Aetna Better Health® of Florida

Provider Monthly Training – General

aetna®

October 24, 2024

Agenda

- Provider Support – Connect with us
- Availity Provider Portal
- Provider Manual Newsletters and Notifications
- ProgenyHealth
- EFT/ERA
- Claim Submissions
- Medicaid Fees Schedule & Reimbursement
- Verifying Eligibility & Benefits
- Prior Authorization
- Timely Filing Requirements
- Grievance & Appeals
- Monthly Provider Trainings
- ABHFL Website - Provider Main Site & Provider Helpful Links

Best Ways to Connect with Us

Provider Support - Connect with Us

You can call OR email our Provider Engagement Team with any questions/inquiries regarding enrollment, joining our network/credentialing, claims, PA and many more.

Phone

MMA:
1-800-441-5501 TTY (711)

LTC:
1-844-645-7371 TTY (711)

FHK:
1-844-528-5815 TTY (711)

Email

FLProviderEngagement@aetna.com

Mail

Aetna Better Health of Florida
ATTN: Provider Relations
261 N University Drive
Plantation, FL 33324

Provider Support - Connect with Us

Still need support?

If you've already tried contacting us using one of the phone, email and mail options with no resolution to your question or issue contact us through our ABHFL website by providing us with specific information when completing the online form.

Online Form

Direct Link:

- https://medicaidportal.aetna.com/mcainteractiveforms/ProviderForms/ProviderRequestForm.aspx?p=FL

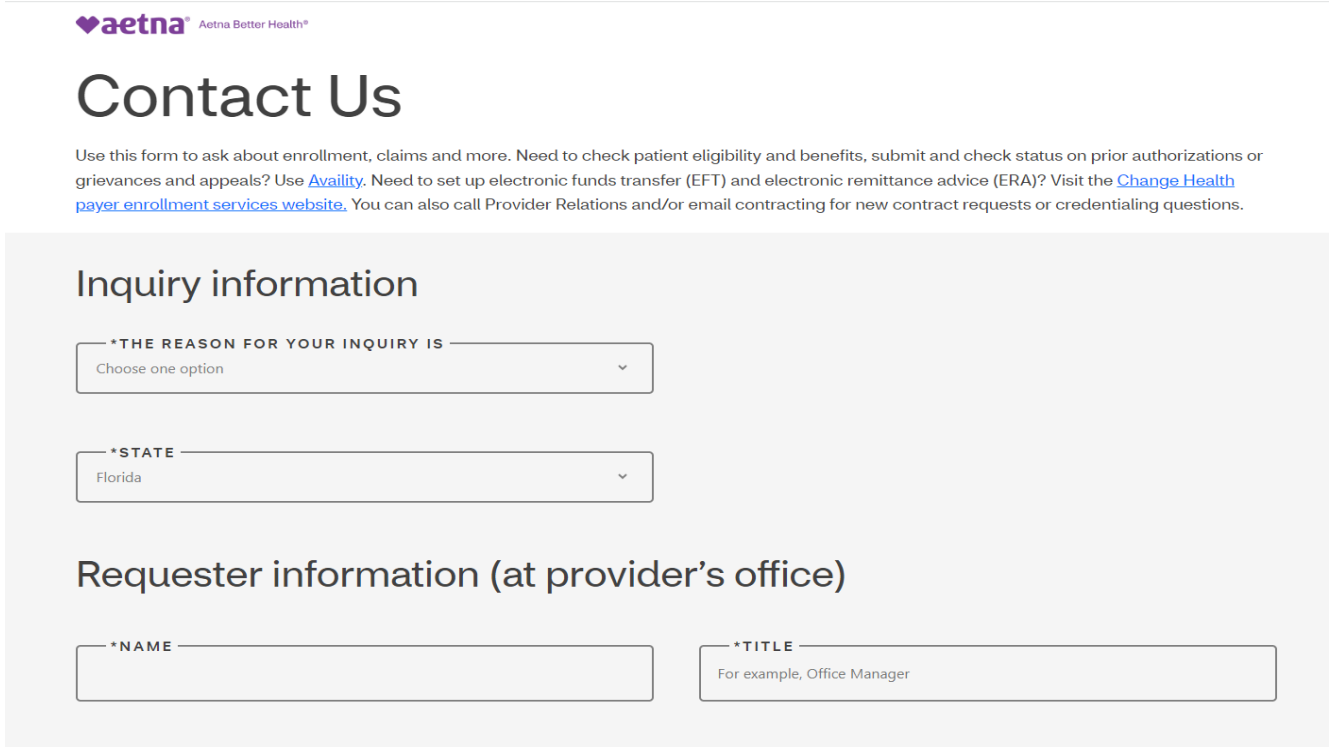
The contact us form allows you to add the proper/required information from the start, so you don't have to spend valuable time tracking down the help you need.

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 depending the reason of the inquiry.

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

Provider Support - Connect with Us

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


aetna Aetna Better Health®

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 Availity. 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!*

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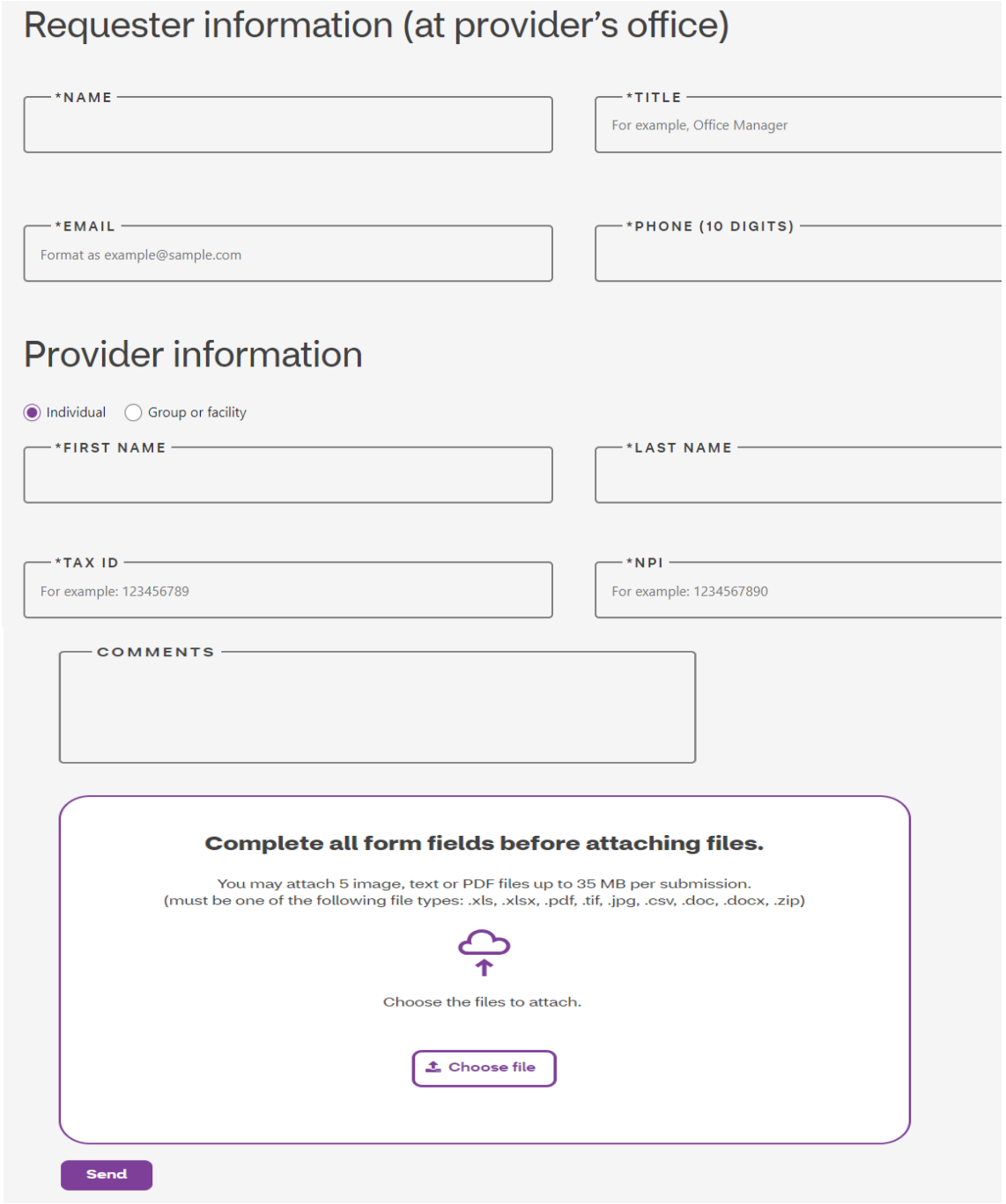
Provider Support - Connect with Us

Use this form to ask about:

- Enrollment
- Claims
- Check patient eligibility
- Patient benefits
- Submit and check status on prior authorizations
- Grievances and appeals

