTSS?

**LTC = Long-term  
care LTSS = Long  
Term Services  
and Supports**



**LTC and LTSS  
are used  
interchangeably**

**Comprehensive** = member has our MMA (managed medical assistance) and our LTC program

**Why comprehensive?** One medical plan to coordinate and monitor all services, integrated person-centered approach, minimize multiple handoffs and duplication of services, robust network of providers, better access to care.

**LTC provides nursing facility** services and home and community-based care to elders and adults (ages 18 yrs and older) with disabilities.

**Home and community-based services (HCBS)** are designed to delay or prevent nursing facility placement. Services such as meal prep, laundry, housekeeping, bathing, dressing, shopping and supervision are LTC services provided in the home. This includes services provide at assisted living facilities.

**LTC pays for services** that are provided at the nursing facility if the member lives there full-time.

# Department Contacts



## UM/Prior Authorization

Email **UM Manager:**  
Natasha Sealey  
**[SealeyN@cvshealth.com](mailto:SealeyN@cvshealth.com)**  
for the following  
inquiries/requests:

- Prior Authorization  
inquires for hospice
- Skilled services
- DME

Note: Nurses/staff are  
assigned using the first letter of  
the member's last name.



## Authorizations + Referrals

**Questions and inquiries  
regarding:**

- Service authorization
- Case Managers
- Staffing Referrals

Email us at:  
**[FL\\_LTC\\_SAT@aetna.com](mailto:FL_LTC_SAT@aetna.com)**



## Care Management Associates

**Contact Care Management  
Associates (CMA) for:**

- Enrollee eligibility questions

Email us at:  
**[ABHLTC-CMA@AETNA.com](mailto:ABHLTC-CMA@AETNA.com)**

# LTC Leadership Team

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**Executive Director – Valerie Williams** [williamsV5@aetna.com](mailto:williamsV5@aetna.com)

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**Senior Manager - Franceska Corentin** [corentinF@aetna.com](mailto:corentinF@aetna.com)

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**Reg 11 Supervisor - Ashley Bishop** [bishopA3@aetna.com](mailto:bishopA3@aetna.com)

**Reg 11 Supervisor - Carlos Orozco** [orozcoC@aetna.com](mailto:orozcoC@aetna.com)

**Reg 11 Supervisor - Ines Gonzalez** [GonzalezI5@aetna.com](mailto:GonzalezI5@aetna.com)

**Reg 11 Supervisor - Shameika Wallen** [wallenS@aetna.com](mailto:wallenS@aetna.com)

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**Reg 6 Supervisor - Josephine Estevez** [EstevezJ1@aetna.com](mailto:EstevezJ1@aetna.com)

**Reg 6 Supervisor - Myrlene Warren** [warrenM3@aetna.com](mailto:warrenM3@aetna.com)

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**Reg 7 Supervisor - Brittany Mathis** [MathisB@aetna.com](mailto:MathisB@aetna.com)

**Reg 7 Supervisor - Regina Henson** [HensonR@aetna.com](mailto:HensonR@aetna.com)

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**Clinical Team Supervisor - Melissa Walmsley** [WalmsleyM@aetna.com](mailto:WalmsleyM@aetna.com)

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**SAT/CMA Teams Supervisor - Zully Taveras** [TaverasZ@aetna.com](mailto:TaverasZ@aetna.com)

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# **EVV**

## **Electronic Visit Verification**

# Electronic Visit Verification (EVV) -



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Aetna Better Health of Florida uses Netsmart for EVV. Netsmart offers EVV provider mobile platform.

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**All providers must comply with Section 409.9132, F.S.**

The Agency for Health Care Administration contracts with a vendor to electronically verify the delivery of home health services provided to recipients in their residence or other authorized setting.

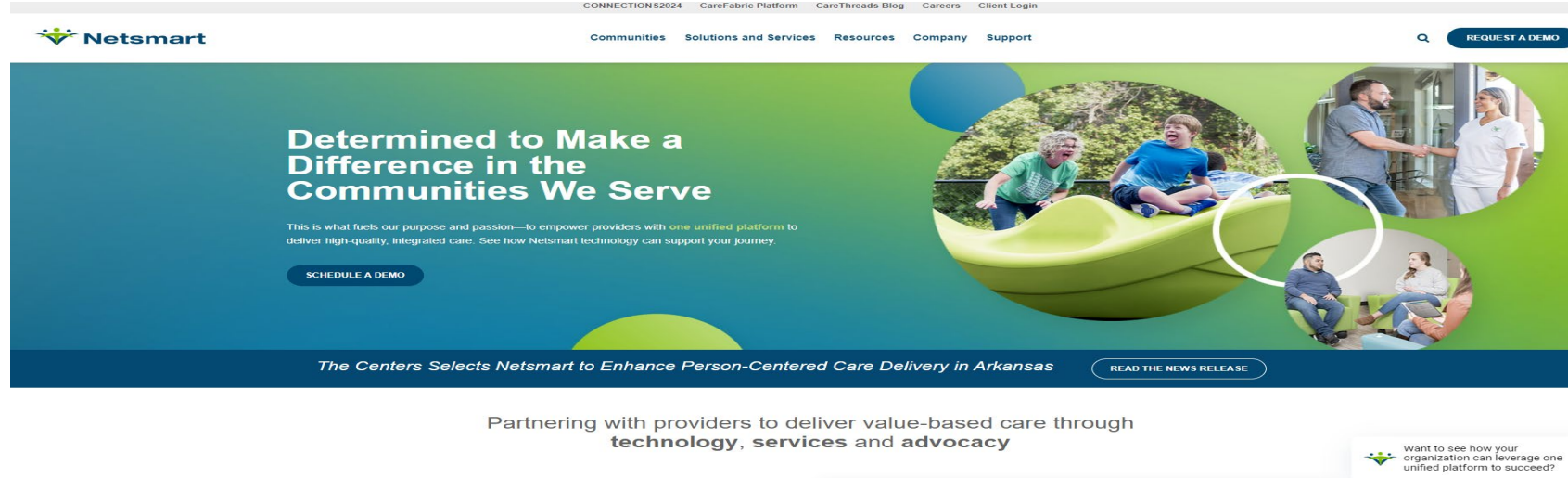
1. Providers must document the home health service encounter for each recipient served (in accordance with the recipient's approved plan of care) and verify the delivery of the services rendered using AHCA's designated vendor's electronic visit verification (EVV) system.
2. Direct service providers must verify delivery of the service using the vendor's system at the beginning and end of each homehealth service encounter.
3. Providers must submit claims through AHCA's designated vendor's system to the Florida Medicaid fiscal agent for services rendered and verified in accordance with the prior authorization in the Florida Medicaid Management Information System.



# Electronic Visit Verification (EVV)

Providers that fail to comply with the Home Health Electronic Visit Verification Program are subject to potential denial or non-payment of claims, sanctions, fines, and suspension or termination from the Florida Medicaid program, in accordance with Rule 59G-9.070, F.A.

