Provider newsletter

Winter 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

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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 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 webinar trainings

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, topics 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.

Contact us

Best ways to connect

We want to make doing business with Aetna as easy as possible, and that includes getting in touch with us when you need support.

- Visit the **Aetna Better Health of Florida provider website** for manuals and quick links.
- Visit **Availity** for real time enrollment, any claim related reviews, eligibility, prior-authorizations, grievance andappeals and questions or inquiries.
- Visit the **Change Health payer enrollment services website** for help with electronic funds transfer (EFT) and electronic remittance (ERA) set up

Need more 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. 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.

How it works

To access the form visit the **Contact Us provider web form**, 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 will be generated with all the details about your request.
- Within 48 hours a case number will be assigned.
- Inquiries will be answered as quickly as possible by our support teams.

When should I use this form?

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

ProgenyHealth

Pregnant and postpartum Aetna Better Health® of Florida patients are benefitting from Maternity Case Management.

Aetna Better Health of Florida and ProgenyHealth® have teamed up to offer a **Maternity Case Management program at no additional cost to you or your patient.**

The program:

- **Supports** your patients between office visits with our nurse and social worker case managers
- **Informs** you if your patient reports concerning signs or symptoms
- **Reduces** office phone calls with ongoing education through our maternity app
- **Improves** appointment adherence by keeping patients on schedule
- **Connects** your patients to non-clinical resources and benefits when needed

Here are two recent success stories

Maya / 31 years old

- Pregnant with her third child
- OB identified her as anemic
- Struggling financially and reported food insecurity

ProgenyHealth's case manager:

- Provided education on iron supplements and dietary options to combat anemia
- Connected Maya with WIC and local food pantries to secure healthy food options
- On a follow-up call with her case manager, Maya reported she was getting healthier foods and saw an increase in hemoglobin levels

Monique / 37 years old

- Pregnant with her second child
- Struggling with intense morning sickness
- Multiple visits to the ER for dehydration

ProgenyHealth's case manager:

- Connected her with a home health company covered by her insurance
- Coordinated a request for a Zofran pump with her physician
- Four days after referral to ProgenyHealth, Monique received her Zofran pump to help manage her symptoms

Download the provider information flyer for mmore details about maternity services and postpartum support. To learn more about the ProgenyHealth Maternity Case Management program, call **1-855-231-4730**, Monday – Friday, 8:30 AM – 5:00 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**.

Care champion badges for providers

We have launched a clinical educational hub for health care professionals. The hub, which includes courses, addresses health equity and related topics. The courses are meant to help care teams reduce the barriers that underserved and marginalized patients experience. The hub can help providers with the skills, knowledge and tools needed for everyday interactions with patients.

Clinical educational hub
https://www.cmeoutfitters.com/cvs-health-dei-education-hub

You can access the on-demand, free accredited courses to earn digital care champion badges for your provider profile in three clinical areas of focus:

1. Culturally responsive care
2. LGBTQ+ responsive care
3. Culturally responsive PCP behavioral health care

WanaBana products recall

Aetna Better Health of Florida (ABHFL) would like to inform you that WanaBana USA has recalled all lots of WanaBana Apple Cinnamon Fruit Puree in 3-pack pouches (2.5 oz.) due to reports of elevated levels of lead found in certain units of the product.

The product is also distributed independently in the U.S. as private label brands under the following names:

- Schnucks Applesauce 90g pouches with cinnamon
  Affected lot numbers: 05023:19, 09023:22, 09023:24
- Weis Cinnamon Applesauce 90g
  Affected lot number: 05023:28

Aetna Better Health of Florida asks that you make your patients and parents/guardians aware of this recall. Anyone who may have been exposed to these products should be clinically tested for lead poisoning.

For more information regarding this recall, visit our website bulletin: **WanaBana Products Recall**.

Provider notices and newsletters

Stay informed with the most updated information by visiting our **ABHFL Provider Page**.

Here are some important and helpful links:

- **Provider site**
- **Provider notices, policy updates, newsletters**
- **Orientation and monthly webinar trainings**
- **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)

Home health and personal care services

Billing guideline reminders

When billing codes: **S5130**, **S5135**, **S5170**, **S9122** or **T1019**, each date of service must be billed on a separate line. These codes cannot be billed with a date span.

Code	Type of service	Frequency	Coverage
S5130	Homemaker service	Per 15 minutes	This procedure code does not allow for span dating
S5135	Adult companioncare	Per 15 minutes	This procedure code does not allow for span dating
S5170	Home delivered meals	Per meal	This procedure code does not allow for span dating
S9122	Home health aide or certified nurse assistant providing care in the home	Per hour	This procedure code does not allow for span dating
T1019*	Personal care services	Per 15 minutes	This procedure code does not allow for span dating

*T1019 is not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant).

Reminder – Type of service and frequency determines the unit count to be billed:

- **Per hour – 1 hour = 1 unit**
- **Per 15 minutes – 1 hour = 4 units**

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

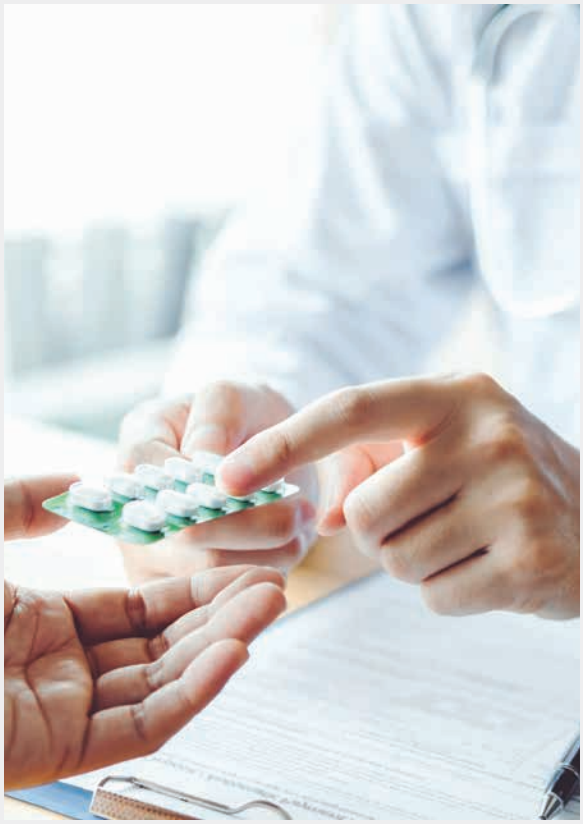
You can access our preferred drug list and formularies at AetnaBetterHealth.com/Florida. Information on the PDL and formularies can be found under the “For Providers” tab, “Pharmacy” subtab, “Preferred Drug List and Formulary” drop-down.

This direct link provides you 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 any questions regarding 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**



Provider collaborations

Aetna Better Heath would like to understand how primary care and behavioral health providers communicate and coordinate care. Please take a few minutes to complete the survey by clicking one of the links below and sharing your feedback.

- Provider surveys can be located on our ABHFL website by visiting the **provider survey section** on our main page.
- **ABHFL behavioral health and primary care provider collaboration**
- **ABHFL primary care and behavioral health provider collaboration**

Information obtained from the survey allows Aetna Better Health to measure how well we are meeting the expectations and needs of our network providers and practitioners.