Aetna Better Health® of Florida

Provider Monthly Training

April 27, 2023

Agenda

- Timely Filing Requirements
- Grievance & Appeals
- Prior Authorization
- EFT/ERA
- Provider Surveys
- Availity Provider Portal
- Provider Manual, Newsletters, and Notifications
- Shared Decision-Making Aids

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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.

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)

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Grievance & Appeals

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

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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

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**

You can also call us with your complaint or appeal:

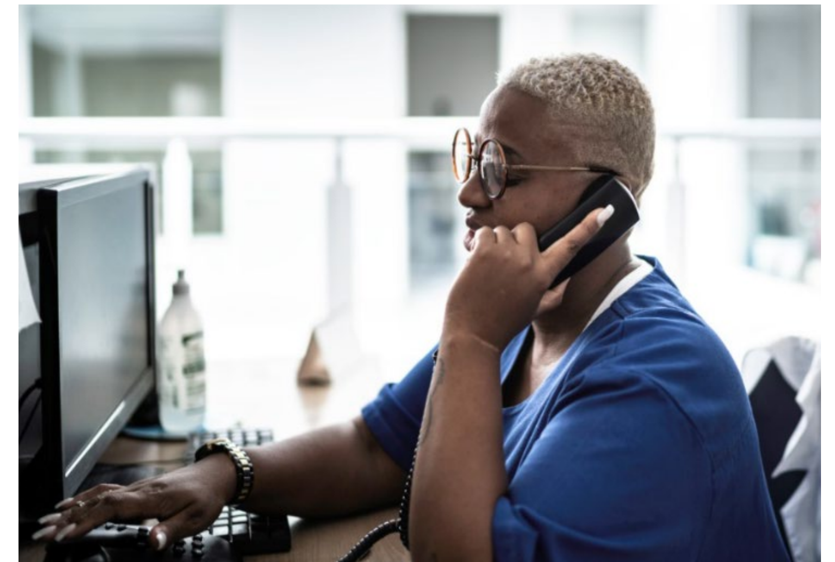
- Medicaid Managed Medical Assistance: 1-800-441-5501 (TTY: 711)
- Long-Term Care: 1-844-645-7371 (TTY: 711)
- Florida Healthy Kids: 1-844-528-5815 (TTY: 711)

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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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**

Login

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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)

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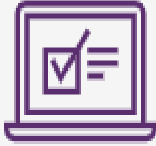
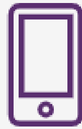
How to request PA



Online

Ask for PA through our Provider Portal.

Visit the Provider Portal



By phone

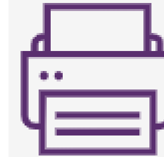
Ask for PA by calling us:

- 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

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

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

All ABHFL EFT/ERA Registration Services (EERS) are managed by Change Healthcare. EERS gives payees multiple ways to set up EFT and ERA in order to receive transactions from multiple payers.

Electronic funds transfer (EFT)

EFT makes it possible for us to deposit electronic payments directly into your bank account. Some benefits of setting up an EFT include:

- Improved payment consistency
- Fast, accurate and secure transactions

Electronic remittance advice (ERA)

ERA is an electronic file that contains claim payment and remittance info sent to your office. The benefits of an ERA include:

- Reduced manual posting of claim payment info, which saves you time and money, while improving efficiency
- No need for paper Explanation of Benefits (EOB) statements

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

How to enroll

To enroll in EFT/ERA Registration Services (EERS) visit
Change Health payer enrollment services website

- Create your enrollment by filling out the Provider Information, Contact Information, Bank Information (only if adding EFT enrollment(s)), and Enrollment Information.
- Submit your enrollment(s) and you will receive an email notification confirming submission to Change Healthcare.
- Log in to the Provider Portal to check the status of your enrollment(s).

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Provider Surveys

Provider Satisfaction Surveys

Your opinion matters!

Aetna Better Health of Florida will be conducting its annual Provider Satisfaction Survey starting **in May 2023 through June 2023.**

This is your opportunity to tell us how we are doing operationally, and with the administration of our programs.

We will be contacting randomly selected providers from our network across Florida.

If you receive one of our surveys, please complete it and return it as instructed.

Your feedback will help us greatly to improve our services to your and your practice.

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Provider Surveys

We have added a NEW “**Provider surveys**” section on our website.