Netsmart web site: <https://www.ntst.com/>



If you have any Netsmart EVV system questions or concerns, please contact Netsmart at:

- **1-800-842-1973** or
- <https://www.ntst.com/support/client-support>
- **Mobile Caregiver + EVV Support: 1-833-483-5587**

# **Clinical Care Management, Case Coordination/UM**

# Care Management Service Levels/Care Management Colleagues

## Intensive

### Focus

Complex clinical care coordination  
Biopsychosocial approach  
Root cause resolution

### Characteristics

- Behavioral & Physical Health Co-morbidities
- Higher risk, high cost (includes high risk pregnant members with significant co-occurring disorders)
- Chronic condition management incorporated
- Face-to-face visits offered
- Frequent member and care team contact
- Interdisciplinary care team coordination
- Smaller caseloads

## Clinical Care Manager

### Registered Nurse or Licensed Behavioral Health Clinician

Unencumbered clinical license in Florida, works with intensive members

## Supportive

### Focus

Problem and solution focused  
Standard care coordination and planning

### Characteristics

- Acute and Chronic Condition management
- Routine care coordination
- High risk pregnancies
- State mandated populations (e.g., lead-exposed children)
- Larger caseloads due to less frequent contact and coordination activities

## Care Management Coordinator - CMC

### Bachelor degree required.

Degree / Relevant Experience in: Physical or Behavioral Health, Human Services e.g., psychology, social work, counseling etc.  
Works with supportive members only

## Community Health Workers- CHW

**High School/ GED** at minimum required. Relevant Experience in: Community Resources, Health Care and Human Services, etc. Field based position

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# **Encounters & ALF Payments**

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## Encounters & ALF Payments

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### **ALFs must submit the encounter claims for which capitated payments have been received within 30 days of date of service**

- Assisted Living Facilities are paid through a capitation agreement for Aetna members residing in the facilities.
- Members are assigned to the ALF to ensure payments are processed and paid monthly.
- The monthly capitation is run on the 1st Sunday.
- LTSS check are date for the Thursday following the cap run
- Retro Cap Amounts will be reflected on monthly payments (positive or negative balances)

*If you do not receive a payment for an Aetna member, please reach out to your assigned Network Consultant for assistance.*



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## **Home Health & Personal Care Services**

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# Home Health & Personal Care Services – Billing Guidelines

When billing codes: S5130, S5135, S5170, S9122, or T1019, each date of service must be billed on a separate line. These codes cannot be billed with a date span.

## HOME HEALTH & PERSONAL CARE SERVICES

### BILLING CODES, FREQUENCY, AND COVERAGE

CODE	TYPE OF SERVICE	FREQUENCY	COVERAGE
<b>S5130</b>	HOMEMAKER SERVICE	PER 15 MINUTES	This procedure code does not allow for span dating
<b>S5135</b>	ADULT COMPANIONCARE	PER 15 MINUTES	This procedure code does not allow for span dating
<b>S5170</b>	HOME DELIVERED MEALS	PER MEAL	This procedure code does not allow for span dating
<b>S9122</b>	HOME HEALTH AIDE OR CERTIFIED NURSE ASSISTANT PROVIDING CARE IN THE HOME	PER HOUR	This procedure code does not allow for span dating
<b>*T1019</b>	PERSONAL CARE SERVICES	PER 15 MINUTES	This procedure code does not allow for span dating

\*T1019 is not for an inpatient or resident of a Hospital, Nursing Facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by Home Health Aide or Certified Nurse Assistant).

### Reminder- Type of Service & Frequency determines the unit count to be billed:

- Per Hour – 1 hour = 1 Unit
- Per 15 Minutes – 1 hour = 4 Units

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## **Best Ways to Connect with Us**

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# Best Ways to Connect with Us



## Need Support?

Use our new provider contact us form to tell us more about your specific request or inquiry.

- This form allows you to share the right information from the start, so you don't have to spend valuable time tracking down the help you need.
- As an added benefit for us both, we have ensured that any request or inquiry made through this form is routed to the appropriate department.

## HOW IT WORKS !

Start by selecting the reason for your inquiry, then share the appropriate contact at your practice, and add essential information like your Tax ID, NPI and more.

You can also include up to 5 files with your inquiry if needed.

**To access the form visit "Contact Us" provider web form.**

# Best Ways to Connect with Us



## Contact Us

Use this form to ask about enrollment, claims and more. Need to check patient eligibility and benefits, submit and check status on prior authorizations or grievances and appeals? Use [Availability](#). Need to set up electronic funds transfer (EFT) and electronic remittance advice (ERA)? Visit the [Change Health payer enrollment services website](#). You can also call Provider Relations and/or email contracting for new contract requests or credentialing questions.

### Inquiry information

\*THE REASON FOR YOUR INQUIRY IS  
Choose one option

\*STATE  
Florida

### Requester information (at provider's office)

\*NAME

\*TITLE  
For example, Office Manager

**NOTE:** Please make sure that you have your provider's office information handy while submitting the request as there are required fields to submit the inquiry/request. (Requestor's name, title, email, phone, provider's name, TIN, NPI)

## Contact Us

### Inquiry Reason - Options

- ✓ Claims Inquiry or Disputes
- ✓ Grievances & Appeals
- ✓ Delegated Group Updates
- ✓ New Contract Request
- ✓ Provider Enrollment or Adds to an Existing Par Group
- ✓ Provider Demographic Data Update
- ✓ Provider Terms, Leaving Practice, Retiring, Closing Practice
- ✓ Status Inquiry of previous email submission
- ✓ Other

*\*Additional options will be added as we work through this new process!*

# Best Ways to Connect with Us

## Provider Relations/Engagement Team Email Address

As we continue to grow and make updates in our departments to better assist all of our providers we have updated our email address.

The [FLProviderRelations@aetna.com](mailto:FLProviderRelations@aetna.com) email address is in the process of being sunset.

Our NEW and updated email address that is currently functional and handled by our Provider Engagement team is: [FLProviderEngagement@aetna.com](mailto:FLProviderEngagement@aetna.com)

We strongly recommend that you only use the NEW email for timely responses.

