



Aetna Better Health[®] of Florida

Behavioral Health Provider Training



March 30, 2023

Agenda

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Grievance & Appeals

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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.

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

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

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

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



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: <https://medicaidportal.aetna.com/propat/Default.aspx>

Login

 Aetna Better Health[®] of Florida

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Menu

Prior authorization

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[Behavioral Health PA Request Form](#)

➤ https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/florida/provider/pdf/abhfl_bh_pa_form.pdf

Search ProPAT



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

Step 1 Enter CPT or HCPCS Code(s)

OR Select CPT Group: Include *only* CPT or HCPCS codes where PA is required?

Select Plan: **ABH of Florida MMA/FHK** **Step 2**

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?".

Step 3 Search Clear Export

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 HCPCS code entered.

CPT Code	CPT Description	CPT Group	PA Required?	Variance Detail	Svc Partner Detail
T1017	TARGETED CASE MANAGEMENT EA 15 MINS	HCPCS - STATE MEDICAID AGENCY	YES		

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”.

CPT Code	CPT Description	CPT Group	PA Required?	Variance Detail	Svc
T1017	TARGETED CASE MANAGEMENT EA 15 MINS	HCPCS - STATE MEDICAID AGENCY	YES		

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.

HEDIS

Quality Management & Performance Improvement

Aetna Better Health of Florida (ABHFL) aims to enhance the quality of care, emphasize, and improve the quality of patient outcomes. This is accomplished through our Quality Improvement (QI) Program. We use various measurements and quality indicators to evaluate the services rendered to our members against accreditation (NCQA) standards and regulatory requirements (AHCA, FHKC).

ABHFL's Behavioral Health Liaisons play a vital role in maximizing performance with Behavioral Health measures by:

- Creating research-based, targeted interventions and action plans to improve behavioral health measures reported through HEDIS
- Bridging members to Behavioral Health providers and coordinating care
- Linking the member, the provider and the health plan

Meet our BH Liaisons:



Isaac Sochaczewski, LMHC
Sochaczewskii@aetna.com
T) 954.858.3370



Yentl Lega, RD/LDN, RMHCI
LegaY@aetna.com
T) 954.858.3201



Breanna McIntosh, LCSW
McintoshB@aetna.com
T) 954.858.3207

Please contact our Behavioral Health Liaisons directly

What is HEDIS?

HEDIS = Healthcare Effectiveness Data and Information Set

The National Committee for Quality Assurance (NCQA) defines HEDIS as, “a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans.”

NCQA and AHCA requires health plans to report on 6 behavioral health (BH) measures.



ABHFL’s Behavioral Health Liaisons are currently involved in the rate improvement of 3 of those BH measures:

- ❖ Follow-Up After Hospitalization for Mental Illness (FUH)
- ❖ Follow-Up After Emergency Department Visit for Mental Illness (FUM)
- ❖ Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

Useful Links:

- **NCQA/ HEDIS:** <https://www.ncqa.org/>
- **ABHFL:** <https://www.aetnabetterhealth.com/florida>
- **ABHFL’s Provider Directory:** <https://www.aetnabetterhealth.com/florida/members/provider-directory>

