Provider newsletter

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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In this issue

Utilization management *(continued from previous page)*

criteria and policies rather than financial incentives.

- UM decisions are based only on appropriateness of care and service and the existence of coverage
- We do not reward practitioners, providers or other individuals conducting utilization review for issuing denials of coverage or service care.
- The compensation that we pay to practitioners, providers and staff assisting in utilization related decisions does not encourage decisions that result in underutilization or barriers to care or service.

The UM staff is available to discuss specific cases or UM questions by phone by calling **1-800-441-5501** (Medicaid), **1-844-645-7371** (Comprehensive Long-term Care) or **1-844-528-5815** (Florida Healthy Kids); (**TTY: 711**), from 8 AM to 7 PM ET. UM staff is available on holidays and weekends by voice mail and fax.

Referrals

The primary care provider (PCP) is responsible for coordinating the provision of specialist services. The specialist and PCP work together to coordinate medical care for the member.

Why are referrals important?

- Support coordination of care between PCP and specialist
- Promote the right care at the right time
- Ensure enrollees receive preventive, primary care services, not just specialty care

No PCP referral is required for the following direct-access services: chiropractic, dermatology (five visits/year), routine podiatric care, optometry, behavioral health and OB/GYN. PCP referrals are required for all other specialist services.

Referrals can be made electronically via our secure portal at **AetnaBetterHealth.com/Florida/providers/provider-portal**. If a paper version is preferred, it can be downloaded and printed from our website under Authorizations at **AetnaBetterHealth.com/Florida/providers/provider-auth**.

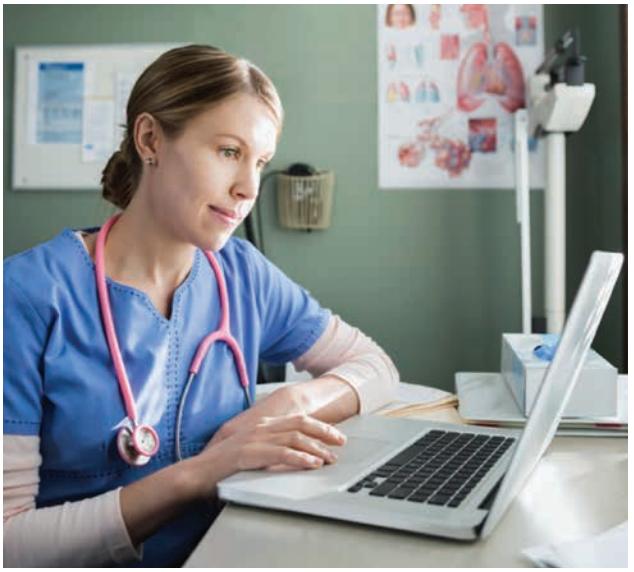
Specialists will coordinate the provision of specialist services with the PCP in a prompt and efficient manner and furnish a written report within 10 business days of the specialist services. Specialists will refer the member back to the PCP if they determine the member needs the services of another specialist.

Provider webinars & training

Aetna Better Health of Florida is here for our network of health care providers. We do our best to provide you with the most updated information and tools. We offer a variety of webinars and training opportunities throughout the year to help you and your staff stay up to date.

We offer monthly provider webinar trainings. We'll notify you in advance via fax when the next available webinar training is scheduled. The notification will include the date, time, topic and any necessary log-in information.

If you miss a webinar, you can find the presentations on our ABHFL website under **past webinar training presentations**.



Member rights & responsibilities

We have adopted the Florida Member's Bill of Rights and Responsibilities. Members can request a copy of it from their doctor or from Member Services.