Our preferred and fastest contact method is the **"Contact Us" provider web form.**



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**Availity**

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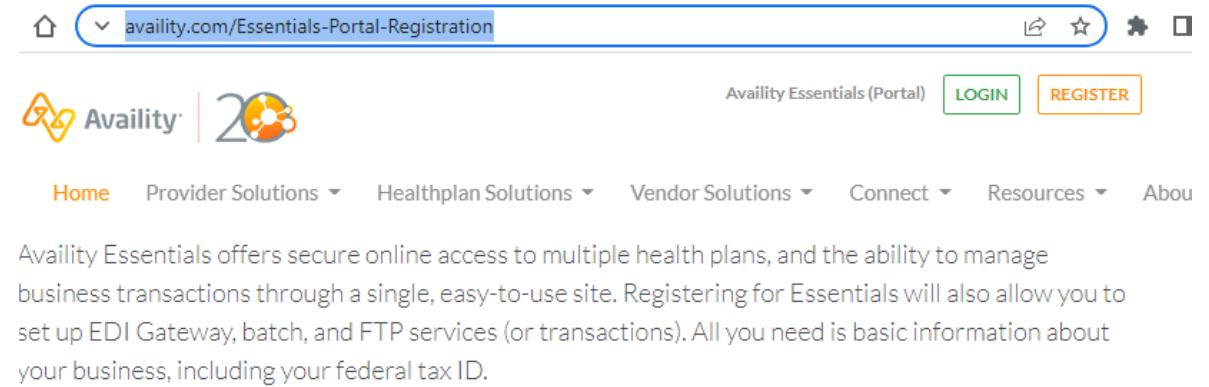


# Availity Provider Portal

- [Availity Essentials](https://availability.com/Essentials-Portal-Registration), is our preferred and trusted source for payer information.
- If your organization isn't registered with Availity, we strongly recommend that you get started today at:
- [\*\*https://availability.com/Essentials-Portal-Registration\*\*](https://availability.com/Essentials-Portal-Registration)



Click on the **Providers** button as indicated below in red to get stated.



Locate your organization type below, then click the arrow to get started



# Availity Provider Portal



## Create Account

- [Click here to get started in creating an account](#)
- Fill out all required fields

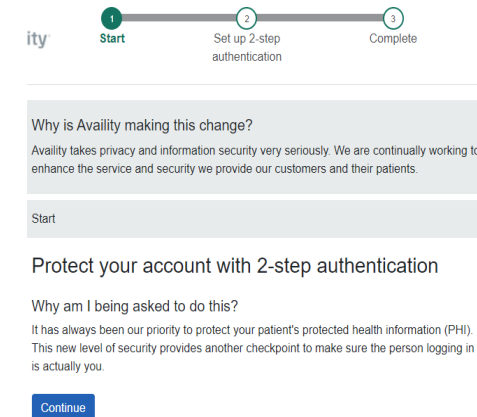
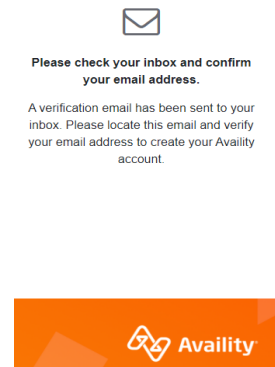
## Check your email

- You will receive a verification email.
- Open email and click the link provided to verify the account.

## Login

- Now you will need to login using the username/password created.
- Set up your 2-step authentication

The screenshot shows the 'Create Account' form in a web browser. It includes fields for First Name, Last Name, Email Address, User ID, and Password. Below these fields is a section for 'Choose a region where you do business' with a dropdown menu. A 'Continue' button is at the bottom.



Note: For registration, login or technical issues please contact Availity Client Services at 1-800-282-4548

# Availity Provider Portal

In order to start using Availity tools and applications you must first **register your organization**.

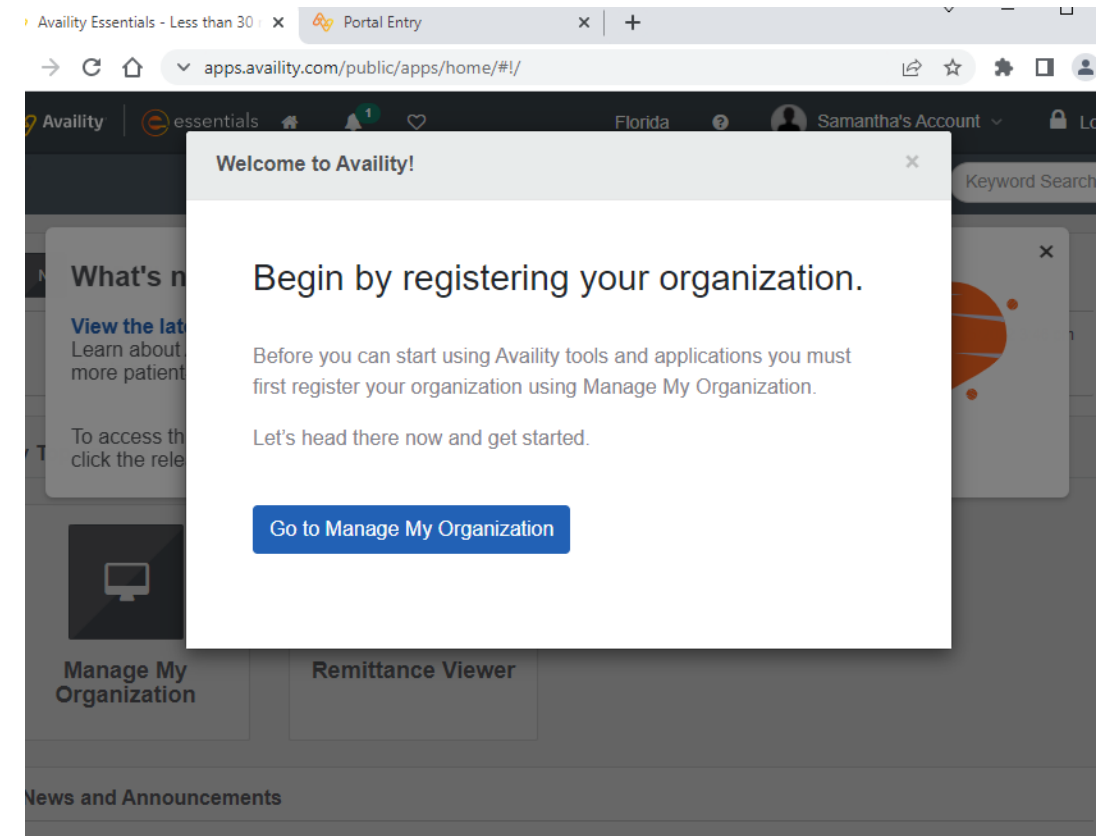
## Additional Availity Essentials Resources

The resources below will take you to guides that will visually walk you through the steps needed to complete the registration process.

- [Infographic for New Users Who Register with Availity\(opens in a new tab\)\(opens in a new tab\)](#)
- [Infographic for Availity Essentials Login Process and Your Data Privacy\(opens in a new tab\)\(opens in a new tab\)](#)
- [Infographic for Availity Essentials Login Process for Primary Admins](#)



Click the button “Go to Manage My Organization” and follow the prompts to complete the process.



## Availity Provider Portal

Providers support capabilities offered through Availity include the ability for providers to:

- **Claim Submissions**
- **Claim Status Inquiries**
- **Payer Space**
- **Contact Us Messaging**
- **Appeals & Grievance**
- **Appeals & Grievance Status**
- **Panel Rosters**
- **Specialty Pharmacy Prior Authorization**
- **Prior Authorization Submission**
- **Prior Authorization Status**
- **Eligibility and Benefits**
- **Reports & PDM**

Availity allows providers to directly communicate with Aetna's clinical and administrative staff through the Contact Us application.