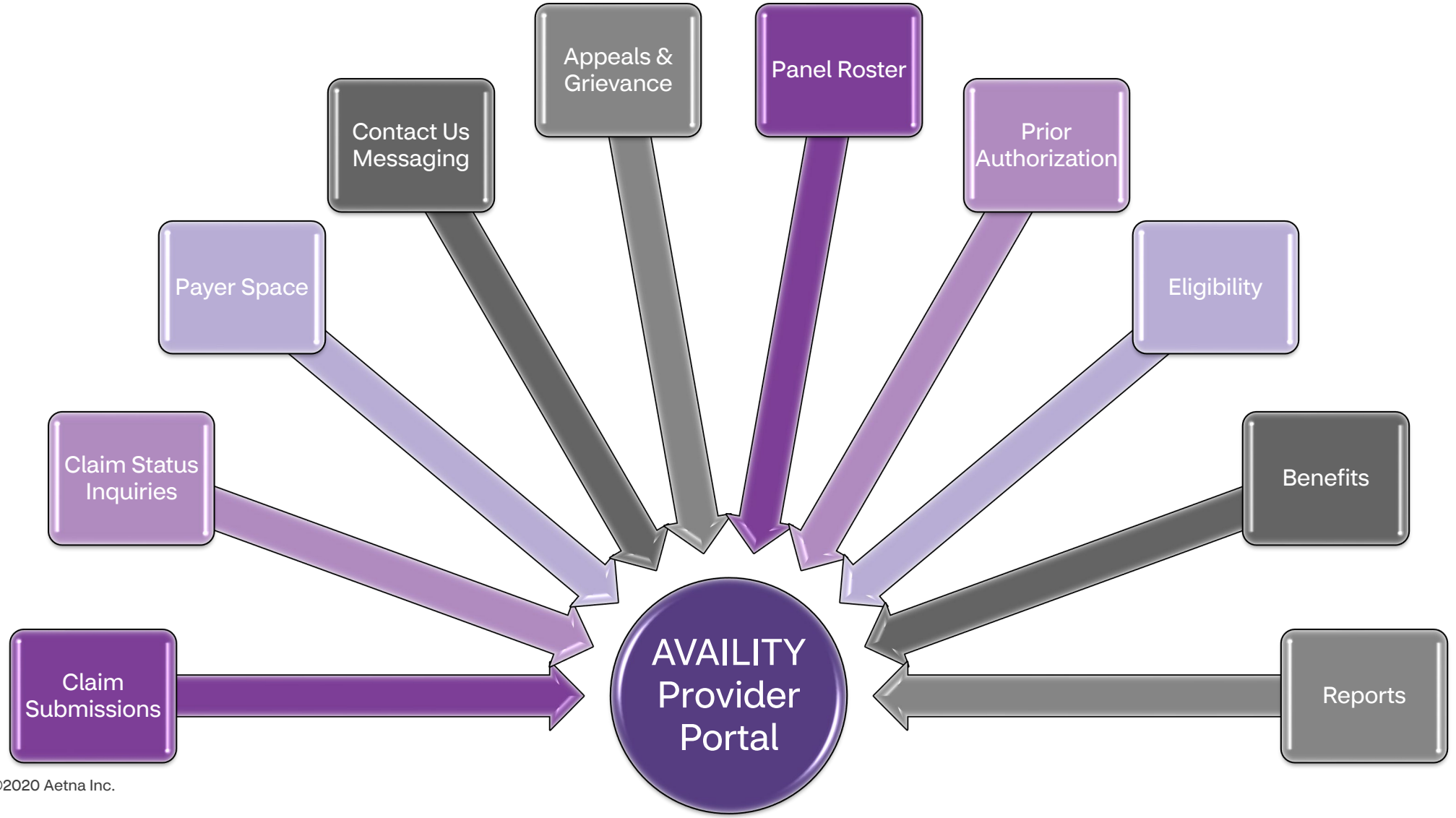
Another way to connect with us is by using our Availity system.



Availity

Availity Provider Portal

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



Availity Provider Portal

The Availity Provider Portal gives you the info, tools and resources you need to support the day-to-day needs of your patients and office.

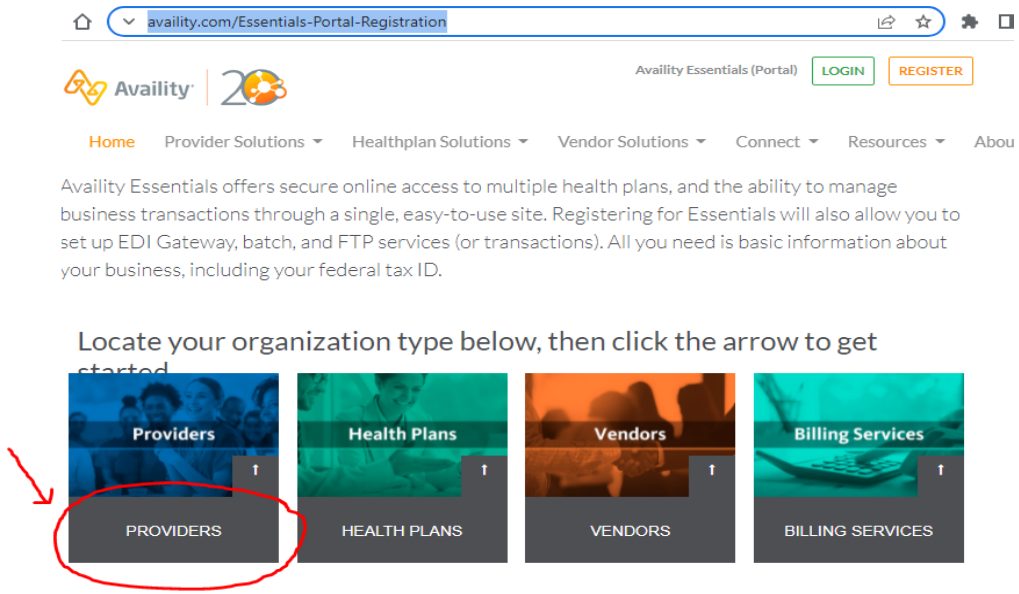
To access the Provider Portal visit: https://www.aetnabetterhealth.com/florida/providers/portal.html

Availity Essentials, is our preferred and trusted source for payer information.

HOW TO REGISTER

If your organization isn't registered with Availity, we strongly recommend that you get started today by:

1. **Visit the portal registration page:**
   - **https://availity.com/Essentials-Portal-Registration**
2. **Call Availity for assistance at:**
   - **1-800-282-4548**



You can still access the old Medicaid Web Portal (MWP) too. If you need help, email Provider Relations.

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**. 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

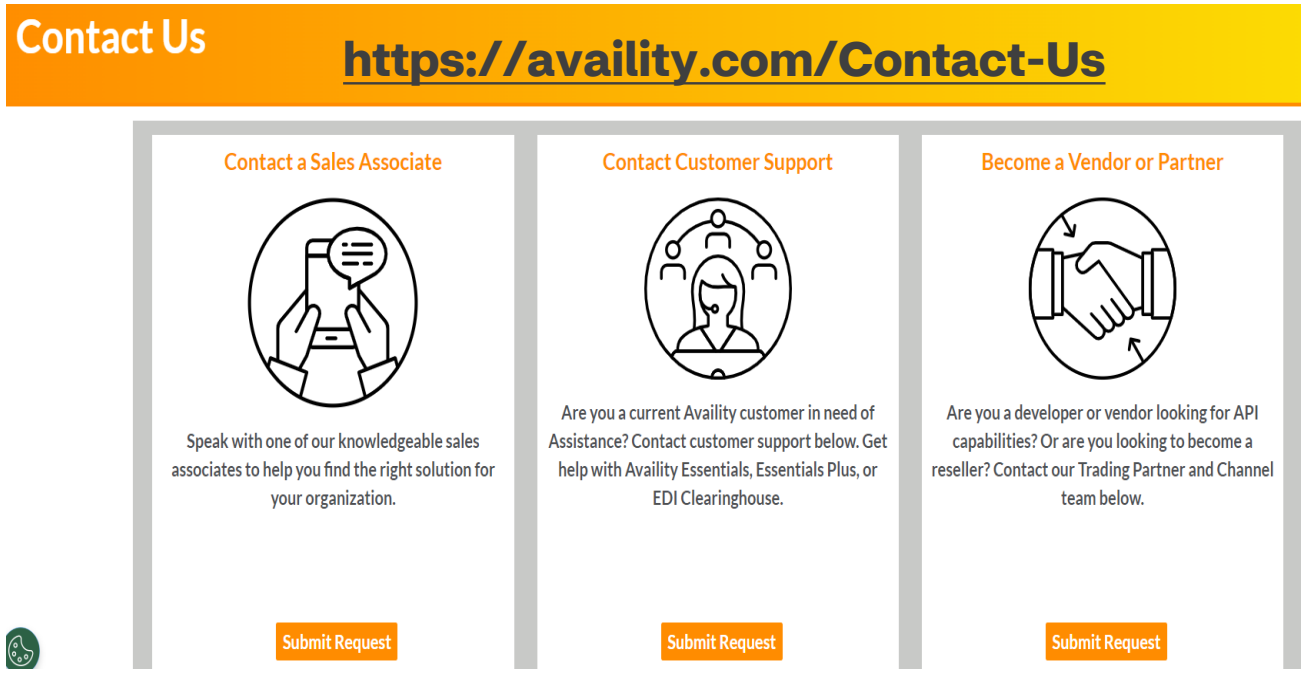
Help is available! Any issues related to Availity contact them directly via the Contact-Us button on the website or by calling one of the phone numbers below depending on your question/inquiry/issue.