Member rights

1. Members have the right to have their privacy protected.
2. Members have the right to a response to questions and requests.
3. Members have the right to know who is providing services to them.
4. Members have the right to know the services that are available, including an interpreter if they don't speak English.
5. Members have the right to know the rules and regulations about their conduct.
6. Members have the right to be given information about their health.
7. Members have the right to get service from out-of-network providers for emergency services.
8. Members have the right to get family planning services from any participating Medicaid provider without prior authorization.
9. Members have the right to be given information and counseling on the financial resources for their care.
10. Members have the right to know if the provider or facility accepts the assignment rate.
11. Members have the right to receive an estimate of charges for their care.
12. Members have the right to receive a bill and to have the charges explained.
13. Members have the right to be treated regardless of race, national origin, religion, handicap or source of payment
14. Members have the right to be treated in an emergency.
15. Members have the right to know if medical treatment is for purposes of experimental research and to give their consent or refusal to participate in such research.
16. Members have the right to file a grievance if they think your rights have been violated.
17. Members have the right to information about our doctors.
18. Members have the right to be treated with respect and with due consideration for their dignity and privacy.
19. Members have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand.
20. Members have the right to participate in decisions regarding their health care, including the right to refuse treatment.
21. Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
22. Members have the right to request and receive a copy of their medical records and request that they be amended or corrected.
23. Members have the right to be provided health care services in accordance with federal and state regulations.
24. Members are free to exercise their rights, and the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat them.
25. Members have the right to make a complaint about the health plan or the care it provides.
26. Members have the right to file a grievance about any matter other than an adverse benefit determination.
27. Members have the right to appeal a decision the health plan makes.
28. Members have the right to make a recommendation regarding the health plan's member rights and responsibilities.

Member responsibilities

Aetna Better Health of Florida members, their families or guardians are responsible for:

1. Members should provide accurate and complete information about their health.
2. Members should report unexpected changes in their condition.
3. Members should report that you understand your care and what is expected of them.
4. Members should follow the recommended treatment plan.
5. Members should keep appointments.
6. Members should follow their doctor's instructions.
7. Members should make sure their healthcare bills are paid.
8. Members should follow health care facility rules and regulations.
9. Members should understand their health problems and participate in starting equally agreed-upon treatment goals.

Clinical practice guidelines

Aetna Better Health of Florida makes clinical decisions regarding members' health based on the most appropriate care and service available. We make these decisions based on appropriate clinical criteria. The criteria used in the decision-making process is provided upon request by calling Member Services at the number listed on the back of the member's ID card.

Criteria may be viewed on **AetnaBetterHealth.com/Florida** or a hard copy may be requested. We adopt evidence-based clinical practice guidelines (CPG) from national recognized sources. These guidelines have been adopted to promote consistent application of evidence-based treatment methodologies and made available to practitioners to facilitate improvement of health care and reduce unnecessary variations in care.

Aetna Better Health reviews the CPGs every two years or more frequently if national guidelines change within the two-year period. CPGs that have been formally adopted can be found at **AetnaBetterHealth.com/Florida**. The CPGs are provided for informational purposes only and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider's clinical judgment regarding the appropriate treatment of a patient in any given case.

Aetna Better of Florida continues to require notification of admission/prior authorization for all inpatient hospital confinements. This requirement is inclusive of all maternity-related inpatient confinements. Please make sure that ALL inpatient confinements including short stays (1-2 days) have the required authorization or they will be subject to claims denial.

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

The 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 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 and Constitution)** or refer to our **Aetna Better Health of Florida Provider Manual**.

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 and NICU care management, to deliver continuous support for your maternity patients. Our program ensures ongoing monitoring, risk identification, and care coordination to bridge the gaps between visits and keep you informed of significant developments.

How our program benefits your pregnant patients:

- **Nurse and 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.

And, you can always **contact ProgenyHealth at any time during your patient's pregnancy and postpartum journey**, even after an initial referral. We communicate consistently with the patient's care team and can provide support for any concerns you may identify.

Recent success story: Cherice, 17 years old

Cherice, pregnant with her first child, was referred to a maternal fetal medicine specialist due to a high-risk pregnancy. Confused about her referral, our ProgenyHealth case manager explained the situation clearly, reviewed her ultrasound, and outlined the importance of specialized care. Cherice also joined Florida's **Healthy Start program** for ongoing support and education throughout her pregnancy. Cherice also wanted to breastfeed her baby, so our team stayed in regular contact with Cherice after her delivery to help support her through that journey.

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.

To learn more about the ProgenyHealth Maternity Case Management program, call **1-855-231-4730**, Monday – Friday, 8:30 AM – 5 PM ET, or email **maternity@progenyhealth.com**. You can also refer your 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.

Provider support

Use our new provider contact us form to tell us more about your specific request or inquiry. This form allows you to share the right information from the start, so you don't have to spend valuable time tracking down the help you need.

How it works

To access the form visit the **Contact Us** provider web form. Start by selecting the reason for your inquiry, then share the appropriate contact at your practice, and add essential information like your tax ID, NPI and more. You can also include up to 5 files with your inquiry if needed.