# Availity Provider Portal

**Live webinars are available for Availity portal users!**

Once you're registered, sign in at **[Apps.availity.com/availity/web/public.elegant.login](https://Apps.availity.com/availity/web/public.elegant.login)**. The Availity Learning Team offers regularly scheduled live webinars on a variety of topics.

Explore the training site to register for a live webinar session, review recording, and access additional resources.

[Availity Essentials – Live Webinars](#)



## Availity & Helpful Links:

- [Availity Main Page](#)
- [Availity Provider Portal](#)
- [Availity Portal-Registration](#)
- [Availity Get Started](#)
- [Availity Log In](#)
- [Availity Training-and-Education](#)

# Availity Provider Portal



**Help is available!** Any issues related to Availity you can contact them directly via the [Contact-Us](#) button on the website or by calling one of the phone numbers below depending on your question/inquiry/issue.

## Availity Essentials, Essentials Plus, or EDI Clearinghouse Customers:

If you have an Availity Essentials, Essentials Plus, or EDI Clearinghouse account and cannot log in to submit a ticket, call **1-800-282-4548** for support.

## Availity Essentials PRO (RCM) Customers:

If you have an **Availity Essentials Pro** account and cannot log in to submit a ticket, call **1-877-927-8000** for support.

## Contact Us

<https://availity.com/Contact-Us>

### Contact a Sales Associate



Speak with one of our knowledgeable sales associates to help you find the right solution for your organization.

Submit Request

### Contact Customer Support



Are you a current Availity customer in need of Assistance? Contact customer support below. Get help with Availity Essentials, Essentials Plus, or EDI Clearinghouse.

Submit Request

### Become a Vendor or Partner



Are you a developer or vendor looking for API capabilities? Or are you looking to become a reseller? Contact our Trading Partner and Channel team below.

Submit Request



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## **Electronic Funds Transfers (EFT) Electronic Remittance Advice (ERA)**

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# EFT/ERA

## **Change HealthCare and Cyber Attack & EFT/ERA Information**

As we are all aware, Change HealthCare went through a Cyber Attack and many of the accounts were affected.

- If you were enrolled with EFT/ERA with Change HealthCare **prior** to the Cyber attack and you are able to log in to your account with no problems, you are okay and will continue EFT/ERA with Change HealthCare. **No changes for you.**
- If your account was affected during the cyber attack, we have been advising all providers to sign up for EFT/ERA using ECHO Health.

**Website:** [echohealthinc.com](https://echohealthinc.com)

All fillable forms are available in availability portal

Under provider form, EFT/ERA.

We also have a Provider Payments portal guide available that includes all the instructions.



# Electronic Funds Transfers (EFT) Electronic Remittance Advice (ERA)

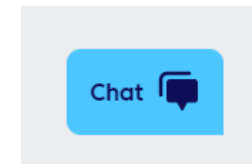
## Change Healthcare's Payer Enrollment Services FAQ's

- ▶ What is Payer Enrollment Services (PES)?
- ▶ How do I log in?
- ▶ How do I submit an enrollment?
- ▶ How do I check the status of the enrollments that I submitted?
- ▶ How do I know when my enrollment(s) were successfully approved by the payer?
- ▶ Where can I submit new enrollments?
- ▶ How do I withdraw an enrollment?
- ▶ Who can I contact for help?
- ▶ What do the statuses in Provider Portal mean?
- ▶ Which payer(s) can I submit EFT and/or ERA enrollments to using PES?

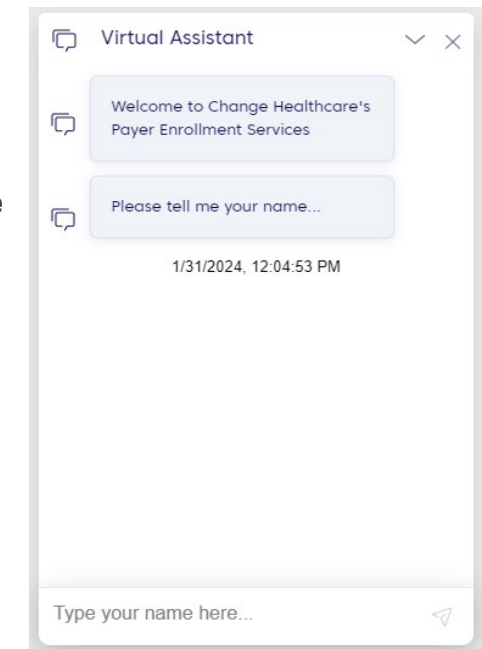


## Support Team

Change Healthcare Support Team  
can be contacted at  
**1-800-956-5190** Monday through  
Friday 8:00AM – 5:00PM CST



**Virtual Assistance  
is also available!**



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## **Prior Authorization**

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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: [Search ProPAT](#)

[Login](#)

Aetna Better Health® of Florida

  
Menu

## 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.

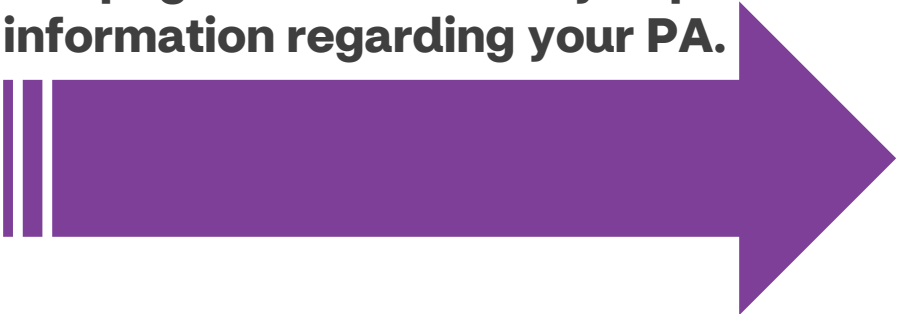
[Search ProPAT](#)



# Prior Authorization

## ProPAT is ABHFL Participating Provider Prior Authorization Requirement Search Tool.

We highly recommend that you **READ** all the exception details that are outlined on this page. It contains very important information regarding your PA.



Participating Providers: To determine if prior authorization (PA) is required, enter up to six Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes or a CPT group and select SEARCH. 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.

Exception Detail, Svc Partner Detail - When the  symbol is displayed for the code, place your cursor over the symbol to review additional information regarding PA submission or service partner requirements.


### General Information/Code Search:

- The term Prior Authorization (PA) is the utilization review process used to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage.
- The five character codes included in the Aetna Medicaid PA Requirement Search Tool are obtained from Current Procedural Terminology (CPT), by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five-character identifying codes and modifiers for reporting medical services and procedures performed by physicians.
- Benefit coverage may vary by plan or may be subject to special conditions. For additional information regarding benefit coverage [click here](#) or call your provider services representative for Aetna Better Health of Florida at 1-844-645-7371, TTY 711, for Comprehensive, 1-800-441-5501 for Medicaid and 1-844-528-5815 for Florida Healthy Kids.
- PA requirement results are valid as of today's date only. Future changes to CPT or Healthcare Common Procedure Coding System (HCPCS) codes that require PA will be communicated by Aetna Better Health of Florida in writing and on the home page of Aetna Better Health of Florida's secure web portal.