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.

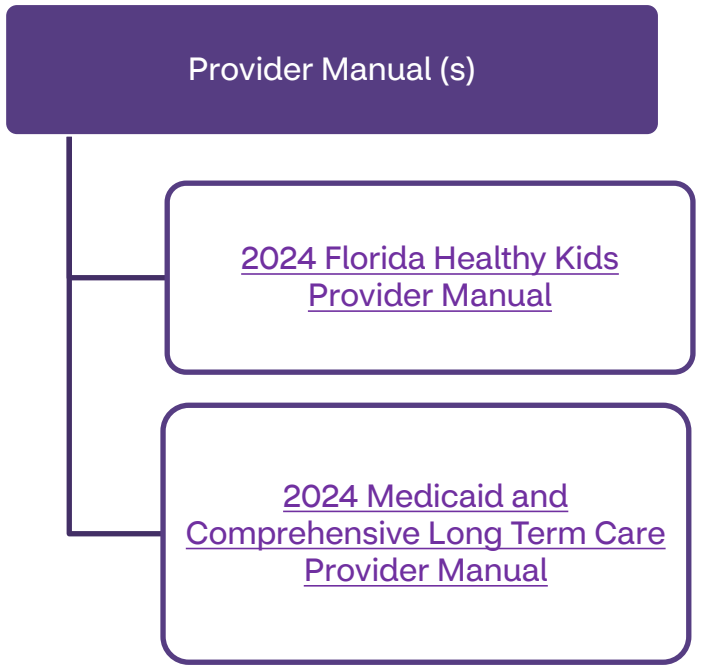


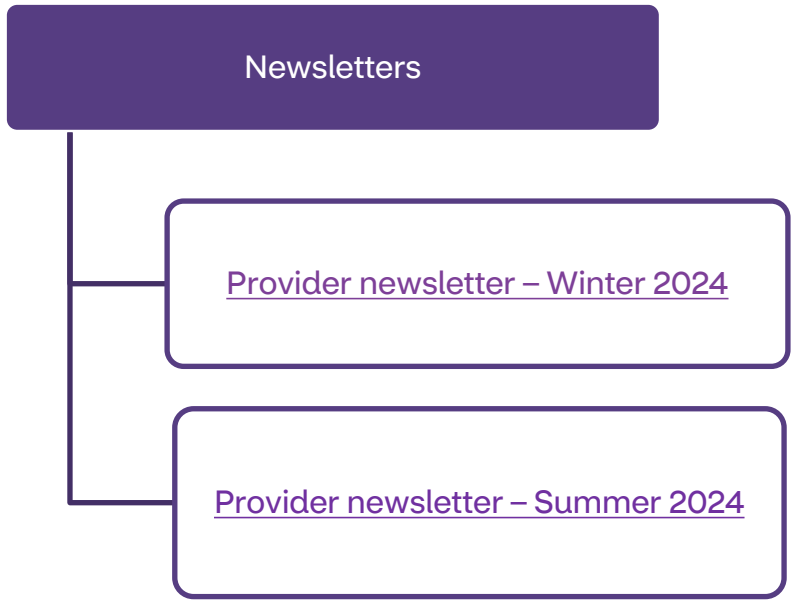
Provider Manual
Newsletters and Notifications

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)

Summer 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 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

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AetnaBetterHealth.com/Florida

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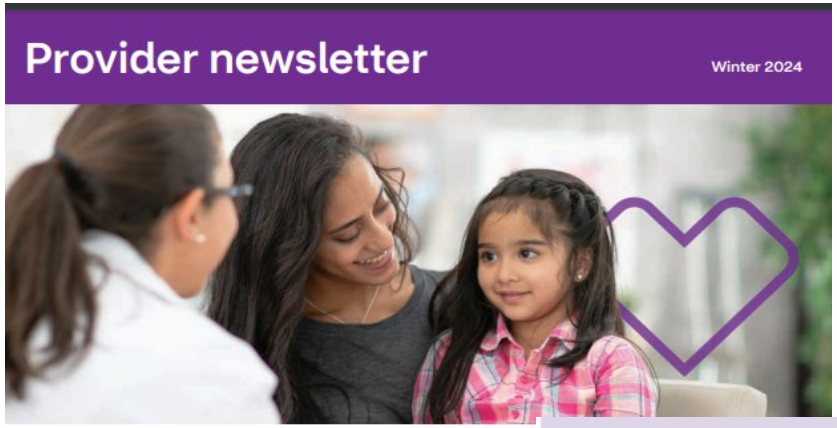
In this issue

Winter 2024



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AetnaBetterHealth.com/Florida

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In this issue

Provider Notifications (Fax blasts)

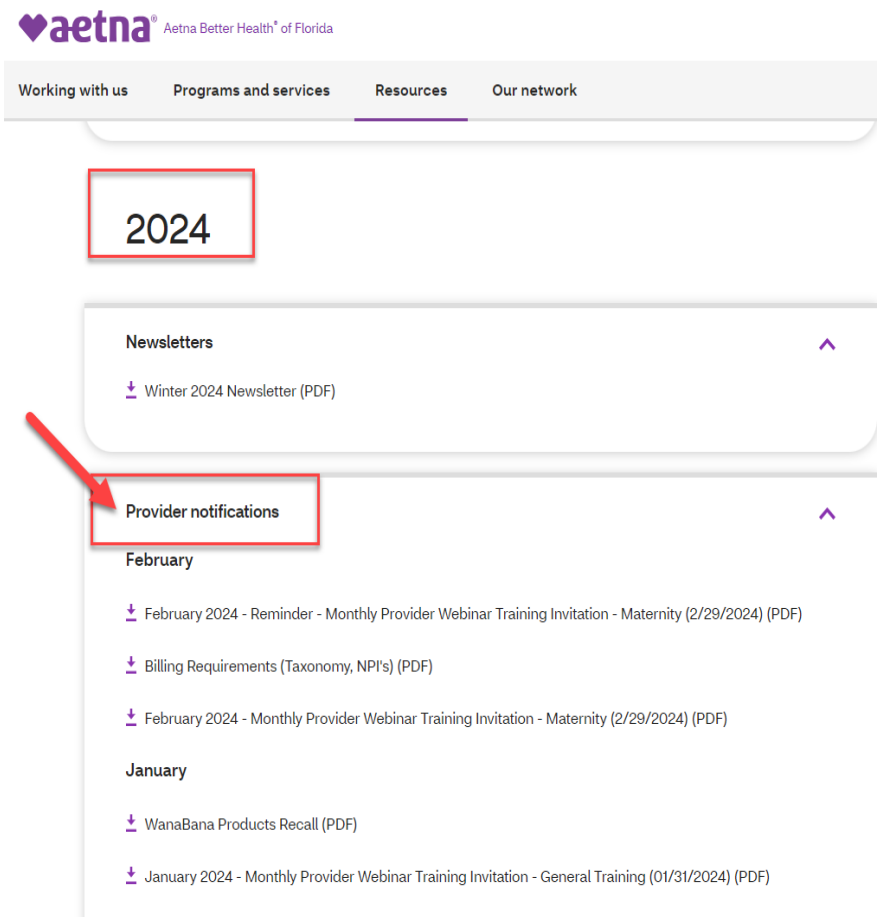
To stay informed with the most updated information please visit our ABHFL under the provider tab: ABHFL Provider Page

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)

April 2024

- April 2024- Monthly Provider Training - Maternity (PDF)
- April 2024 - Monthly Provider Training - General Training (PDF)

May 2024

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

June 2024

- Hadlima added to Medicaid PDL (PDF)
- 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)
- June 2024 - Monthly Provider Training - LTC Training (06/28//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

July 2024

- July 2024 - Monthly Provider Training - General Training (07/24/2024) (PDF)

August 2024

- No communications were sent out

September 2024

- Hurricane Helene provider communication (PDF)
- ECHO Health Partnership for EFT/ERA Services (PDF)

October 2024

- ProgenyHealth's Maternity Case Management Program (PDF)
- Aetna and Quest Analytics Partnership (PDF)
- Hurricane Milton Provider Communication (PDF)
- Diabetic Supplies - Pharmacy Services changes effective 10/01/2024 (PDF)

ProgenyHealth

ProgenyHealth®

Supporting Your Maternity Patients Between Office Visits

Clinical, behavioral, and social issues often arise between routine prenatal and postpartum appointments.

That's why Aetna Better Health of Florida® has teamed up with ProgenyHealth®, a leading expert in Maternity & NICU Care Management, to deliver continuous support for your maternity patients.

