Aetna Better Health® of Florida

Behavioral Health Provider Training

aetna®

December 14, 2022

Continuity of Care

For more information visit our website:
https://www.aetnabetterhealth.com/florida/providers/continuity-care.html

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

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

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

Timely Filing Requirements

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

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

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

Provider / Claim Type	Guideline
Plan Participating Providers	Provider shall mail or electronically transfer (submit) the claim within **180 days** after the date of service or discharge from an inpatient admission. (F.S. 641.3155)
Non-Participating Providers	Provider shall mail or electronically transfer (submit) the claim within **365 days** after the date of service or discharge from an inpatient admission. (SMMC Contract) (Section VIII.D)(E)(2)
Plan as Secondary Payor	When the Managed Care Plan is the secondary payer, the provider must submit the claim within **ninety (90) calendar days** after the final determination of the primary payer. (SMMC Contract) (Section VIII)(E)(1)(h)
Medicare Crossover	When the Managed Care Plan is the secondary payer to Medicare, and the claim is a Medicare cross over claim, these must be submitted within **36 months** of the original submission to Medicare. (SMMC Contract) (Section VIII)(E)(2)(d)(2)
Corrected Claims	Provider shall mail or electronically transfer (submit) the corrected claim within **180 days** from the date of service or discharge from an inpatient admission. (F.S. 641.3155)
Return of requested additional information (itemized bill, ER records, med records, attachments)	A provider must submit any additional information or documentation as specified, within **thirty-five (35) days** after receipt of the notification. Additional information is considered received on the date it is electronically transferred or mailed. Aetna Better Health cannot request duplicate documents. (F.S. 641.3155(2)(c)(2)

Grievance & Appeals Summary

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

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

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

Interfiling vs. Bundling

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

Claim Resubmissions

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

Appeals Submissions

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

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

Appeals, Complaints and Grievances

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

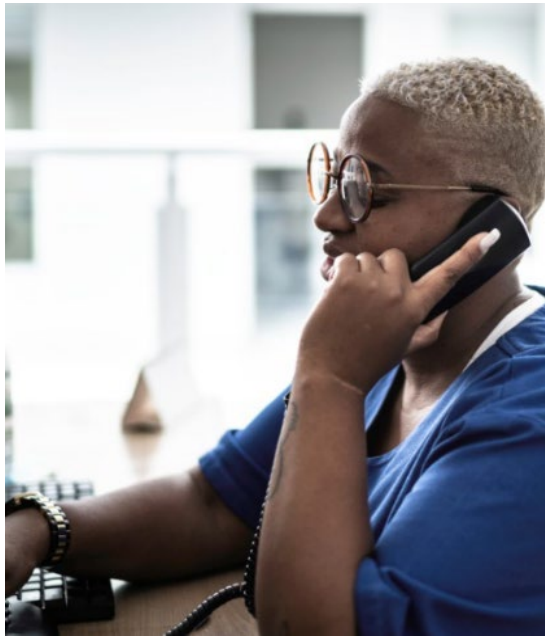
- It is preferred that you submit through the Availity provider portal using the direct application for Appeals, Complaints and Grievances: https://apps.availity.com/availity/web/public.elegant.login
- You may submit by fax to: **1-860-607-7894**

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

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

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

Complaints/Grievances may be submitted at any time.



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.

Prior Authorization Link: https://www.aetnabetterhealth.com/florida/providers/prior-authorization.html

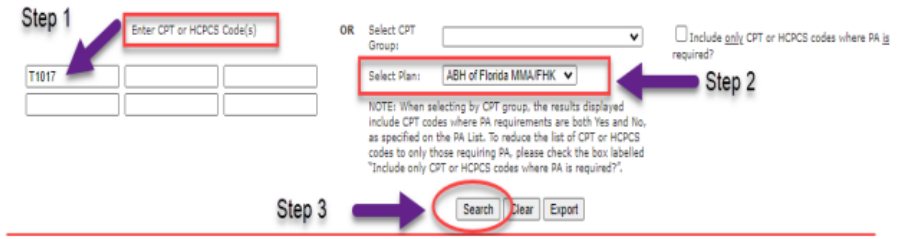
Behavioral Health PA Request Form
https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/florida/provider/pdf/abhfl_bh_pa_form.pdf