Direct link for Provider Surveys

Login

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Menu

Welcome providers

We offer benefits and services for those who qualify for Medicaid programs and Florida Healthy Kids (FHK). As a network provider, you enjoy a lot of benefits, from ongoing support and training to timely claims processing and competitive compensation. Together, we can improve health care access and quality in Florida.

How to join

HELPFUL LINKS

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

Forms

- Prior authorization (PA) forms
- Claim forms
- Pharmacy prior authorization forms
- Provider surveys
  - ABH FL Provider Data Validation
  - ABH FL Provider Data Change Form
  - Aetna Better Health of Florida Behavioral Health and Primary Care Provider Collaboration
  - Aetna Better Health of Florida Primary Care and Behavioral Health Provider Collaboration

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ABH FL Provider Data Validation

Provider Online Directory Attestation

It is important to Aetna Better Health of Florida (ABHFL) and your patients that your provider directory demographics are accurate. In support of NCQA, federal, and CMS regulations and standards, ABHFL requires participating providers to visit our Provider Online Directory at each calendar quarter to validate the accuracy of your practice information.

Actively managing the accuracy of provider data is critical to ensuring our members can access medical care. Incorrect information within provider directories can lead to confusion and frustration for members and providers. Without consistently checking the information through provider data validation, inaccuracies can grow, and this can become a significant barrier in accessing care.

Please take a moment to review the Provider Online Directory and provide your attestation below.

Click here to start completing your Provider Online Directory Attestation

EXIT

ABH FL Provider Data Validation

Provider Online Directory Attestation

It is important to Aetna Better Health of Florida and your patients that your provider directory demographics are accurate. In support of NCQA, federal, and CMS regulations and standards, Aetna Better Health of Florida requires participating providers to visit our Provider Online Directory at https://www.aetnabetterhealth.com/florida/find-provider each calendar quarter to validate the accuracy of your practice information.

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Please take a moment to review the Provider Online Directory and provide your attestation below.

* Based on your review of the Provider Online Directory, please click the following statement that applies:

- ◯ I have reviewed the Provider Online Directory and attest that all information is complete and accurate to the best of my knowledge.
- ◯ I have reviewed the Provider Online Directory and some information requires updates. I will access the Provider Data Change Form (https://www.surveymonkey.com/r/MVJZ67M) and follow the instructions on the form to complete the required updates with Aetna Better Health of Florida.

* Group Practice and Contact Information

Group Practice Name	
Group Tax ID (TIN)	
Group NPI	
Name of Person Completing Survey	
Title	
Phone Number	
Email Address	

Please continue to the next page to answer a few questions.

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ABH FL Provider Data Change Form

Accurate data matters!

Keeping your practice data up to date through Aetna Better Health of Florida's online Provider Data Change Form is essential to ensuring member satisfaction, appropriate referrals, appointment availability, and accurate and timely claims processing.

Instructions: Please complete the Provider Data Change Form (PDCF) for each practitioner in your practice that requires changes and only fill out the fields that require changes in the system.

[Click here to start completing your Provider Data Change Form](#)

NOTE: This form is not for New Providers, Contractual or Credentialing updates. If you are adding a practitioner to an existing group, please submit a credentialing application.

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NOTE: This form is not for New Providers, Contractual or Credentialing updates. If you are adding a practitioner to an existing group please submit a credentialing application.

* Submitter Information

First and Last Name

Title

Phone

Email Address

* Provider Online Directory Changes Required (select all that apply).

☐ Provider Name	☐ Gender	☐ Handicap Accessibility
☐ Provider Title	☐ Ethnicity/Race	☐ Languages and Training
☐ Provider NPI	☐ State License Number	☐ Hospital Affiliations
☐ Accepting New Patients	☐ Website	☐ Group Affiliations
☐ Ages Served	☐ Service Location Address	☐ Line of Business (Plan)
☐ Primary Specialty	☐ Service Location Phone	☐ Telehealth
☐ Secondary Specialty	☐ Service Location Fax	☐ Pay-To Address
☐ Board Certifications	☐ Office Hours	
☐ Other (please specify)		

Note: If you are adding Group Affiliations to a practitioner and the Group is not contracted please complete the Provider Nomination Form and follow the instruction on the form.

