Aetna Better Health of Florida

May Monthly Claims Training

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Learning objectives

As part of your Aetna Better Health of Florida's monthly claims training, we will

- Discuss Telemedicine Guidelines
- Review Telemedicine Requirements
- Discuss Telemedicine Billing
- Discuss EVV (electronic visit verification) verification
- Discuss Billing
- Discuss Change Healthcare Web Connect Tool
- Introduce Availity- New Provider Web Portal
- Explain Timely Filling Guidelines
- Inform the importance of EFT/ERA Registration

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Telemedicine Guidelines

Telemedicine Guidelines

Who can provide telemedicine?

- ✓ Practitioners, including MDs, DOs, and physician extenders (physician assistants and advanced practice nurses)
- ✓ Clinic providers (county health departments, rural health clinics, and federally qualified health clinics)
- ✓ Behavioral Health providers -Behavioral health providers should contact ABHFL's behavioral health subcontractor, Beacon Health Solutions at (844) 513-4954 for coverage and billing guidelines.

What services can be provided via telemedicine?

Covered medical services include evaluation, diagnostic, and treatment recommendations for services included on the Agency's practitioner fee schedule to the extent telemedicine is designated in the American Medical Association's Current Procedural Terminology (i.e., national coding standards). All service components included in the procedure code must be completed in order to be reimbursed.

ABHFL reimburses services using telemedicine at the same rate detailed on AHCA's practitioner fee schedule or contracted percentage thereof.

Providers must append the GT modifier to the procedure code in the fee-for-service delivery system.

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Telemedicine Requirements

Telemedicine Requirements

As a participating Aetna Better Health of Florida provider offering Telemedicine, you must meet the following requirements:

- Ensure the services provided are medically necessary and performed in accordance with the applicable Medicaid service policy. Ensure the patient and parent or guardian, as applicable, are present for the duration of the service provided using telemedicine except when using store and forward modalities.

- Ensure telemedicine is not used if it may result in any reduction to the quality of care or if the service delivered through this modality could adversely impact the recipient.

- Include Documentation regarding the use of telemedicine in the progress notes for each encounter with a recipient. All other documentation requirements for the service must be met as described in the coverage policy.

- Comply with the Health Insurance Portability and Accountability Act (HIPAA) when providing services; all equipment and means of communication transmission must be HIPAA compliant.

- Ensure that the recipient has compatible equipment and the necessary connectivity in order to send and receive uninterrupted video. Telephone or electronic-based contact with a Florida Medicaid recipient without a video component is not permitted.

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Telemedicine Requirements

- Have Fraud, Waste and Abuse Policies and Procedures specific to telemedicine that address:
  - Authentication and authorization of users;
  - Authentication of the origin of the information;
  - The prevention of unauthorized access to the system or information;
  - System security, including the integrity of information that is collected, program integrity and system integrity; and
  - Maintenance of documentation about system and information usage.
- Have available Audio/Video Equipment (real time 2-way audio/video live communication only).
- Ensure equipment and operations comply with technical safeguards in 45 CFR 164.312.
- Provide training to clinical personnel on Telemedicine Requirements.
- Supervision requirements within a provider's scope of practice continue to apply for services provided through telehealth.

Providers are required to sign an attestation indicating all telemedicine requirements have been met.

The Telemedicine Requirements can be found in the provider manual at https://www.aetnabetterhealth.com/florida/providers/provider-manual

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Billing

Telemedicine Billing

ABHFL will reimburse each service once per day per recipient, as medically necessary, at the rates detailed in the table below or the contracted percentage thereof.

Service	Procedure Code	Modifier Required	Medicaid Reimbursement Rate	
			Maximum Fee*	Maximum Facility Fee**
Store-and-forward	G2010	CR	$7.69	$5.66
Telephone Communications - *Existing* Patients	99441	CR	$9.05	$8.05
	99442	CR	$17.65	$16.10
	99443	CR	$25.80	$23.94
Telephone Communications - *New* Patients	99441 CG	CR	$9.05	$8.05
	99442 CG	CR	$17.65	$16.10
	99443 CG	CR	$25.80	$23.94
Remote patient monitoring	99453	CR	$11.77	N/A
	99454	CR	$39.15	N/A
	99091	CR	$37.12	N/A
	99473	CR	$7.02	N/A
	99474	CR	$9.51	$5.44
	99457	CR	$32.36	$19.80
	99458	CR	$26.48	$19.80

On the AHCA practitioner fee schedule, this represents the fee schedule increase rate, which is the base Florida Medicaid rate with a 4% increase included for all ages. **The facility fee is the reimbursement rate for a practitioner performing services in one of the following places of service: outpatient hospital-off campus (19), inpatient hospital (21), outpatient hospital-on campus (22), emergency room hospital (23), or ambulatory surgical center (24), according to Medicare's designation.

Key Reminders

- Place of Service = always use 02
- Modifiers= Use CR for phone only, Use GT for phone and video.
- Claim Service Location (Box 32- CMS 1500 Form)
  - PCPs that have multiple service locations should list the location that the member is assigned to.