ProgenyHealth's Maternity Case Management Program (PDF)

Our program ensures ongoing monitoring, risk identification, and care coordination to bridge the gaps between visits and keep you informed of significant developments.

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Aetna Better Health® of Florida

Progeny HEALTH®

aetna®

ProgenyHealth®

How Our Program Benefits Your Pregnant Patients:

Nurse & Social Worker Support: Our dedicated case managers provide personalized support between appointments.

Real-time Updates: We promptly notify you of any concerning changes reported by your patients.

Educational Resources: Our Maternity App offers ongoing education, reducing unnecessary phone calls.

Appointment Adherence: By keeping patients informed and supported, we improve appointment adherence.

Access to Resources: We connect patients with non-clinical resources and benefits as needed.

To learn more about the ProgenyHealth Maternity Care Management Program, call **1-855-231-4730**, Monday - Friday, 8:30 AM - 5:00 PM ET, or email **maternity@progenyhealth.com**

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ProgenyHealth®

Referring Your Patients is Simple:

- **Review the Program: Learn more about the ProgenyHealth Maternity Program.**
- **Submit the Florida Medicaid Pregnancy Notification Form: Refer your patients with ease.**
- **Encourage Patient Engagement: Hand out member flyers, encouraging them to download our mobile app using the QR code for immediate support.**

You can also refer patients by sending a completed Florida Medicaid Pregnancy Notification Form via sFax to 1-860-607-8726.

Together, we can provide exceptional care and support for expectant mothers throughout their pregnancy and postpartum journey.

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

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

ENROLLED IN EFT/ERA PRIOR CYBER ATTACK & ABLE TO LOG IN

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.

ENROLLED IN EFT/ERA PRIOR CYBER ATTACK & AND CAN NOT LOG IN

If your account was affected during the cyber attack, we have been advising all providers to sign up for EFT/ERA using **ECHO Health**.

SIGNING UP WITH ECHO

Visit ECHO Website:
echohealthinc.com

All EFT/ERA fillable forms are available in availity portal.

- Under provider form, EFT/ERA.
- We also have a Provider Payments portal guide available that includes all the instructions.

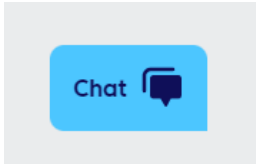
Electronic Funds Transfers (EFT) Electronic Remittance Advice (ERA)

Change Healthcare's Payer Enrollment Services FAQ's

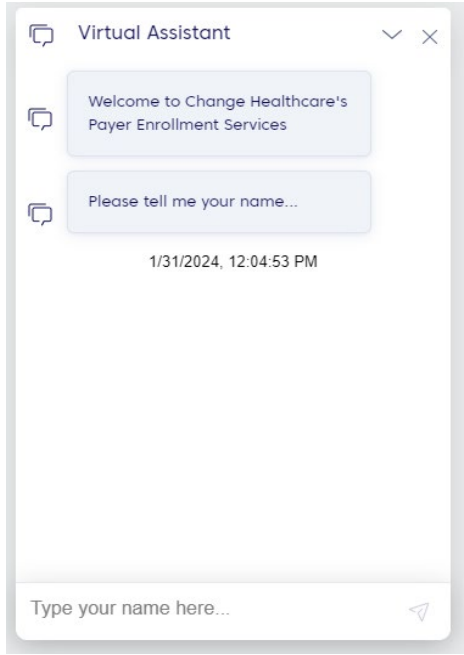
- What is Payer Enrollment Services (PES)?
- How do I log in?
- How do I submit an enrollment?
- How do I check the status of the enrollments that I submitted?
- How do I know when my enrollment(s) were successfully approved by the payer?
- Where can I submit new enrollments?
- How do I withdraw an enrollment?
- 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!



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

Support Team

ECHO Health, Inc

If you need assistance, contact ECHO Health at:

- allpayer@echohealthinc.com
- 1-888-834-3511

WEBSITE:

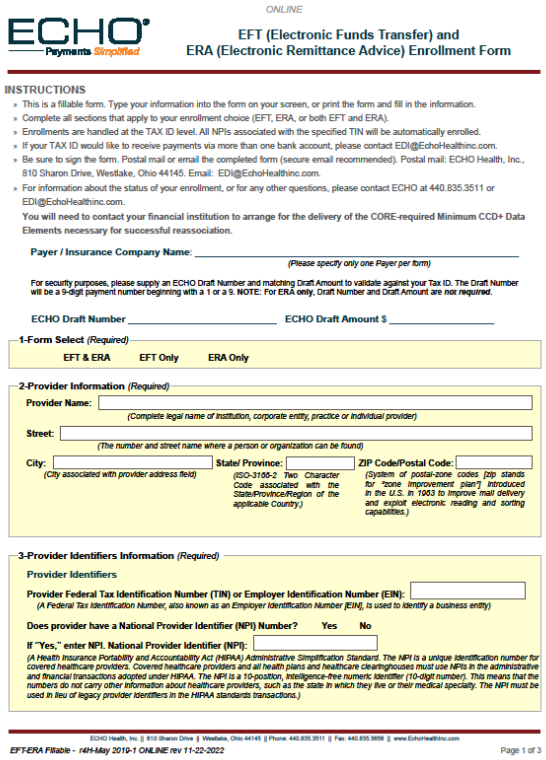
- ECHO Health Provider Login

EFT/ERA ENROLLMENT:

- ECHO Health

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

ECHO FILLABLE EFT/ERA FORMS



ONLINE

ECHO Payments Simplified

EFT (Electronic Funds Transfer) and
ERA (Electronic Remittance Advice) Enrollment Form

INSTRUCTIONS

- This is a fillable form. Type your information into the form on your screen, or print the form and fill in the information.
- Complete all sections that apply to your enrollment choice (EFT, ERA, or both EFT and ERA).
- Enrollments are handled at the TAX ID level. All NPIs associated with the specified TIN will be automatically enrolled.
- If your TAX ID would like to receive payments via more than one bank account, please contact EDI@EchoHealthinc.com.
- Be sure to sign the form. Postal mail or email the completed form (secure email recommended). Postal mail: ECHO Health, Inc., 810 Sharon Drive, Westlake, Ohio 44145. Email: EDI@EchoHealthinc.com.
- For information about the status of your enrollment, or for any other questions, please contact ECHO at 440.835.3511 or EDI@EchoHealthinc.com.

You will need to contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation.

Payer / Insurance Company Name: _____
(Please specify only one Payer per form)

For security purposes, please supply an ECHO Draft Number and matching Draft Amount to validate against your Tax ID. The Draft Number will be a 9-digit payment number beginning with a 1 or a 9. NOTE: For ERA only, Draft Number and Draft Amount are *not required*.

ECHO Draft Number _____ **ECHO Draft Amount $** _____

1-Form Select *(Required)*

EFT & ERA **EFT Only** **ERA Only**

2-Provider Information *(Required)*

Provider Name:
(Complete legal name of institution, corporate entity, practice or individual provider)

Street:
(The number and street name where a person or organization can be found)

City: *(City associated with provider address field)*
State/ Province: *(ISO-3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.)*
ZIP Code/Postal Code: *(System of postal-zone codes [zip stands for "zone improvement plan"] introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.)*

3-Provider Identifiers Information *(Required)*

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):
(A Federal Tax Identification Number, also known as an Employer Identification Number [EIN], is used to identify a business entity)

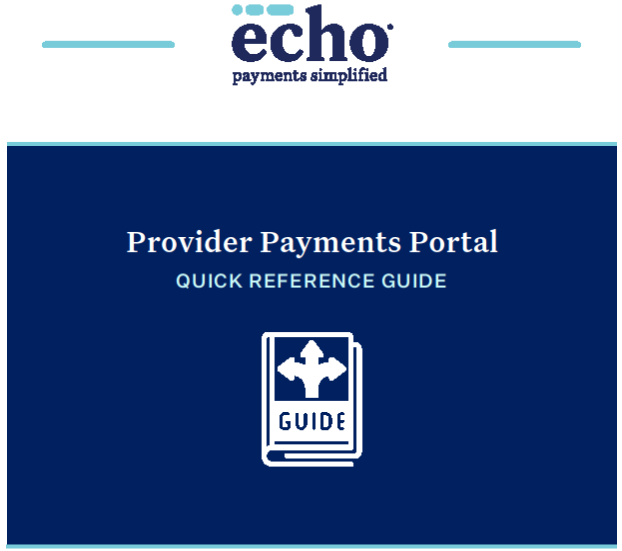
Does provider have a National Provider Identifier (NPI) Number? **Yes** **No**

If "Yes," enter NPI. National Provider Identifier (NPI):
(A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.)