### For Aetna Better Health of Florida - Comprehensive

- If you have any questions about authorization requirements or need help with the search tool, please contact Aetna Better Health of Florida - Comprehensive Provider Relations at 1-844-645-7371, TTY 711.
- Emergent and Urgent Care services do not require PA.
- Search results are not a guarantee of claim payment.

### For Aetna Better Health of Florida for Medicaid and Florida Healthy Kids

Exception Detail, Svc Partner Detail - When the  symbol is displayed for the code, place your cursor over the symbol to review additional information regarding PA submission or service partner requirements.

- If you have any questions about authorization requirements or need help with the search tool, contact Aetna Better Health of Florida Provider Relations at 1-800-441-5501 for Medicaid and 1-844-528-5815 for Florida Healthy Kids.
- For Dental benefits and prior authorization, please contact the member's Dental vendor.
- All inpatient hospital confinements require PA.
- Effective 4/1/2020, all Observation Level of Care authorizations will be waived. ABHFL will pay a maximum of 48 hours of Observation.
- Effective 4/1/2022, Outpatient Hospital Services rendered in place of service 19/22 or with Bill Type 130-138 require authorization based on the procedure code billed. Authorization requirements can be found in the code lookup tool.
- Usually ALL services provided by non-participating providers require PA except Professional Component (i.e.: RADIOLOGY, PATHOLOGY, ANESTHESIOLOGY, and LABORATORY) of Facility (hospital) based services, Urgent Care Services, and Emergency Ambulance Service.
- Home health, infusion, and enteral feeding services require prior authorization.
- All wound care requires prior authorization.
- The following DME, Medical Supplies, Prosthetics & Orthotics require authorization:
  - Any item listed on the fee schedule greater than \$500 allowable
  - Any item not on the DME fee schedule
  - All DME rentals
  - DME items listed as requiring authorization.
- Transplant services (including evaluation) require prior authorization.
- Hospice services require prior authorization.
- All laboratory services related to genetic testing, regardless of place of service, require prior authorization.
- Search results, as well as authorization, are not a guarantee of claim payment.
- eviCore (formerly MedSolutions) performs Utilization Management services on behalf of Aetna Better Health of Florida for High Tech Imaging and Interventional Pain Management. Please submit your prior authorization request directly to evicore at [www.evicore.com](http://www.evicore.com) or you may call 1-888-693-3211 or fax 1-888-693-3210
- The following ancillary providers perform clinical review services on behalf of Aetna Better Health of Florida. Please contact these providers for clinical review and benefit information:



# Prior Authorization

## The ProPAT tool allows providers to:

- Enter CPT or HCPCS Code(s)
- Select Plan
- Search if PA is required or not for service(s)
- Review “Variance Detail” tab

\*This tab provides additional detailed information related to the code that was searched. (ex: lab or path service to be sent to Quest or Labcorp).

Enter CPT or HCPCS Code(s)

85025

OR

Select CPT Group:

Select Plan: ABH of Florida MMA/FHK

☐ Include only CPT or HCPCS codes where PA is required?

NOTE: When selecting by CPT group, the results displayed include CPT codes where PA requirements are both Yes and No, as specified on the PA List. To reduce the list of CPT or HCPCS codes to only those requiring PA, please check the box labelled "Include only CPT or HCPCS codes where PA is required?".

Search Clear Export

CPT Code	CPT Description	CPT Group	PA Required?	Variance Detail	Svc Partner Detail
85025	COMPLETE CBC W/AUTO DIFF WBC	PATH & LAB - HEMATOLOGY AND CO	NO		

# Tips for requesting PA

<b>A request for PA doesn't guarantee payment</b>	<p>We can't reimburse you for unauthorized services. You can make requesting PA easier with these tips:</p> <p><b><u>Register for Availity</u></b> if you haven't already.</p> <p>Verify member eligibility before providing services.</p> <p>Based on the type of request, complete and submit the PA request form.</p> <p>Attach supporting documents when you submit the form.</p>
<b>TYPES OF PA REQUEST FORMS</b>	<p>These forms apply to all plans.</p> <p><b><u>Physical health PA request form (PDF)</u></b></p> <p><b><u>Behavioral health PA request form (PDF)</u></b></p> <p><b><u>Obstetrical notification form (PDF)</u></b></p>
<b>MORE HELPFUL RESOURCES</b>	<p><b><u>Prior authorization rules for Medicaid and Florida Healthy Kids (PDF)</u></b></p> <p><b><u>Quick reference guide — vendor list (PDF)</u></b></p>

# How to request PA



## Online

Ask for PA through our Provider Portal.

[Visit the Provider Portal](#)



## By phone

Ask for PA by calling us:

- Medicaid Managed Medical Assistance:

[1-800-441-5501](#) (TTY: [711](#))

- Florida Healthy Kids:

[1-844-528-5815](#) (TTY: [711](#))



## By Fax

Download and complete the PA request form based on the type of request. Add any supporting materials for the review. Then, fax it to us.

### Fax numbers for PA request forms

- Physical health PA request form fax: [1-860-607-8056](#)
- Behavioral health PA request form fax (Medicaid Managed Medical Assistance): [1-833-365-2474](#)
- Behavioral health PA request form fax (Florida Healthy Kids): [1-833-365-2493](#)

# Incorrect Authorizations

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## **RECEIVING INCORRECT AUTHORIZATION**

If you have received an incorrect authorization, such as:

- units
- hours
- CPT code
- Dates of Service

## **NEXT STEPS:**

Please notify us as soon as possible by sending us an email at:

**[FL\\_LTC\\_SAT@Aetna.com](mailto:FL_LTC_SAT@Aetna.com)**

## **Memory Care Authorizations**

**If members are moved to Memory Care, the ALF needs to notify the CM immediately.**

**If CM is not notified timely this will cause rejections & denials for Memory Care ALF services due to services not authorized on the member's plan of care.**

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## **Timely Filing Requirements**

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# 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 (**see guideline chart on your right**).

For more information  
visit our [\*\*ABHFL  
Complaints and  
appeals\*\*](#) page.