* Group Practice Information (all fields are required)

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Availity

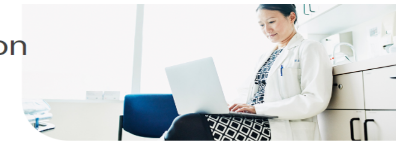
Availity Provider Portal

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).

It's easy to work with us on Availity®



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

Log in to Availity

Log in to MWP

What's new on Availity?

Eligibility and benefits

You now have access to a member's eligibility and benefits in the Provider Portal. Simply click on "Patient Registration" to find the Eligibility and Benefits functionality.

See claims details

You can review claims payment info and download a PDF of the Explanation of Benefits (EOB). Simply submit a claims status inquiry request. Then, choose "View EOB" from the results page.

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Availity Provider Portal

To register, select your organization type below

Select this option if you are a healthcare provider.

If you are a healthcare provider – i.e., physician practice, mental health provider, specialist, medical transportation service, or non-physician provider – click below to register. Questions about registering? Join us for a live webinar or explore other registration resources on our training microsite.

Register

Availity

Availity Essentials (Portal) LOGIN REGISTER

Home Provider Solutions Health Plan Solutions Vendor Solutions Connect Resources About

Get started with Availity today

Create your account

Availity & Helpful Links:

- Availity Main Page
- Availity Provider Portal
- Availity Portal-Registration
- Availity Get Started
- Availity Log In
- Availity Training-and-Education

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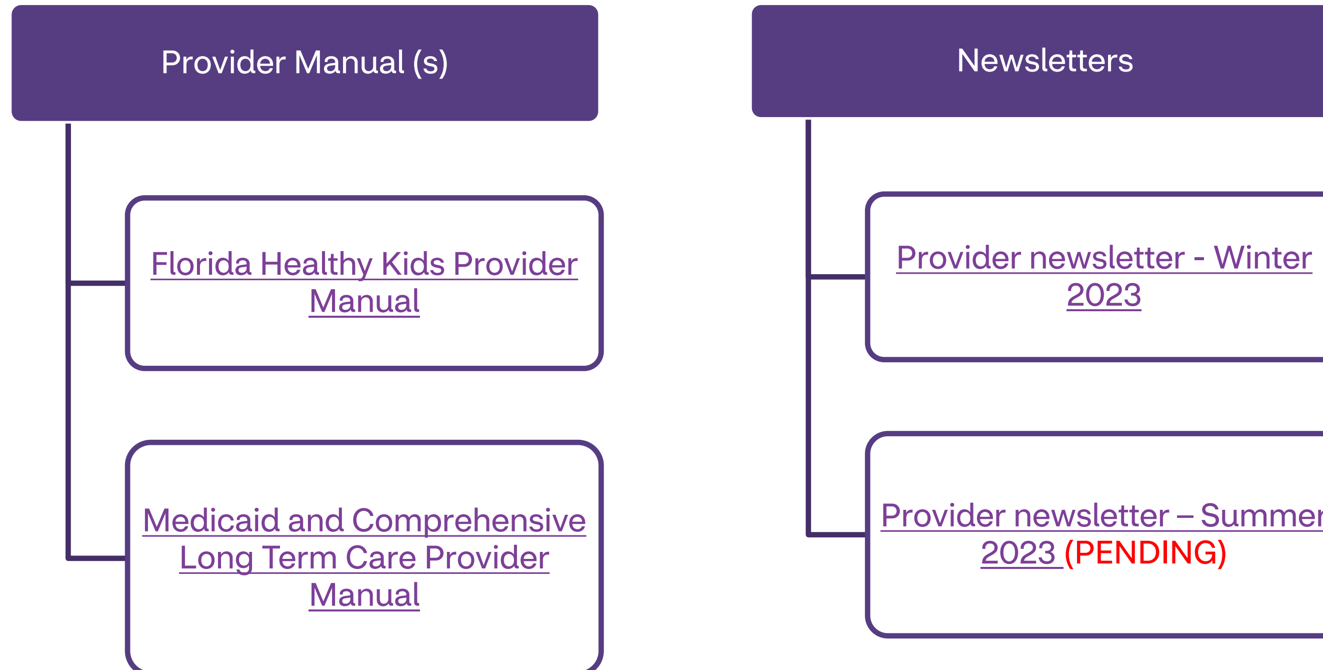
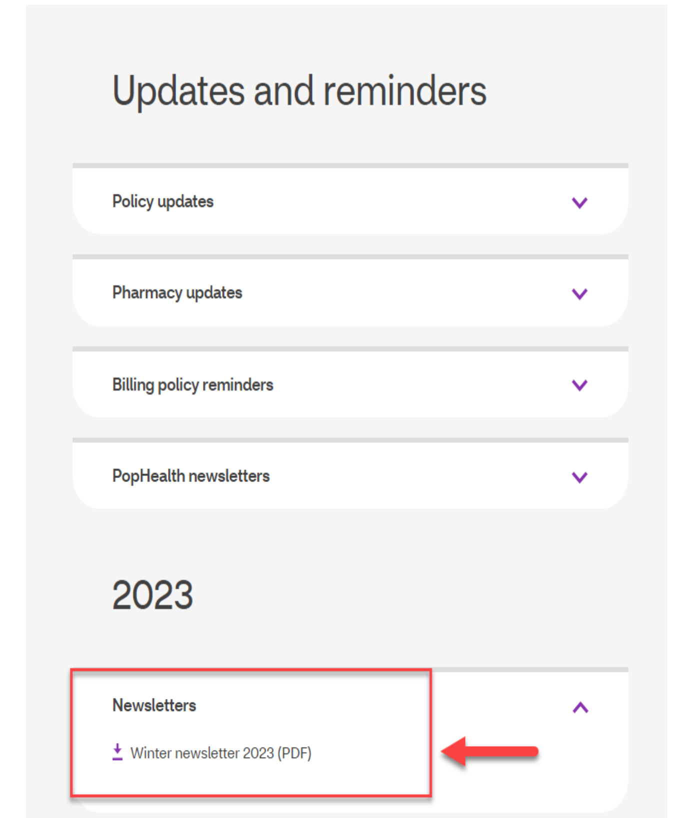
Provider Manual
Newsletters and Notifications