ProPat Examples on next slide

Propat Examples

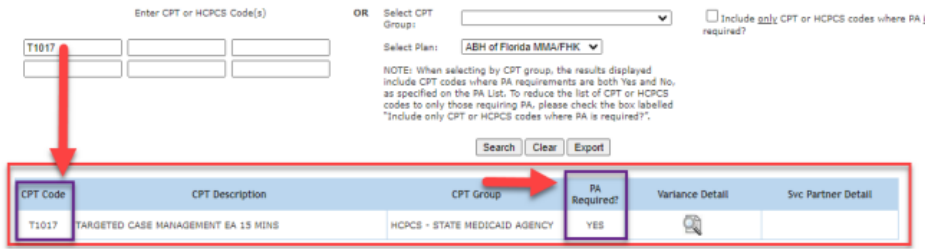
How to Search a CPT or HCPCS Code(s) in Propat & determine if PA Authorization is required?

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



Results – PA Required YES/NO

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



Search result definitions:

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

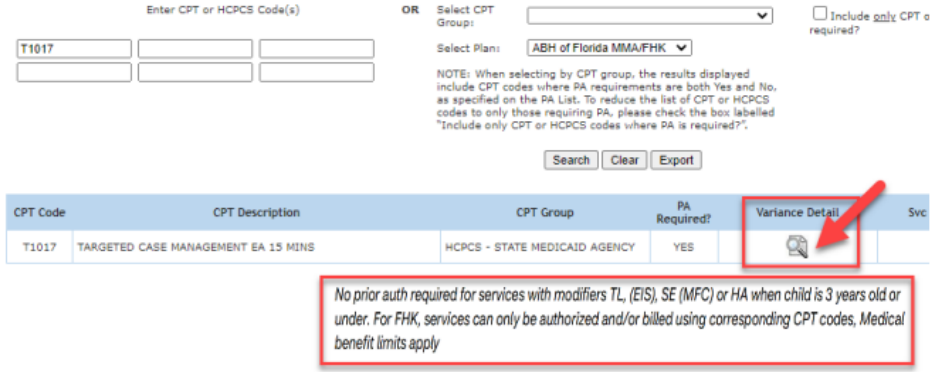
Variance Detail

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

Example

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

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



To request a prior authorization, be sure to:

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

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

BH Service Resource Guide

For our Aetna Medicaid members there are behavioral health treatment options. They are considered in lieu of services that may be medically appropriate alternate treatments for our members.

Members have the choice to receive the Medicaid covered service or an in lieu of service. We ask that providers document in the enrollee record the members choice in the members' record.

For the services outlined below, medical necessity applies.

Description of Service	In lieu of:	Procedure Code	Modifier	PA Required?	Limitations
Crisis Stabilization Unit (CSU)	Inpatient Psychiatric Hospital Care	129		Notification is required within 24 hours of admission. Authorization is provided for the first 3 days of an emergency involuntary (Baker Act) admission. Prior authorization is required for continued stay.	No limits
Addiction Receiving Facilities	Inpatient Detoxification Hospital Care	169		Yes	No limits