ECHO Health, Inc. || 810 Sharon Drive || Westlake, Ohio 44145 || Phone: 440.835.3511 || Fax: 440.835.5656 || www.EchoHealthinc.com

EFT-ERA Fillable - r4H-May 2019-1 ONLINE rev 11-22-2022 Page 1 of 3

ECHO PROVIDER QUICK REFERENCE GUIDE



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www.echohealthinc.com

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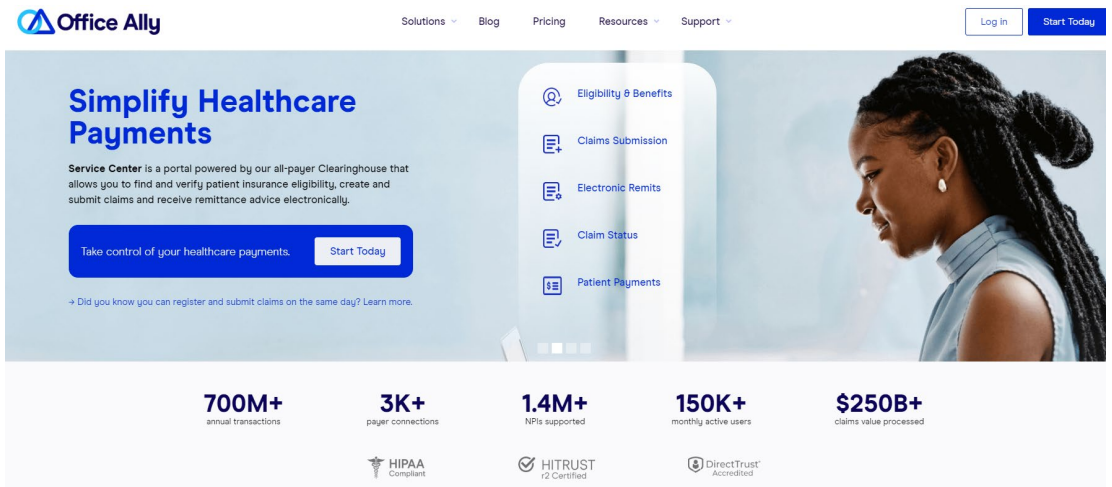
Claim Submissions

Claim Submissions

Claims Submission- For Medicaid please submit claims through Office Ally

- **Providers can register at https://cms.officeally.com/**



REJECTED CLAIMS

- If claims are being rejected, please verify that claims submitted are matching the Taxonomy listed from the Medicaid portal.

- Below is the link of notification sent to providers on the Taxonomy updates. https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/florida/provider/pdf/ABHFL_Claims_and_Encounters_Front_End_Taxonomy_Edits_Reminder_02.26.2024_v1.pdf

Importance of providing primary insurance EOB/EOP when filing claims as a secondary payer

Coordination of Benefits (“COB”) provision applies when a member has health care coverage under more than one plan.

In the event that the Plan is the secondary payer, coordination of benefit claims must be submitted within ninety (90) days after final determination by the primary organization as evidenced by the primary carrier’s Explanation of Payment (EOP) or Explanation of Benefits (EOB) as required under applicable law and regulation. (See Florida Statute 641.3155(2)).

All explanations of payment or denials from the member’s primary carrier must be provided with the claim.

Information should be sent to:

- **Aetna Better Health of Florida**
  P.O. Box 982960
  El Paso, TX 79998-2960

For more information please visit the Florida Statute for COB: Statutes & Constitution :View Statutes : Online Sunshine (state.fl.us) or refer to our Aetna Better Health of Florida Provider Manual https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/florida/provider/pdf/abhfl_fhk_provider_manual.pdf

Corrected or voided claims – REMINDER!

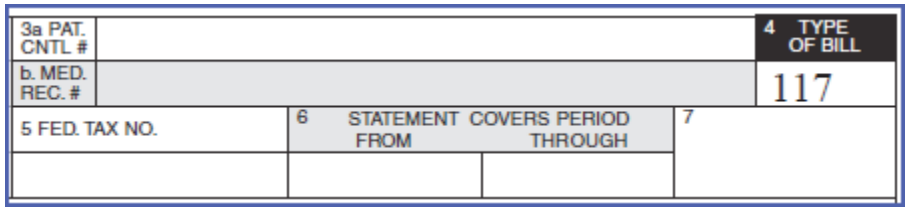
IMPORTANT REMINDER

Please utilize the reference “7” to avoid new claims or denials of duplicate claims.

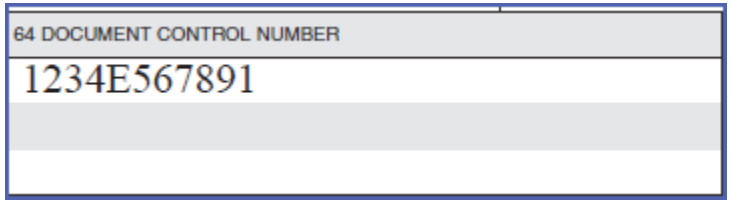
For Institutional claims, provider must include the original Aetna Better Health of Florida claim number and bill frequency code per billing standards.

Examples:

- Box 4 – Type of Bill: the third character represents the “Frequency Code”:



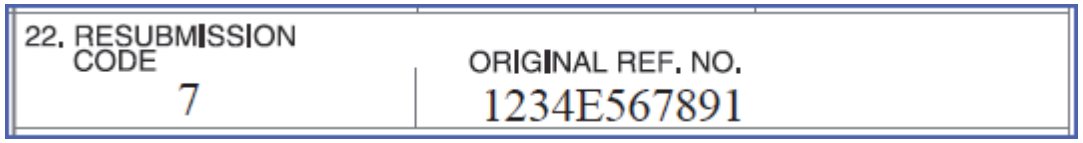
- Box 64 – Place the Claim number of the Prior Claim in Box 64:



Corrected or voided claims – REMINDER!

For Professional claims, provider must include the original Aetna Better Health of Florida claim number and bill frequency code per billing standards. When submitting a Corrected or Voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.

Example:



Any missing, incomplete, or invalid information in any field may cause the claim to be rejected.

Please Note: If the provider handwrites, stamps, or types “Corrected Claim” on the claim form without entering the appropriate Frequency Code (7 or 8) along with the Original Reference Number as indicated above, the claim will be considered a first-time claim submission.

When processing a Corrected or Voided Claim, a Payment Reversal may be generated which may produce a negative amount, which will be seen on a later Remittance Advice than the Remittance Advice that is sent for the newly submitted corrected claim.

Corrected or voided claims – REMINDER!

Corrected or voided EDI claims

Corrected and/or Voided Claims are subject to Timely Claims Submission (i.e., Timely Filing) guidelines.

To submit a Corrected or Voided Claim electronically:

- Loop 2300 Segment CLM composite element CLM05-3 should be ‘7’ or ‘8’ – indicating to replace ‘7’ or void ‘8’
- Loop 2300 Segment REF element REF01 should be ‘F8’ indicating the following number is the control number assigned to the original bill (original claim reference number)
- Loop 2300 Segment REF element REF02 should be ‘the original claim number’ – the control number assigned to the original bill (original claim reference number for the claim to be replaced.)
- Example: REF*F8*Aetna Better Health of Florida Claim number here~
- These codes are not intended for use for original claim submission or rejected claims.

For more information please refer to our Provider Manual

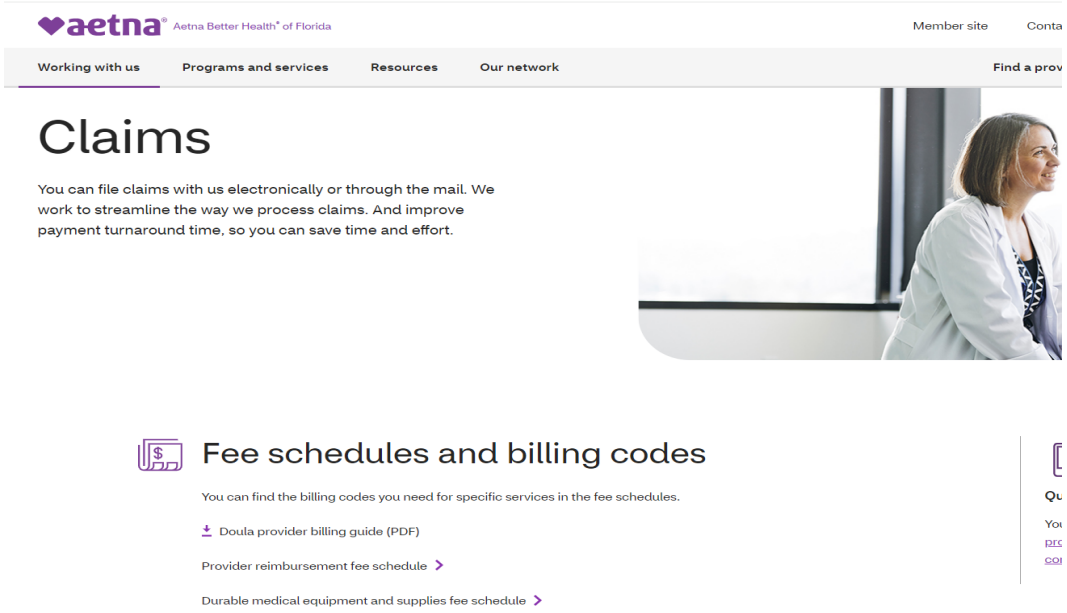
Medicaid Fee Schedule & Reimbursement

Medicaid Fee Schedule & Reimbursement

Billing codes you need for specific services in the fee schedules can be located on our ABHFL website:

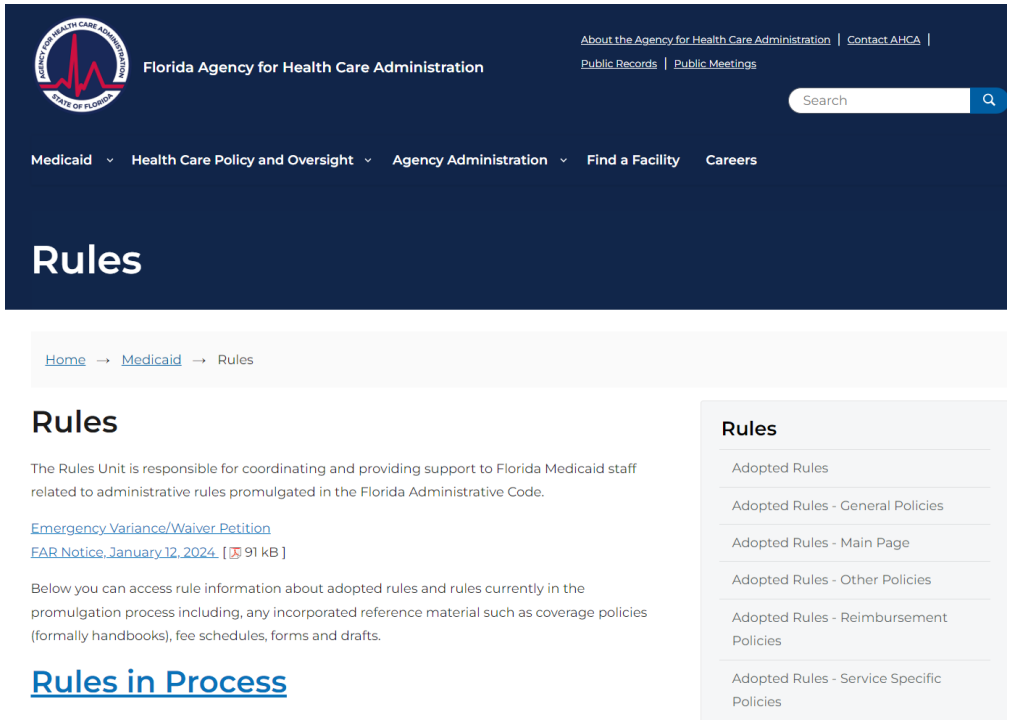
Fee Schedule

- Doula provider billing guide (PDF)
- Provider reimbursement fee schedule
- Durable medical equipment and supplies fee schedule



Florida Medicaid Program Rules and Reimbursement Schedules can be located on the Florida Agency for Health Care Administration (AHCA) page.

- **https://ahca.myflorida.com/medicaid/rules**



Prior Authorization

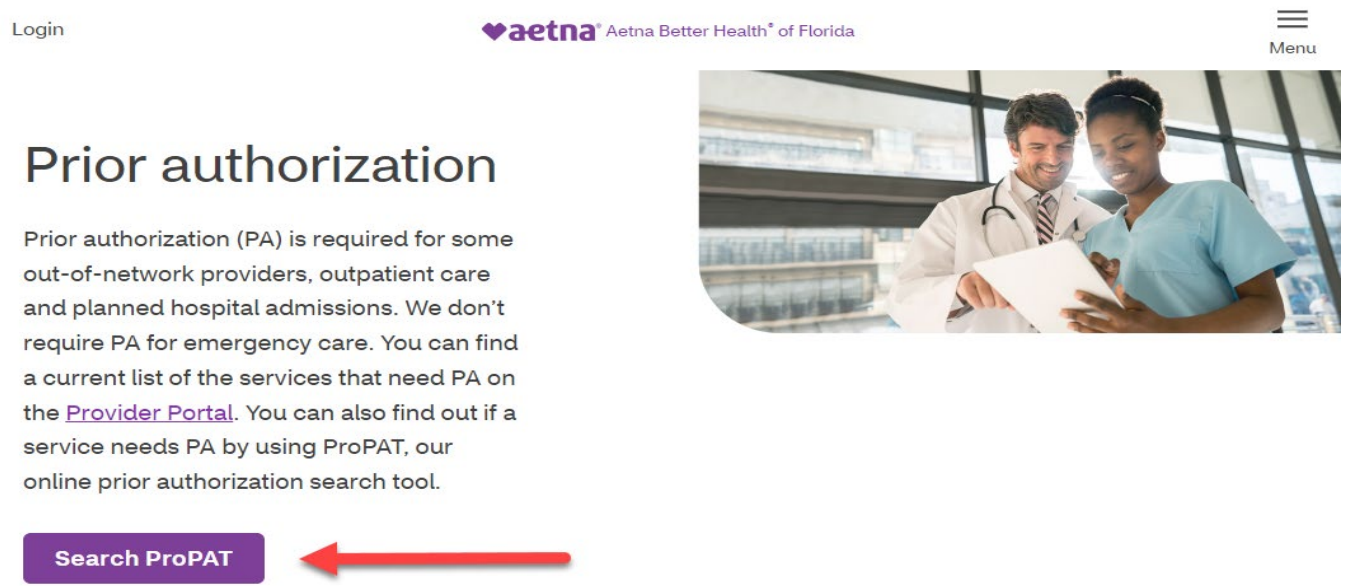
Prior Authorization

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**



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.

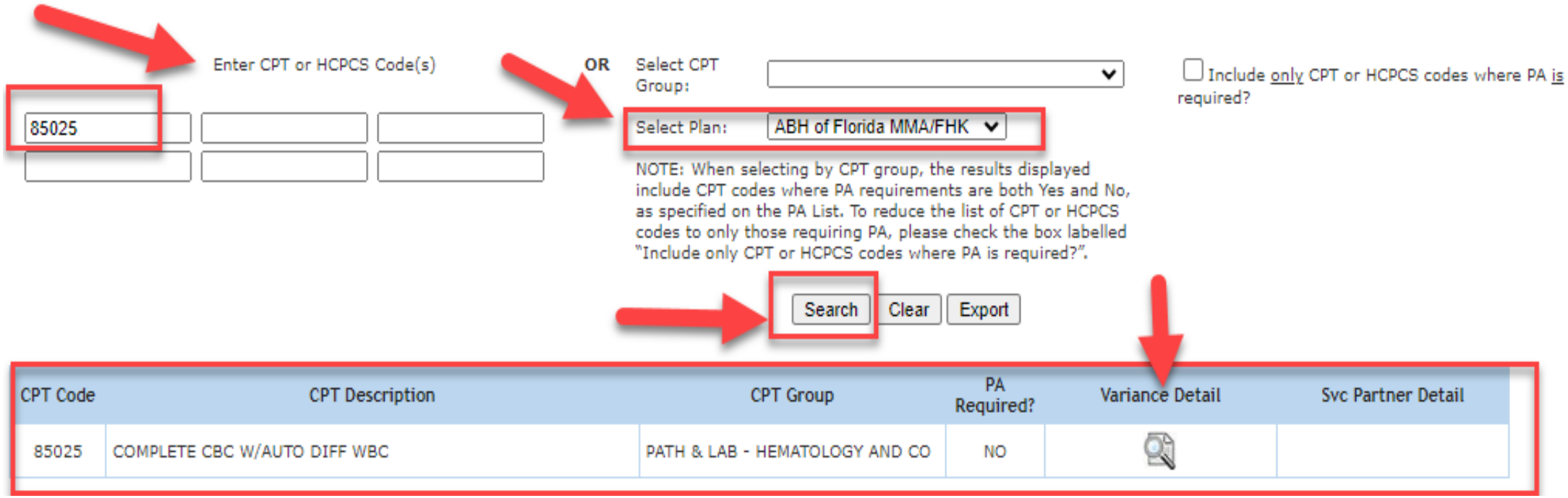
- If you have any questions about authorization requirements or need help with the search tool, contact Aetna Better Health of Florida Provider Relations at 1-800-441-5501 for Medicaid and 1-844-528-5815 for Florida Healthy Kids.
- For Dental benefits and prior authorization, please contact the member's 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 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).



Tips for requesting PA

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

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

Timely Filing Requirements

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
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

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.