## Guidelines Chart

Provider / Claim Type	Guideline
<b>Plan Participating Providers</b>	Provider shall mail or electronically transfer (submit) the claim within <b>180 days</b> after the date of service or discharge from an inpatient admission. (F.S. 641.3155)
<b>Non-Participating Providers</b>	Provider shall mail or electronically transfer (submit) the claim within <b>365 days</b> after the date of service or discharge from an inpatient admission. (SMMC Contract) (Section VIII.D)(E)(2)
<b>Plan as Secondary Payor</b>	When the Managed Care Plan is the secondary payer, the provider must submit the claim within <b>ninety (90) calendar days</b> after the final determination of the primary payer. (SMMC Contract) (Section VIII)( E)(1)(h)
<b>Medicare Crossover</b>	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 <b>36 months</b> of the original submission to Medicare. (SMMC Contract) (Section VIII)( E)(2)(d)(2)
<b>Corrected Claims</b>	Provider shall mail or electronically transfer (submit) the corrected claim within <b>180 days</b> from the date of service or discharge from an inpatient admission. (F.S. 641.3155)
<b>Return of requested additional information (itemized bill, ER records, med records, attachments)</b>	A provider must submit any additional information or documentation as specified, within <b>thirty-five (35) days</b> 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)

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## **Grievance & Appeals**

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# 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

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

**1. ELECTRONIC:** 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: [Availity Provider Portal](#)
- You may submit by fax to **1-860-607-7894**

**2. TELEPHONE:** You can also call us with your complaint or appeal:

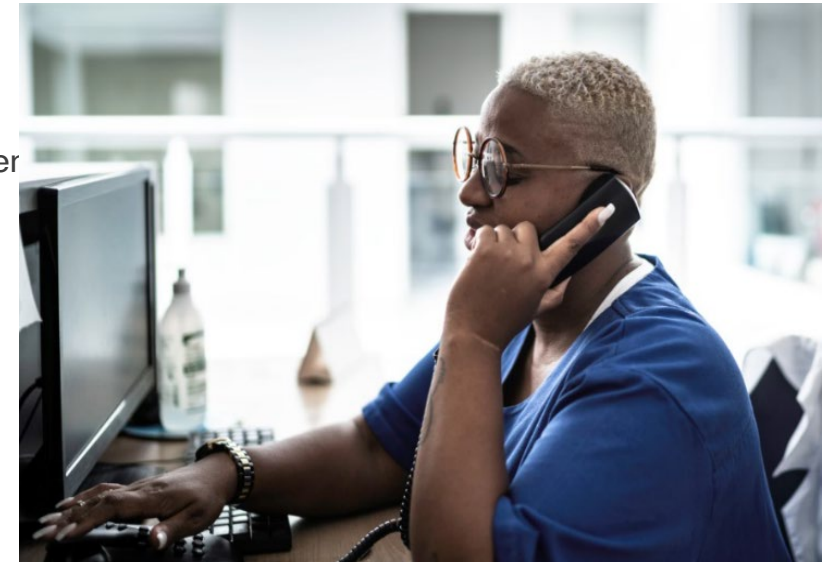
- Medicaid Managed Medical Assistance: [1-800-441-5501](#) (TTY: [711](#))
- Long-Term Care: [1-844-645-7371](#) (TTY: [711](#))
- Florida Healthy Kids: [1-844-528-5815](#) (TTY: [711](#))

**3. MAIL:** 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**

Complaints/Grievances may be submitted at any time.

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



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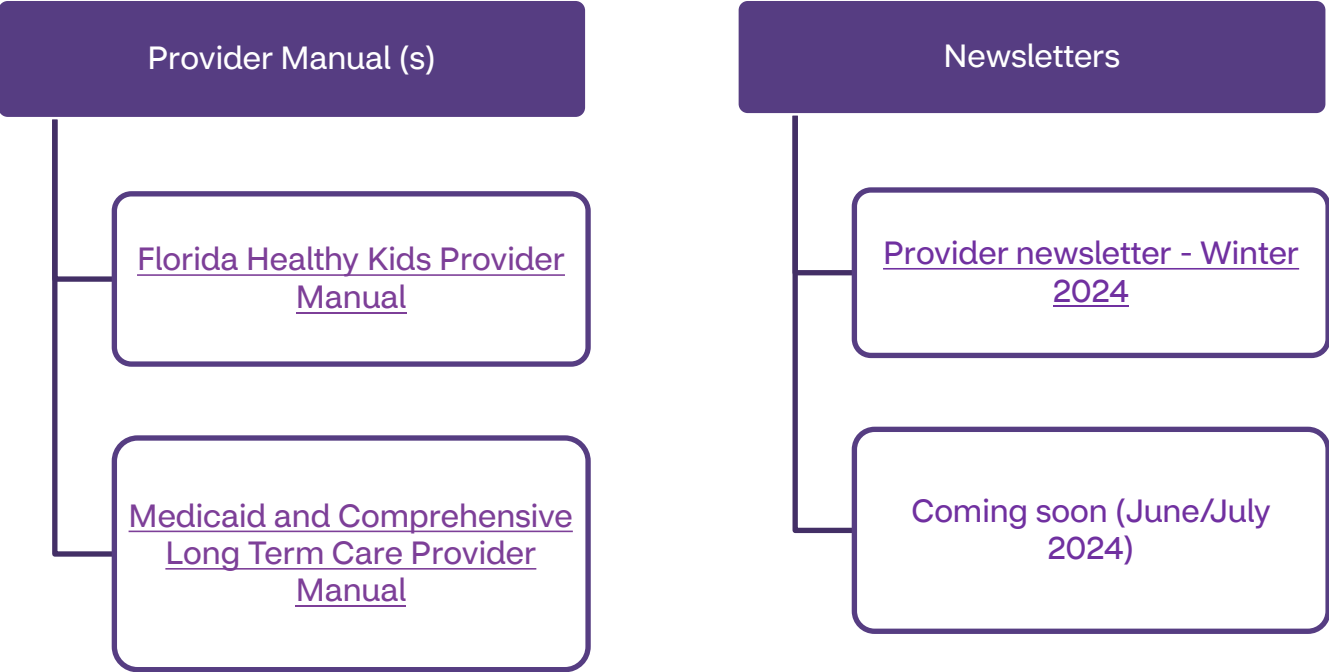
# **Provider Manual Newsletters and Notifications**

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# Provider Manual and Newsletters

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: [ABHFL Provider Page](#)



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

Provider newsletter

Winter 2024

**Utilization management criteria, availability, decisions**

Utilization management (UM) criteria and availability/UM decisions is a system for reviewing eligibility for benefits for the care that has been or will be provided to patients. The UM department includes:

- Preauthorization
- Concurrent review
- Case management too

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

(continued on next page)

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# Provider Notifications (Fax blasts)