BH Service Resource Guide

Description of Service	In lieu of:	Procedure Code	Modifier	PA Required?	Limitations
Intensive Outpatient (IOP)-Substance use disorder (SUD)	**Inpatient Detoxification Hospital Care**	**906 H0015**		**Yes**	**No limits**
Intensive Outpatient (IOP)-Mental Health (MH)	Inpatient Hospital	905 S9480		Yes	No limits
Partial Hospitalization Program (PHP)	Inpatient Psychiatric Hospital Care	Half Day 912 Full Day 913		Yes	No limits
Ambulatory Detox- Substance use disorder (SUD)	Inpatient Detoxification Hospital Care	944		Yes	No limits
Ambulatory Detox-Alcohol	Inpatient Detoxification Hospital Care	945		Yes	No limits
Ambulatory Detox	Inpatient Detoxification Hospital Care	S9475 H0014		Yes	No limits
Substance Abuse Short-Term Residential Treatment (SRT)	Inpatient Detoxification Hospital Care	H0018		Yes	No limits
Self-Help/Peer Support	Psychosocial Rehabilitation	H0038		No	Up to 4 hours (16 units) per day
Community-Based Wrap Around Services	Therapeutic Group Care services or Statewide Inpatient Psychiatric Program (SIPP) services	H2022		Yes	No limits
Drop-In Center	Clubhouse Services	S5102	HE	No	Up to 20 days per year
Mobile Crisis Assessment and Intervention	Emergency Behavioral Health Care	S9484 H2011		No	S9484: Up to 2 hours per day (32 units) H2011: No limits

BH Service Resource Guide

Description of Service	In lieu of:	Procedure Code	Modifier	PA Required?	Limitations
Infant Mental Health Pre & Post Testing Services	**Psychological Testing services**	**T1023**	**HA**	**Yes**	**No limits**
Family Training/Counseling for Child Development	Therapeutic Behavioral On-Site Services	T1027		No	Up to 9 hours (36 units) per month
Behavioral Health Services-Child Welfare	Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services	T2023	HA	Yes	No limits
Nursing Facility Services	Inpatient Hospital Services	0101 0190 0191 0192 0193 0194 0199 0655 0658		Yes	No limits

Availity Provider Portal

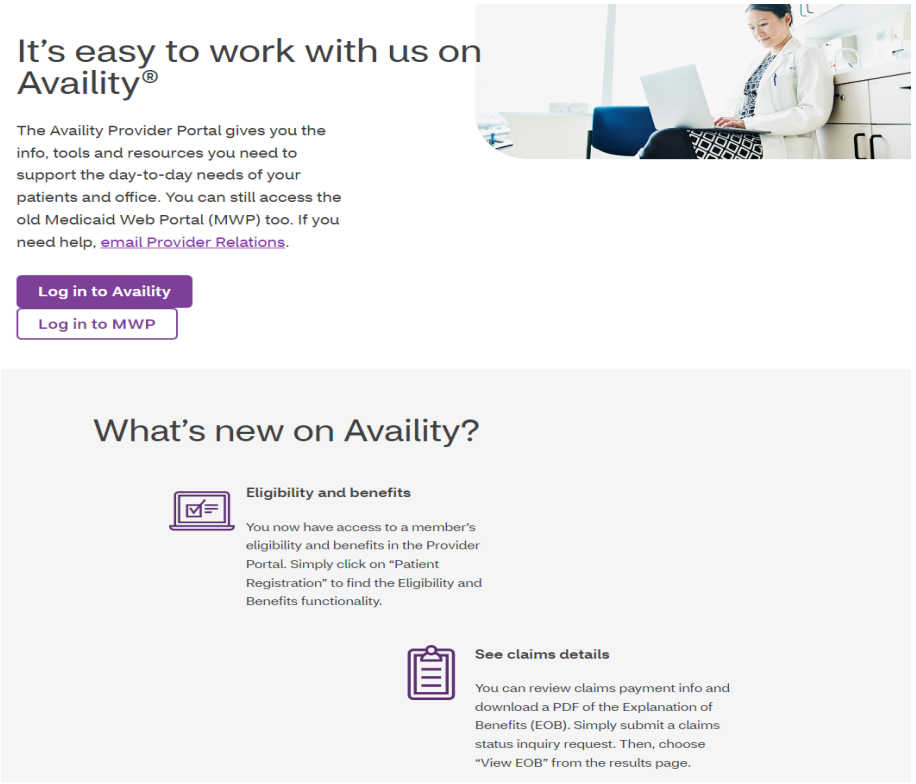
Current Functionalities

- **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).