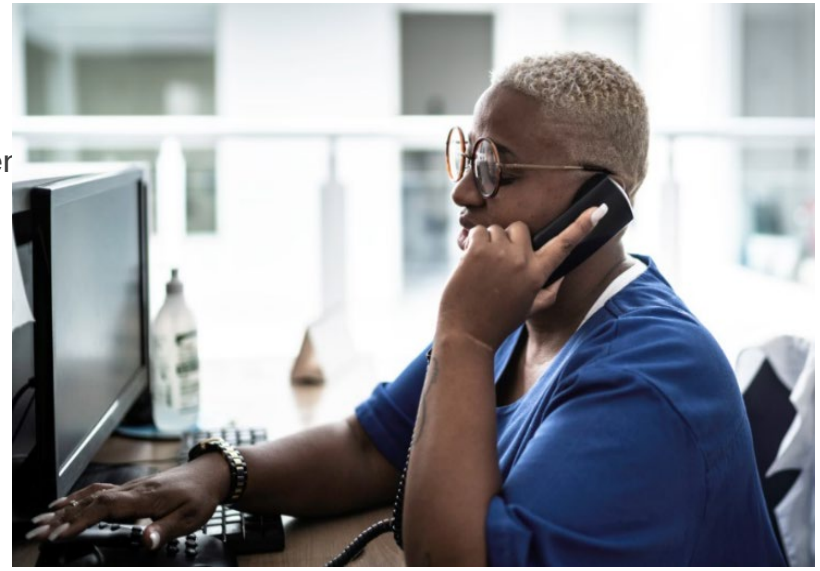
Appeals, Complaints and Grievances

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 ser

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

Monthly Provider Trainings

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**
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)

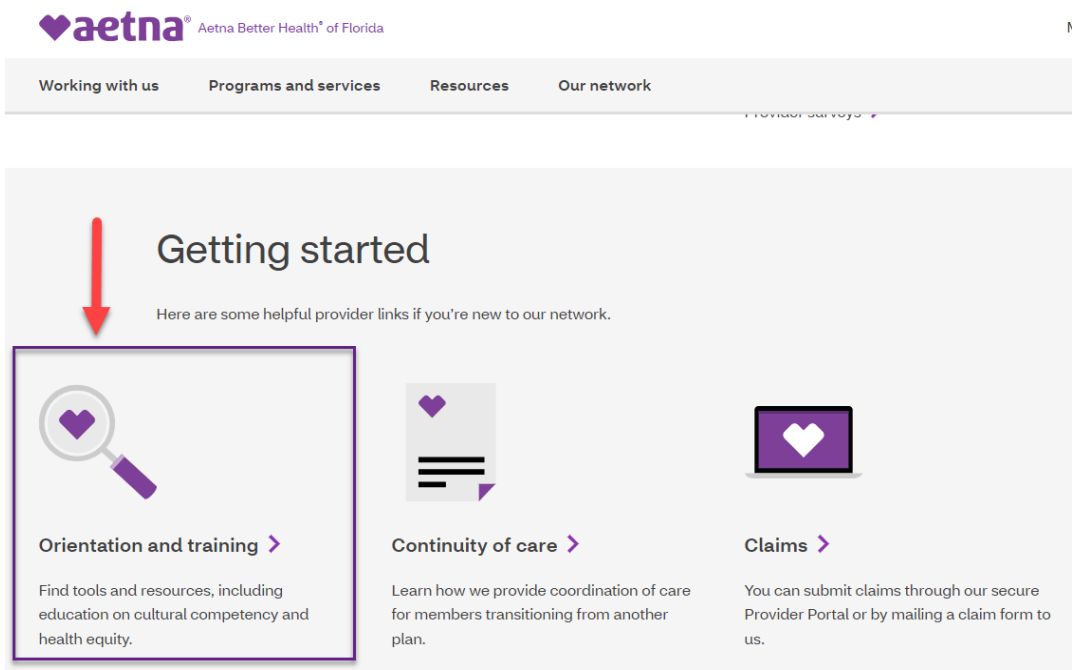
Monthly Provider Trainings

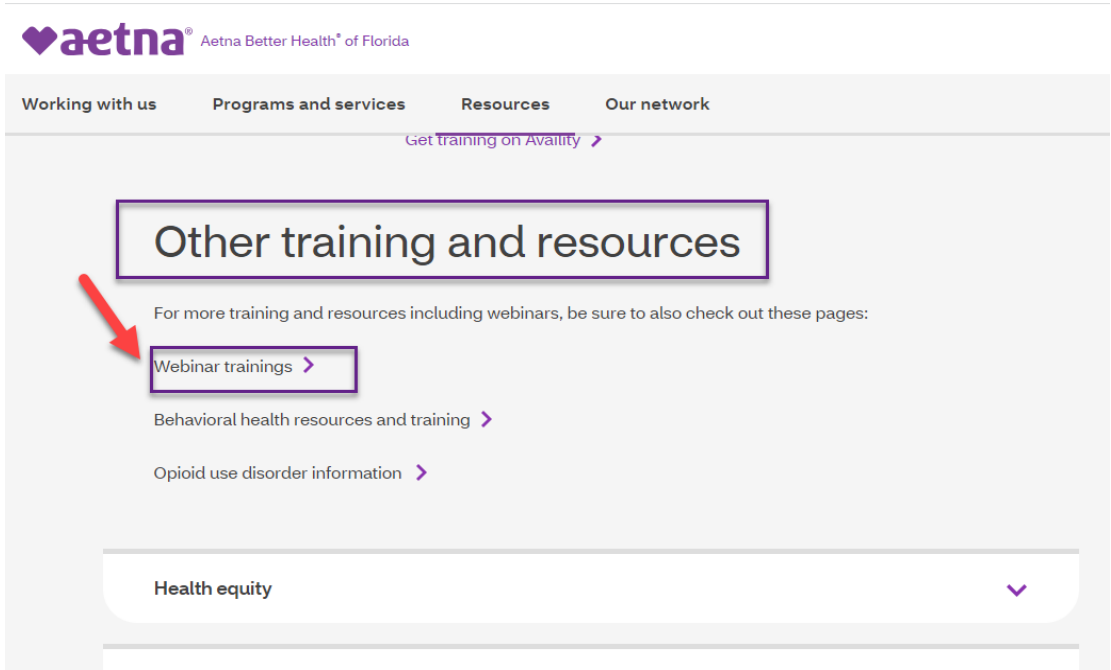
Missed a provider training? No problem!

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!

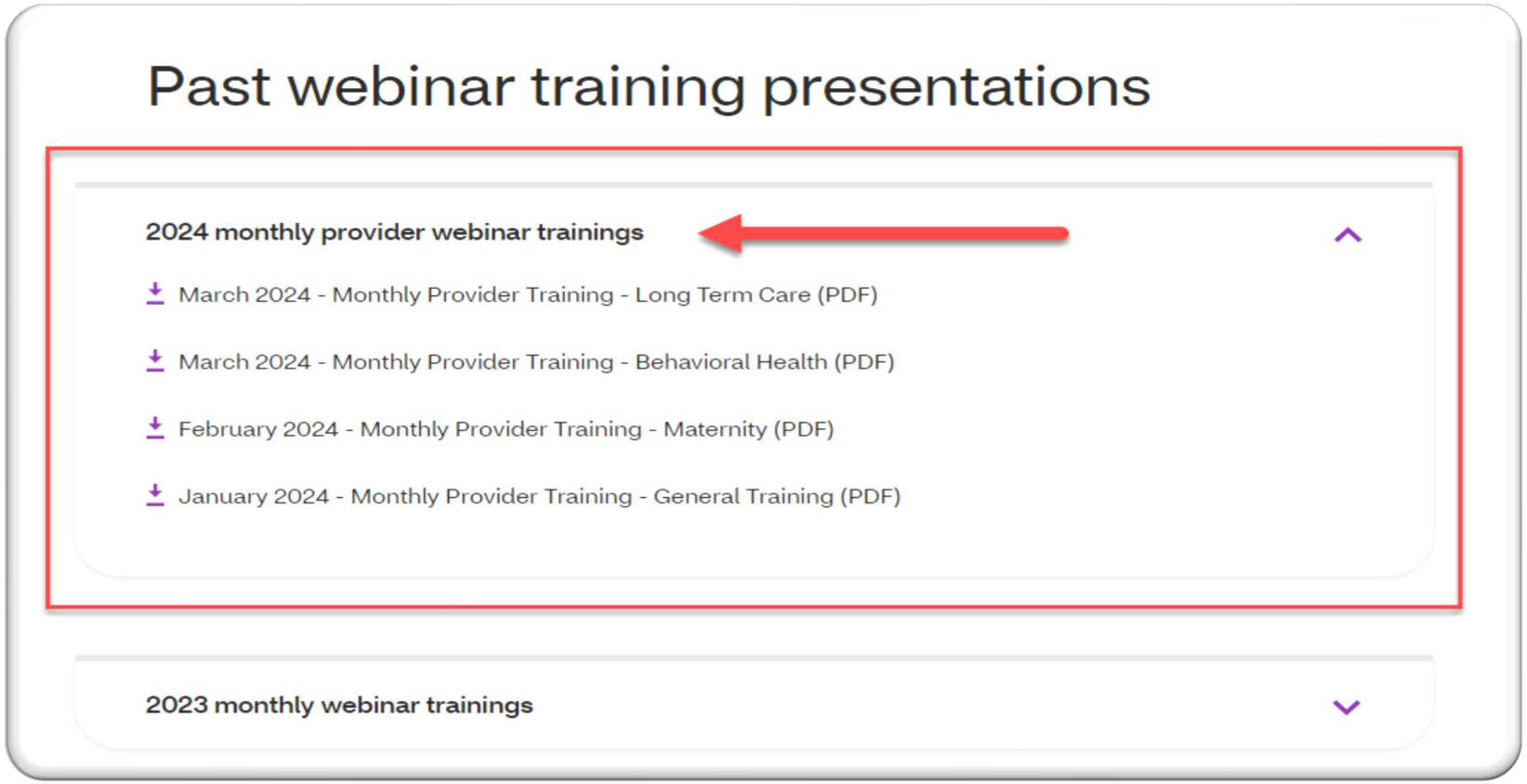
- https://www.aetnabetterhealth.com/florida/providers/materials-forms.html