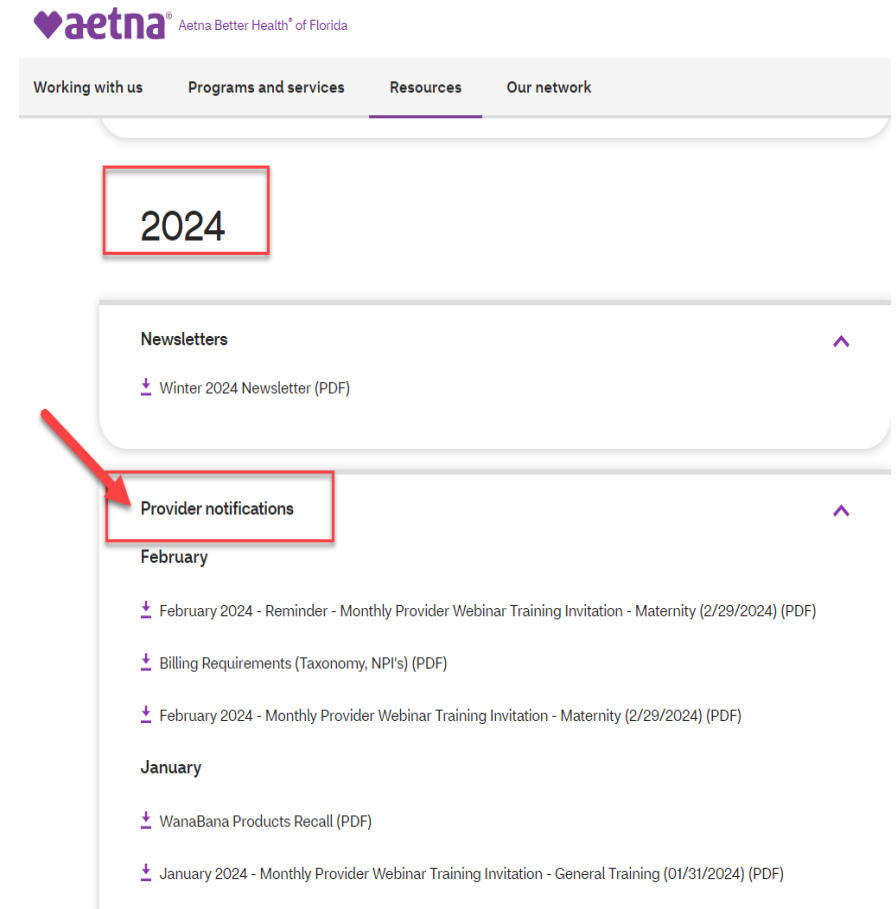
To stay informed with the most updated information please visit our ABHFL under the provider tab: [ABHFL Provider Page](#)

## January 2024

- [WanaBana Products Recall \(PDF\)](#)
- [January 2024 - Monthly Provider Webinar Training Invitation - General Training \(01/31/2024\) \(PDF\)](#)
- [Best Ways to Connect with Us \(PDF\)](#)
- [ProgenyHealth's Maternity Case Management Program \(PDF\)](#)
- [Durable Medicaid Equipment \(DME\) and Medical Supply Services Coverage Policies Update - Effective 01/10/2024 \(PDF\)](#)

## February 2024

- [February 2024 - Reminder - Monthly Provider Webinar Training Invitation - Maternity \(2/29/2024\) \(PDF\)](#)
- [Billing Requirements \(Taxonomy, NPI's\) \(PDF\)](#)
- [February 2024 - Monthly Provider Webinar Training Invitation - Maternity \(2/29/2024\) \(PDF\)](#)



# Provider Notifications (Fax blasts)

To stay informed with the most updated information please visit our ABHFL under the provider tab: [ABHFL Provider Page](#)

## March 2024

- [HCPCS Codes for Depression Screening \(PDF\)](#)
- [March 2024 - Monthly Provider Webinar Training Invitation - Behavioral Health \(3/27/2024\) \(PDF\)](#)

## May 2024

- [iBudget Waiver Program \(PDF\)](#)
- [May 2024 - Monthly Provider Training - Behavioral Health \(05/24/2024\) \(PDF\)](#)

## April 2024

- [April 2024- Monthly Provider Training - Maternity \(PDF\)](#)
- [April 2024 - Monthly Provider Training - General Training \(PDF\)](#)

## June 2024

- [Screen Time and Social Media Usage Questionnaire \(PDF\)](#)
- [Letter of Intent \(LOI\) vs Add Provider to Existing Participating Group \(PDF\)](#)
- [Members Eligibility Changes and Claims Submission - Updated Process \(PDF\)](#)

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## Monthly Provider Trainings

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# Monthly Provider Trainings

Monthly Provider Training Invitations are sent to providers via fax and via email. We also upload the invitation on our ABHFL website for your convenience.

**It is important that we have your most updated fax and email information on file in order for you to receive Monthly Provider Trainings and all of our communications timely.**

## Need to update your information?

1. Contact our provider relations department via email [FLProviderEngagement@aetna.com](mailto:FLProviderEngagement@aetna.com)
2. Complete the ABHFL Provider Data Change Form : <https://www.surveymonkey.com/r/AETPDCF>
3. Call us!
  - MMA: 1-800-441-5501 TTY (711)
  - LTC: 1-844-645-7371 TTY (711)
  - FHK: 1-844-528-5815 TTY (711)