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).

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Provider Notifications (Fax blasts)

Provider Notifications

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

March 2023	Pharmacy and Prescribers Rejections (PDF)
	Claim Edit for Genetic Testing related to Cystic Fibrosis (PDF)
	Provider Taxonomy Requirements on Claims (PDF)
	Monthly Provider Webinar Training - Behavioral Health (03.30.2023)
April 2023	Makena Update (PDF)
	2023 Provider Satisfaction Surveys (PDF)
	Clinical Payment, Coding and Policy Updates - Anatomical Modifiers (Effective 4.10.2023) (PDF)

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2023

Newsletters

Winter newsletter 2023 (PDF)

Provider notifications

April 2023

Makena Update (PDF)

2023 Provider Satisfaction Surveys (PDF)

Clinical Payment, Coding and Policy Updates - Anatomical Modifiers (Effective 4.10.2023) (PDF)

March 2023

Pharmacy and Prescribers Rejections (PDF)

Claim Edit for Genetic Testing related to Cystic Fibrosis (PDF)

Monthly Provider Webinar Training - Behavioral Health (03.30.2023) (PDF)

Provider Taxonomy Requirements on Claims (PDF)

February 2023

Monthly Provider Webinar Training (02/23/2023)

HCPCS Codes for Depression Screening (PDF)

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Shared Decision-Making Aids

Shared Decision-Making Aids

- Shared decision-making aids are communication tools used as a way for providers and patients to make informed health care decisions based on what is important to the patient.

- They do not replace physician guidance but are intended to help complement the discussions between patients and physicians on treatment decisions.

- Below are evidence-based aids that provide information about treatment options, lifestyle changes, and outcomes.

American Heart Association | Health Topics

- Diabetes | American Heart Association
- Flu Prevention | American Heart Association
- Heart Facts | American Heart Association
- Atrial Fibrillation | American Heart Association

Mayo Clinic | Care that fits

- Statin Choice | Mayo Clinic
- Depression Medication Choice | Mayo Clinic
- Cardiovascular Primary Prevention Choice | Mayo Clinic

Shared Decision-Making Aids

Materials

- Helpful resources
- Provider manuals
- Administration
- COVID-19 and flu virus
- Children's health
- Hospice care
- Shared Decision-Making Aids

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Questions?

We have answers!

Contact our Provider Services Department

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

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