Housing Pilot Program

Housing Pilot Program

Goals of the program

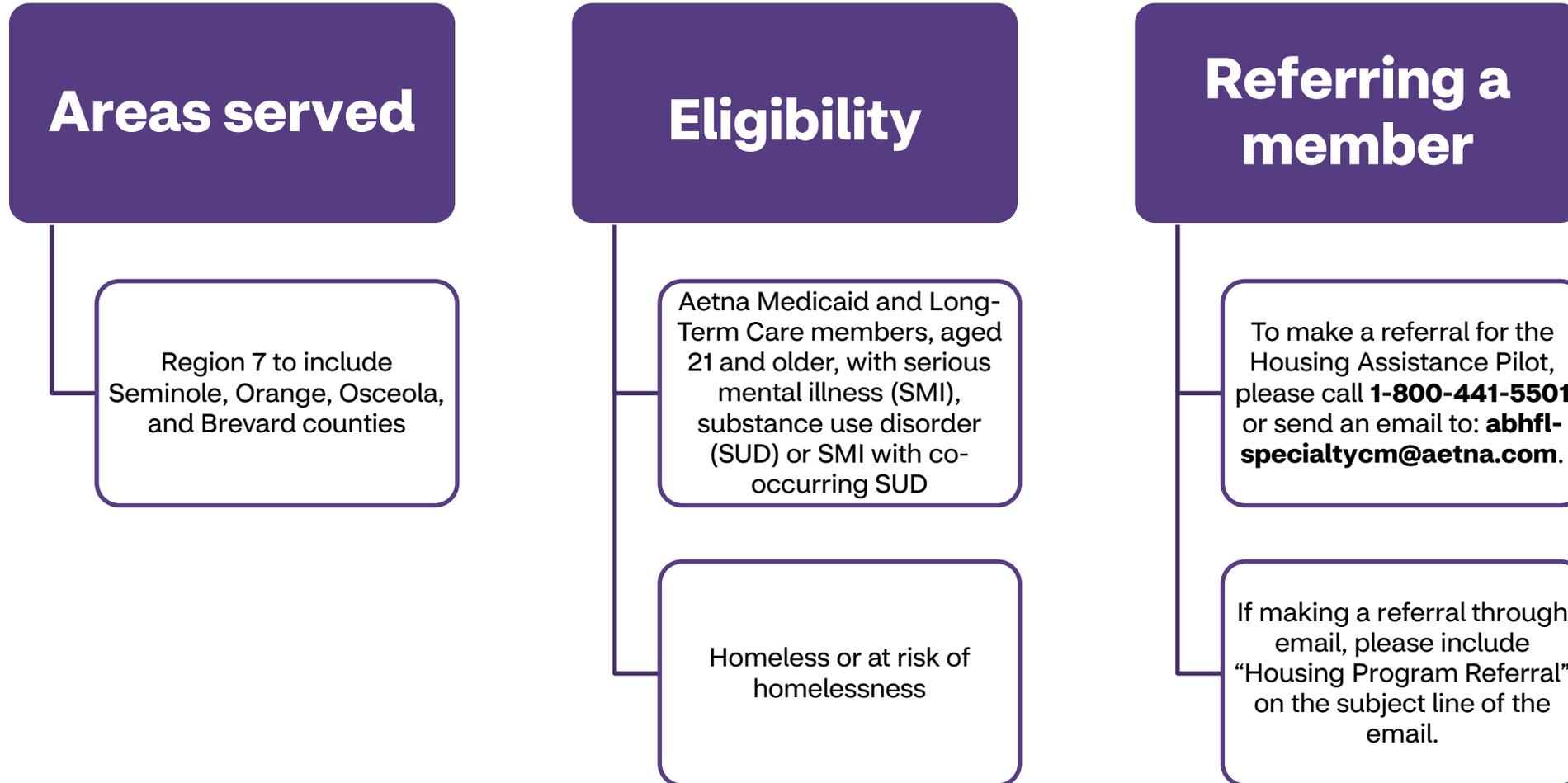
Build multi-sector collaborations and implement evidence-based strategies promoting housing stability, assistance with transitions, crisis intervention services, tenancy support and education, and peer support by partnering with community providers who have current relationships with homeless coalitions in the areas served.

Provide services and support for members who are the most vulnerable while ensuring that they have a stable home and access to health care and community services.

Provide true service integration by connecting behavioral health case management services with physical health case management.

Leverage the capabilities and experience of our behavioral health providers in conjunction with our case management team to transform homeless services to crisis response systems that prevent homelessness and rapidly return people who experience homelessness to stable housing.

Housing Pilot Program



Housing Pilot Program

Transitional housing services:

- Services that support an individual to prepare for and transition into housing, tenant screening and housing assessment, individualized housing support plan, assist with search for housing and application process, identify resources to pay for ongoing expenses like rent, ensure living environment is safe and ready to move-in, cover one-time incidentals such as assistance with deposits up to \$500

Tenancy sustaining services:

- Early intervention for behaviors that might jeopardize housing,
- education/training in roles, rights & responsibilities between tenant and landlord, coaching on developing/maintaining relationships with property managers, assist with resolving disputes, reduce risk of eviction, advocacy and linkage with community resources, assistance with community
- recertification process, review, coordinate and modify housing support and
- crisis plans

Mobile Crisis Management:

- Delivery of immediate de-escalation services for emotional symptoms and/or behaviors at the location in which the crisis occurs, behavioral health
- crisis team available 24/7/365, prevent loss of housing or emergency
- inpatient behavioral health admission when possible

Self-Help/Peer Support:

- Person-centered services promoting skills for coping with and managing symptoms, utilizing natural resources and preservation or enhancing
- community living skills with the assistance of a peer support specialist

In Lieu of Services Resource

In Lieu of Services 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

In Lieu of Services 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

In Lieu of Services 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

BH Service Resources

Opioid Resources:

- <https://www.aetnabetterhealth.com/florida/providers/opioid-use-disorder.html>

Clinical Practice Guidelines:

- <https://www.aetnabetterhealth.com/florida/providers/clinical-guidelines-policy-bulletins.html>

AHCA Resource Guide:

- https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/florida/provider/pdf/abhfl_provider_resource_guide.pdf
 - Updated quarterly
 - Housed both on the ABHFL website and on AHCA website

Availity Provider Portal

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).