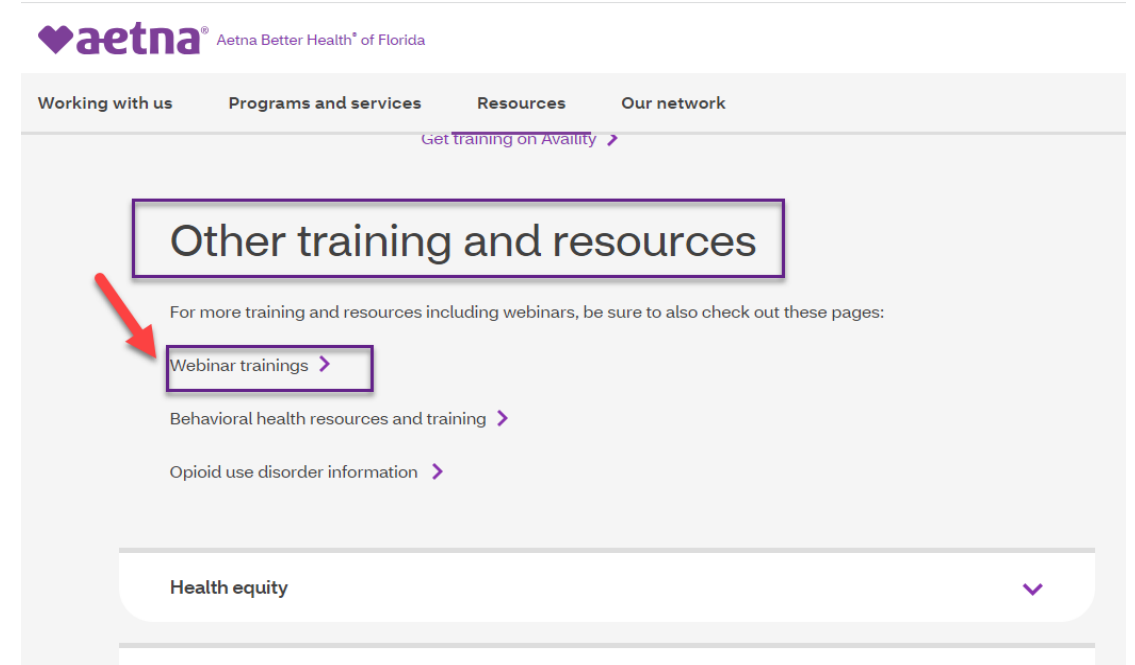
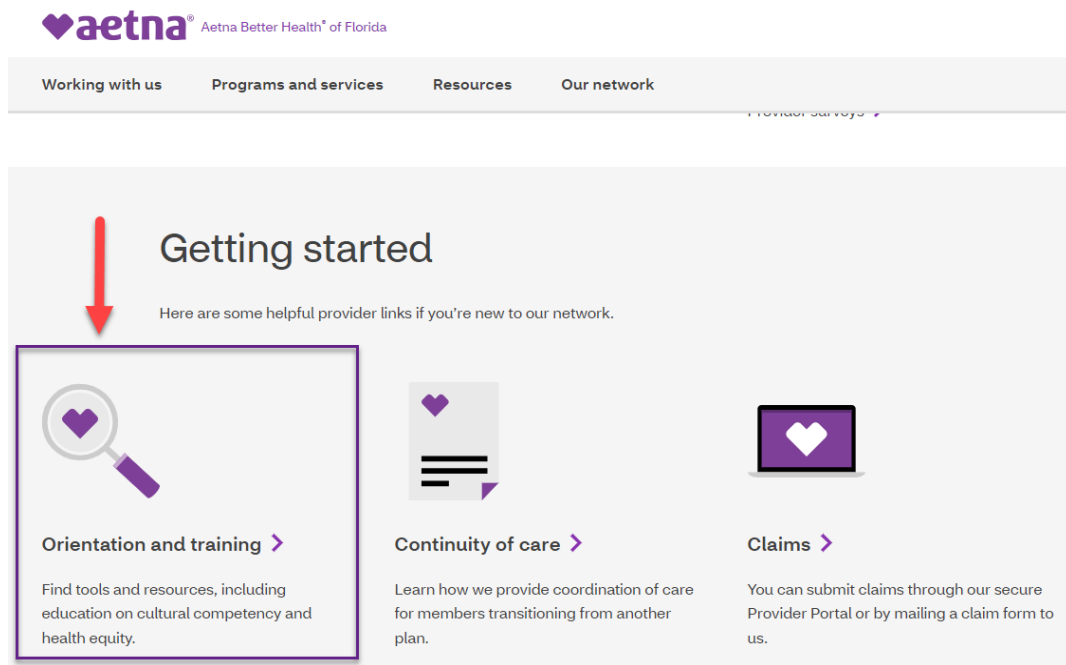
# Monthly Provider Trainings

## Missed a provider training? No problem!

Our provider trainings are uploaded on our website on a monthly basis.

Visit our ABHFL website under the Provider Site and you will find all of our trainings!

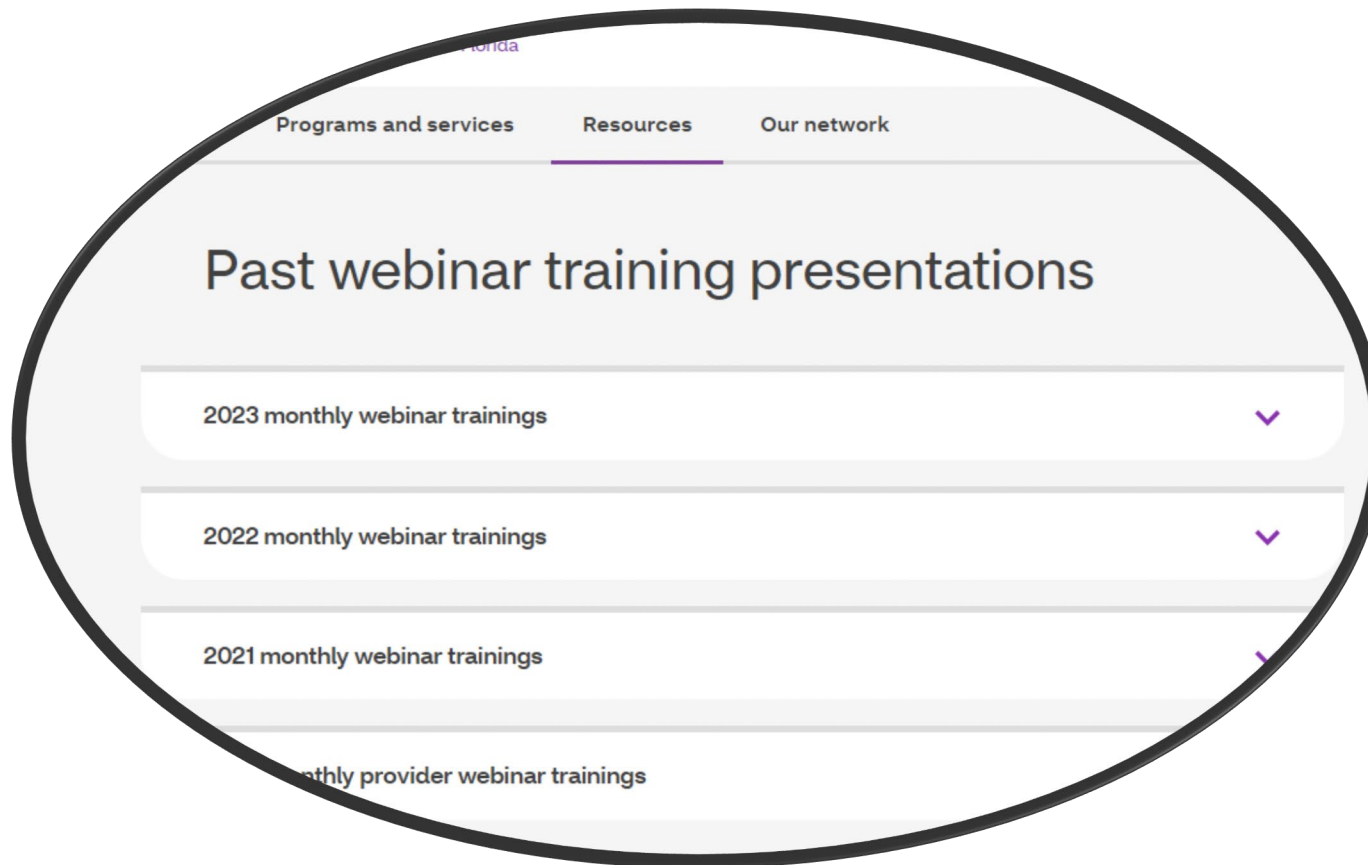
- <https://www.aetnabetterhealth.com/florida/providers/materials-forms.html>





# Monthly Provider Trainings

<https://www.aetnabetterhealth.com/florida/providers/webinar-trainings.html>





# Questions?

## We have answers!

**Contact our Provider Services Department**

**Phone:** [1-844-528-5815](tel:1-844-528-5815) (TTY: [711](tel:711))

**Email:** [FLProviderEngagement@aetna.com](mailto:FLProviderEngagement@aetna.com)