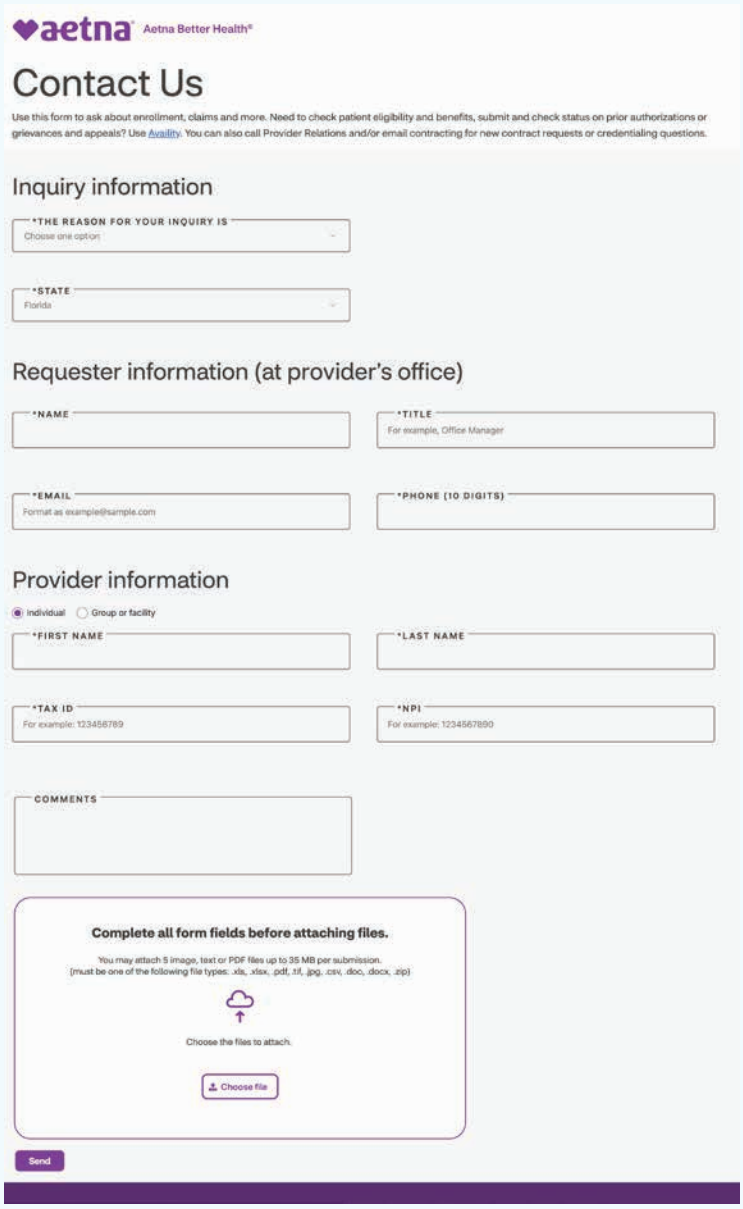
Frequently asked questions

What happens after I submit a request?

- Once the form is submitted, an email confirmation is generated with the details about your request.
- Within 48 hours, a case number is assigned.
- Inquiries are answered as quickly as possible by our support teams.

When should I use this form?

Demographic changes, updates or terms; new provider adds to existing group contracts; terming providers due to office closures, retirement, and leaving medical group; large add/change/term files; W-9 submissions.



Hadlima being added to Medicaid preferred drug list (PDL)

Hadlima will be added to the Medicaid (MMA) PDL in the coming weeks. This means that there will be a biosimilar medication available at parity to Humira in the autoimmune drug class of adalimumab products. Biosimilars are cost-effective alternatives and provide an opportunity to increase patient access to medications. All adalimumab biosimilar products have similar pharmacokinetic characteristics and can be dosed at a 1:1 conversion ratio since dosing for approved indications are the same. When switching to a biosimilar, it will continue to work right away, and the body should respond the same way as the original.

Biosimilars cannot be automatically substituted by the pharmacy without a new prescription. If writing for a biosimilar, make sure to send a new prescription to the pharmacy so the member can fill the biosimilar without issue. Please also educate the member on how a biosimilar works and that it can be thought of similarly to using a generic medication.