Availity & Helpful Links:

- <https://availity.com/>
- <https://www.aetnabetterhealth.com/florida/providers/portal.html>
- <https://www.availity.com/Essentials-Portal-Registration>
- https://www.availity.com/documents/learning/LP_AP_GetStarted/index.html#/
- <https://apps.availity.com/availity/web/public.elegant.login>
- <https://availity.com/Training-and-Education>

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

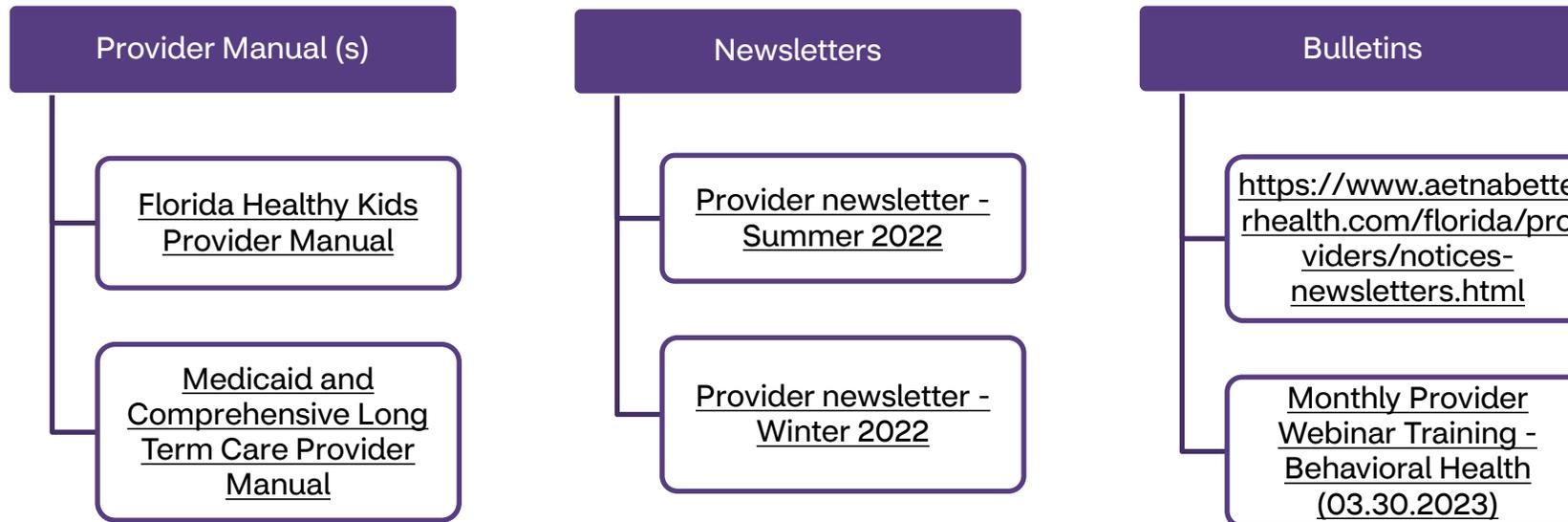
You can review claims payment info and download a PDF of the Explanation of Benefits (EOB). Simply submit a claims status inquiry request. Then, choose "View EOB" from the results page.

Stay Informed

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/>



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

Updates and reminders

- Policy updates
- Pharmacy updates
- Billing policy reminders
- PopHealth newsletters

2023

Newsletters

Provider notifications

March 2023

- Provider Taxonomy Requirements on Claims (PDF)
- Monthly Provider Webinar Training (02/23/2023)

February 2023

- HCPCS Codes for Depression Screening (PDF)

January 2023

- EFT/ERA Registration Services (EERS) (PDF)
- Claims Received Report (PDF)
- Clinical Payment, Coding and Policy Reminders (1/27/2023) (PDF)
- Maternity Provider Training Invitation (01.26.2023 & 01.31.2023)
- Home Health (HH) - Home & Community Based Services (HCBS) Amendment Rates Increase (PDF)

Questions? We have answers!

Contact our Provider Services Department

Phone: 1-844-528-5815

Email: FLMedicaidProviderRelations@aetna.com