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EVV- Electronic Visit Verification

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Aetna Better Health of Florida is currently live with Tellus for EVV, and many providers are submitting claims to us via the Tellus Claims Portal.

Providers (Home Health Care) are required to verify delivery of services using EVV system (i.e., by having caregivers logging visits with EVV app). This will ensure that your claims will be paid accurately and on time.

As a provider, it is your responsibility to be compliant with the EVV mandate by AHCA, State Agency.

Need Help?

If you have any Tellus EVV system questions or concerns, please contact Tellus at 833-483-5587 or support@4tellus.com.

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EVV- Claim Submissions

Aetna Better Health of Florida (ABHFL) would like to inform all Home Health and Personal Care Services Providers of the new requirements by the federal 21st Century Cures Act and the State Medicaid Managed Care (SMMC)

Effective for dates of service beginning June 21, 2021, Medicaid Home Health and Personal Care Services claims must be submitted through Tellus, our Electronic Visit Verification (EVV) vendor. Please be advised that Aetna Better Health of Florida will deny any claims that are submitted outside of Tellus Electronic Visit Verification (EVV) system.

Claims for personal care services and home health services may be processed outside of the managed care plan's EVV vendor system on a **case-by-case** basis where there is a documented plan vendor system issue that prevents the provider from billing through the plan's EVV vendor

As a provider, it is your responsibility to be compliant with the EVV mandate.

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Billing

CPT codes –EVV Billing

CODE	DESCRIPTION
S9122	Personal care by a home health service provider
T1030	Registered Nurse (RN) visit
T1031	Licensed Practical Nurse (LPN)Visit
T1021	Home Health Aide (HHA) Visit
S9123	Private duty nursing rendered by an RN
S9124	Private duty nursing rendered by an LPN
S5135	Companion Care, Adult per 15 min
S5136	Companion Care Adult per diem
S5130	Home Maker Services per 15 min
T1019	Personal Care

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Change Healthcare Web Connect Tool

Web Connect Tool

We are pleased to announce the availability of our new and improved solution for verifying member information and submitting claims to Aetna Better Health.

Within the next month, ConnectCenter will replace Emdeon Office, giving you a more reliable, more complete way to submit claims, all at no cost to you. Get started TODAY!

You will be able to use your ConnectCenter and Emdeon Office accounts at the same time until 5/31/2021.

You will be able to setup a new account in just seconds. Once you have received your new credentials, you may immediately begin checking eligibility.

Claim submission will be available to you within one business day of setting up your account. Be sure to bookmark the new login page: https://physician.connectcenter.changehealthcare.com/#/site/home?payer=214558

Link:
https://physician.connectcenter.changehealthcare.com/#/register/step1/PQCGR5mGCwgELkrDndrXQaA6NIakfqyNVLp3Qt-1Q-sI6IP6mLTz8Qf_jaeJUM9-

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Availity

Availity Provider Portal- Live 1/19/2021

Current Functionalities

- ✓ Payer Spaces
- ✓ Claim Submission Links (CHC)
- ✓ Contact Us messaging
- ✓ Claim Status Inquiry
- ✓ Appeal & Grievance Submissions
- ✓ Reports (Ambient)
- ✓ Prior Authorization – Submission and Status Lookup

Future Functionality Releases

Q2 2021
- Eligibility and Benefits

Q3 2021
- Remit PDF
- Enhanced Panel Roster
- Enhanced G&A Tool

Our communications will be transitioning from fax blast to via email in the near future. Keeping our providers informed is our priority. If you have not yet reached out to us to ensure we have your most recent email address, we ask that you do so now!

How to submit your most updated email address to us?

It's simple, just follow one of these steps:
1. Complete the following survey monkey: https://www.surveymonkey.com/r/W8QDMS7
2. Send us an Email at: FLMedicaidProviderRelations@Aetna.com
   - Your email subject line should include the title and + NPI #. Example (Email Address Update + 12345678).

Be on the lookout over the next few months for co-branded emails directly from Availity as new products roll out and training plans are developed.

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Timely Filling Guidelines

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)

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EFT/ERA Registration

EFT and ERA Registration

Aetna Better Health provider portal has moved into the Availity system effective January 2021.

Providers will be taken to our health plan website where the EFT and ERA forms are housed when clicking on the EFT and ERA applications.

Why should Providers Register?

- Save time and money with these electronic tools
- Electronic remittance advice (ERA) provides claims payment explanations in HIPM· compliant files.
- Electronic funds transfer (EFT) puts payment right into your account.
- Explanations of Benefits (EOBs) are on our secure provider website. Patient cost estimator is available on our provider portal on Availity.

We highly encourage providers to register for EFT and ERA. Please call our Provider Services Department at 1-844-528-5815 for assistance or your assigned Network Consultant.

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Questions? We’ve got answers.

Just call our Provider Services Department at 1-844-528-5815 .

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