Note: Hadlima will be the only biosimilar available for Medicaid members at this time. Florida Healthy Kids already has 3 biosimilars on the formulary: adalimumab-adaz, adalimumab-fkjp, and Hadlima. These all require new prescriptions as well.

Provider notices and newsletters

Aetna Better Health of Florida (ABHFL) regularly updates and uploads provider bulletins, provider manuals and provider newsletters on our ABHFL website. **Stay Informed with the most updated information by visiting our ABHFL Provider Page.**

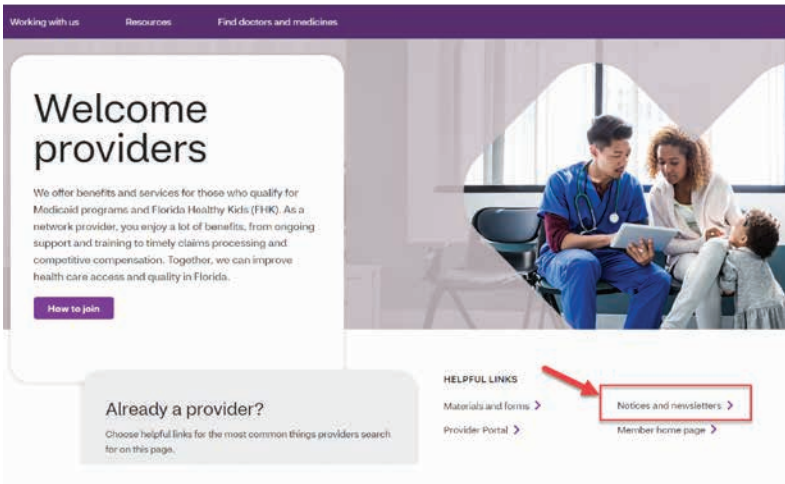
Other important and helpful links:

- Provider site
- Provider notices, policy updates, newsletters
- Orientation and monthly webinar training
- Materials, authorizations, forms
- Provider manuals
- Provider portal
- Health equity

Questions?

Just call Provider Relations. We're here to help.

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



Availity

Availity Essentials is our preferred and trusted source for payer information. If your organization isn't registered with Availity, we strongly recommend that you get started **today by clicking here.**

Provider support capabilities offered through Availity include:

- Claim submissions
- Claim status inquiries
- Payer space
- Contact us messaging
- Appeals and grievance submissions and status
- Panel rosters
- Prior authorization submissions and status
- Specialty pharmacy prior authorization
- Eligibility and benefits
- Reports and PDM

Additional resources

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

- New Users Who Register with Availity
- Availity Essentials Login Process and Your Data Privacy
- Availity Essentials Login Process for Primary Admins

Availity Client Services

For registration, log-in or technical issues, contact Availity Client Services at 1-800-282-4548.

Pharmacy restrictions and preferences, how to access our preferred drug list (PDL) and formularies

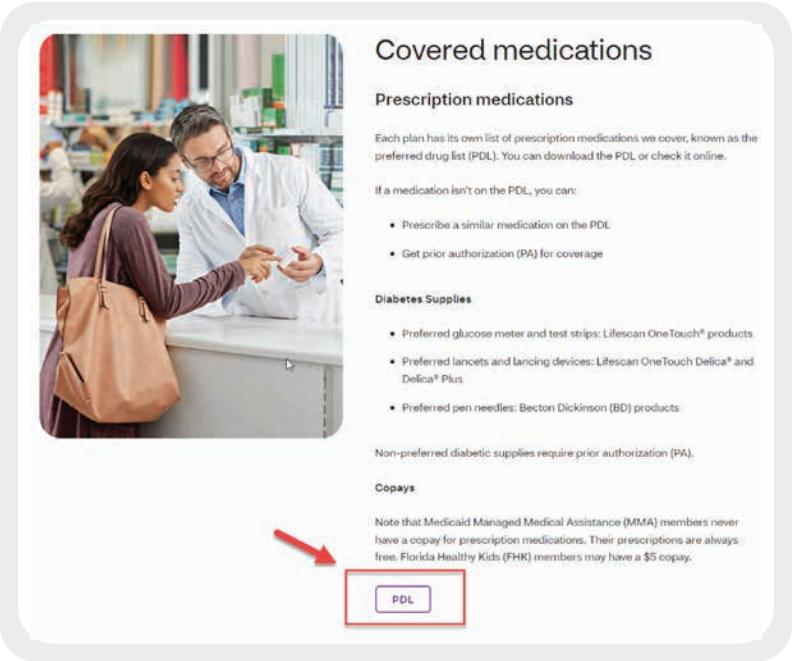
You can access our preferred drug list and formularies at AetnaBetterHealth.com/Florida. Information on the PDL and formularies can be found under the "For Providers" tab, "Pharmacy" subtab, "Preferred Drug List and Formulary" drop-down.