Helpful links to find information about Availity:

- https://www.aetnabetterhealth.com/florida/providers/portal.html
- https://apps.availity.com/availity/web/public.elegant.login



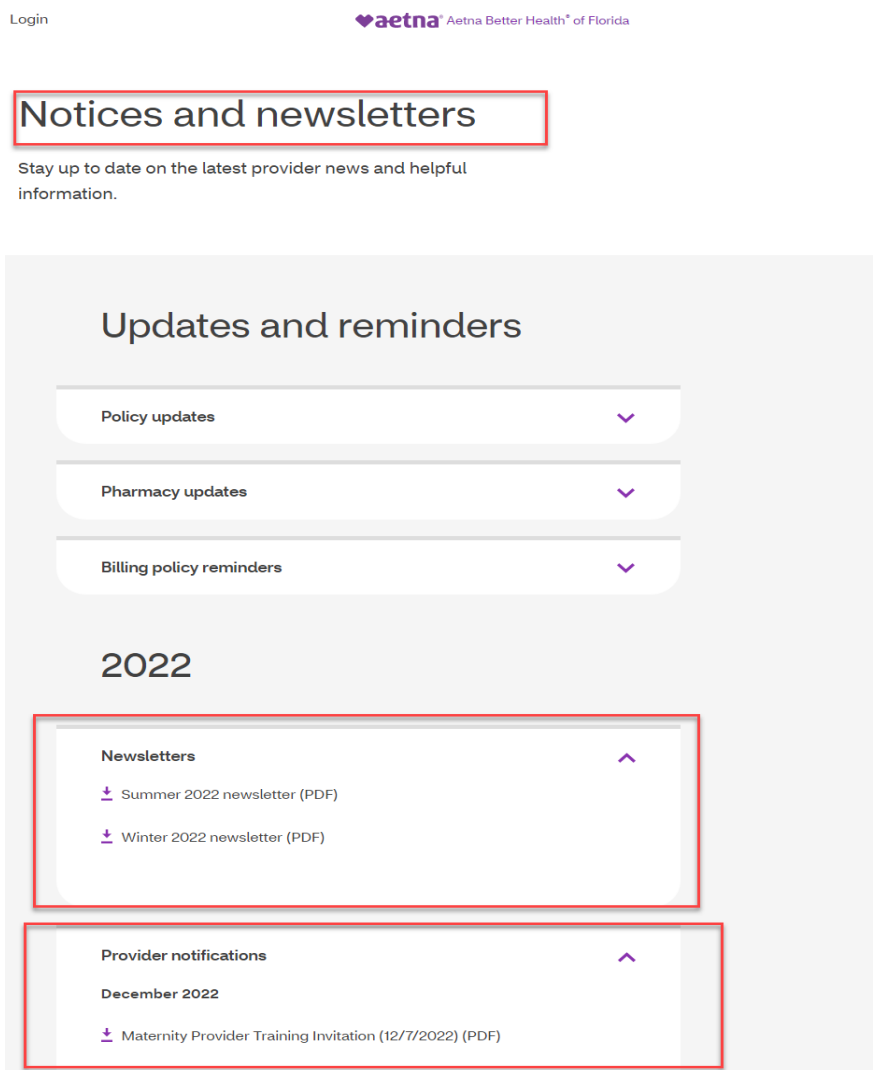
Stay Informed

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

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

- **Provider Manual (s)**
  - **Florida Healthy Kids Provider Manual**
  - **Medicaid and Comprehensive Long Term Care Provider Manual**
- **Newsletters**
  - **Provider newsletter - Summer 2022**
  - **Provider newsletter - Winter 2022**
- **Bulletins**
  - Emcara Health Partnership (PDF)
  - HCPCS Codes for Depression Screening (PDF)
  - Availity Webinars Invitation (PDF)

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



Questions? We have answers!

Contact our Provider Services Department
by calling us at: 1-844-528-5815
or via email at:
FLMedicaidProviderRelations@aetna.com

Thank you all!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