Monthly Provider Trainings

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



ABHFL Website
Provider & Helpful Links

Provider Main Site

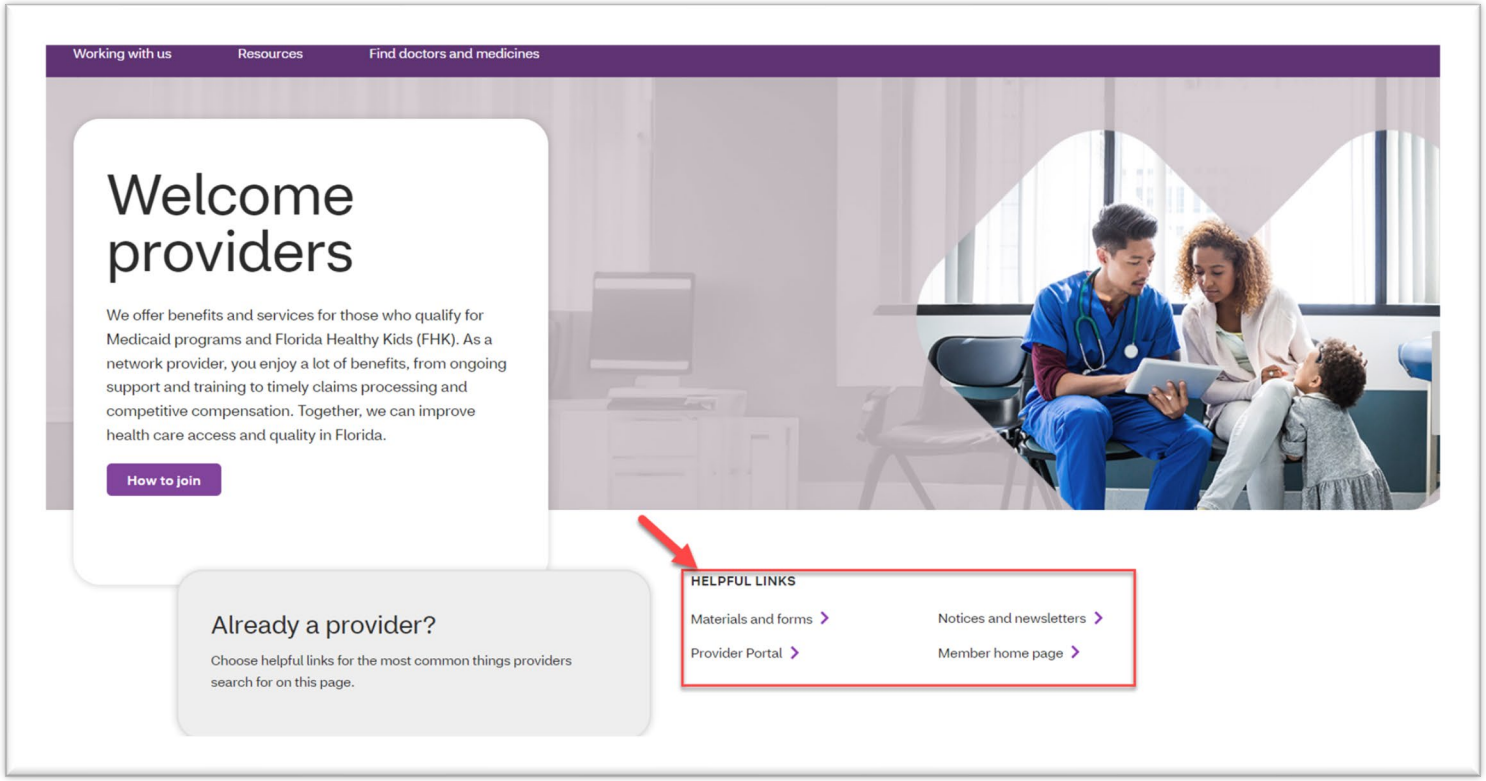
Our ABHFL website

ABHFL Provider Site Direct Link:

- https://www.aetnabetterhealth.com/florida/providers/index.html

Our Provider Site Main Page contains “Helpful Links”:

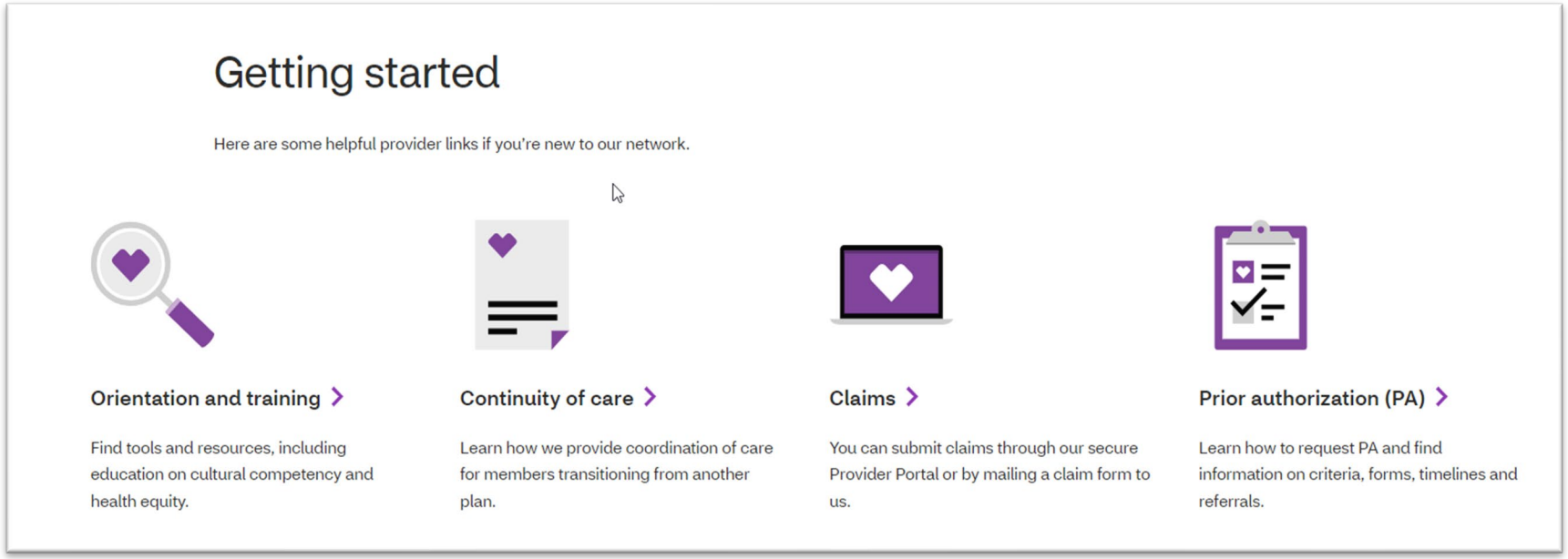
- Materials and forms
- Provider Portal
- Notices and newsletters
- Member home page



Provider Main Site

Getting started - Here are some helpful provider links if you're new to our network.

- Orientation and training
- Continuity of care
- Claims
- Prior authorization



Provider Helpful Links

Materials and Forms

- Under materials and forms you will find helpful information that includes:
  - Behavioral Health Services
  - In-Network Relations Representatives
  - ABHFL Resource Guide
  - ABHFL Vendor List
  - And much more!
- **https://www.aetnabetterhealth.com/florida/providers/materials-forms.html**

Provider Portal

- Quick access to connect with us via Aetna Better Health of Florida Portal or Availity Portal.
  - Availity
  - ABHFL Portal
- **https://www.aetnabetterhealth.com/florida/providers/portal.html**

Provider Surveys

- Multiple provider surveys are available and can be used to update information.
  - ABH FL Provider Data Validation ABH FL Provider Data Change Form
  - ABHFL Provider OB/GYN Survey (PDF)
  - Aetna Better Health of Florida Behavioral Health and Primary Care Provider Collaboration
  - Aetna Better Health of Florida Primary Care and Behavioral Health Provider Collaboration
  - ABH FL Provider Office Hours & Telemedicine Services Survey
- **https://www.aetnabetterhealth.com/florida/providers/materials-forms.html**

Notices & Newsletters

- Important updates and most recent information is in this section.
  - Policy Updates
  - Pharmacy updates
  - Billing policy reminders
  - PopHealth Newsletters
  - Provider Notifications
  - Newsletters
- **https://www.aetnabetterhealth.com/florida/providers/notices-newsletters.html**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Questions?

We have answers!

Contact our Provider Services Department

Phone: 1-844-528-5815 (TTY: 711)
Email: FLProviderEngagement@aetna.com

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