Direct link. Provides access to the Florida Medicaid preferred drug list (PDL) and the Florida Healthy Kids formulary search tool and formulary document.

Please note, the formulary can change at any time, due to the ever-changing world of medicine.

If you have questions about the formulary, contact us at the toll-free numbers below or visit our website.

- Medicaid / LTSS Provider Relations: 1-800-441-5501
- Florida Healthy Kids Provider Relations: 1-844-528-5815



Treating a member in crisis

A mental health crisis can happen to anyone, even those who don't have an existing mental health condition. We have multiple options on how to assist a member who may be facing a crisis:

Option 1

Call 911 or send the member to the nearest hospital if:

- They have thoughts of harming themselves or someone else
- They have an emergency and need help right now

Members can use any hospital for emergency care, even if it isn't in our network. They just need to show their member ID card.

Option 2

The National Suicide Prevention Lifeline has counselors who will talk with members 24 hours a day, 7 days a week. Members can:

- Call **1-800-273-TALK (8255)**
- Text "HELLO" to **741741**

Option 3

You can also call our behavioral health hotline by calling Member Services and choosing the crisis option. We're here to help 24 hours a day, 7 days a week, and can link you to the right resources. Members can also call us directly.

Member Services:

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

Accurate provider data matters!

Keeping your practice data up to date is essential to ensuring member satisfaction, correct directory listings, appropriate referrals, appointment availability, important communications, training invitations, and accurate and timely claims processing.

The following elements are critical to the accuracy of our directory:

- Name of facility/provider office
- Street address
- Phone number
- Email address
- Fax number
- TTY number
- Website
- Languages spoken
- Board certifications
- Ability to accept new patients
- Ages of patients seen
- Hours of operation
- Hospital affiliations
- Handicap accommodations (parking, restroom, exam room and equipment)
- Close to public transportation
- Special training (cultural competency, etc.)
- Telemedicine availability

We have multiple options on how to submit updated information to us:

1. Email our provider relations department at FLProviderEngagement@aetna.com
2. Complete the **ABHFL provider data change form**
3. Call us:

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

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

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

Provider EFT/ERA enrollment with ECHO

Not registered in EFT/ERA? To initiate the enrollment process, visit echohealthinc.com.

How does it work?

Complete the [EFT/ERA enrollment form](). Upon submission, paperwork outlining the terms and conditions will be emailed to you directly along with additional instructions for setup.

ECHO Health supports both NPI and TIN level enrollment. You will be prompted to select the option that you would like to use during the enrollment process.

If you need assistance, contact ECHO Health at allpayer@echohealthinc.com or [888-834-3511](tel:888-834-3511).

For additional information, visit our availity portal where we have a [quick reference guide]() available for your review.

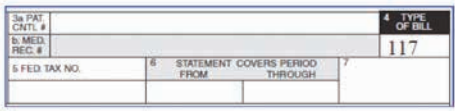
Reminder about corrected or voided claims

Use the reference "7" to avoid new claims or denials of duplicate claims

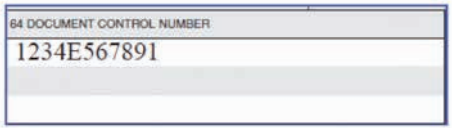
For Institutional claims, the provider must include the original Aetna Better Health of Florida claim number and bill frequency code per billing standards.

Examples:

- **Box 4 – Type of bill: the third character represents the "frequency code":**

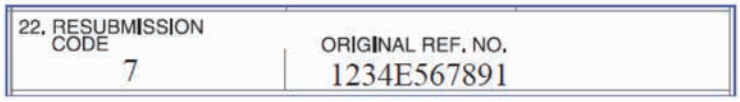


- **Box 64 – Place the claim number of the prior claim in box 64:**



For professional claims, the 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 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**.