Monthly Provider Claims Training

Claim Submissions

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April 2020

Insurance Verification- Member Eligibility

Insurance Verification

- ✓**Eligibility**
- ✓**Benefits**
- ✓Referral
- ✓Prior Authorization
- ✓Utilization Management
- ✓Copay

Verifying Eligibility & Benefits

Eligibility: Presentation of an Aetna ID card is not a guarantee of eligibility. The Provider is responsible for verifying a member's current enrollment status before providing care.

Benefits: Benefits vary. Prior to rendering service, verify that the service is a covered benefit under the member's plan.

Member Eligibility and Benefits can be verified two ways:

Online	Telephone
Through the Secure Web Portal at aetnabetterhealth-florida.aetna.com	Call the Member Services department at **1-800-441-5501**

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Prior Authorization Requirements

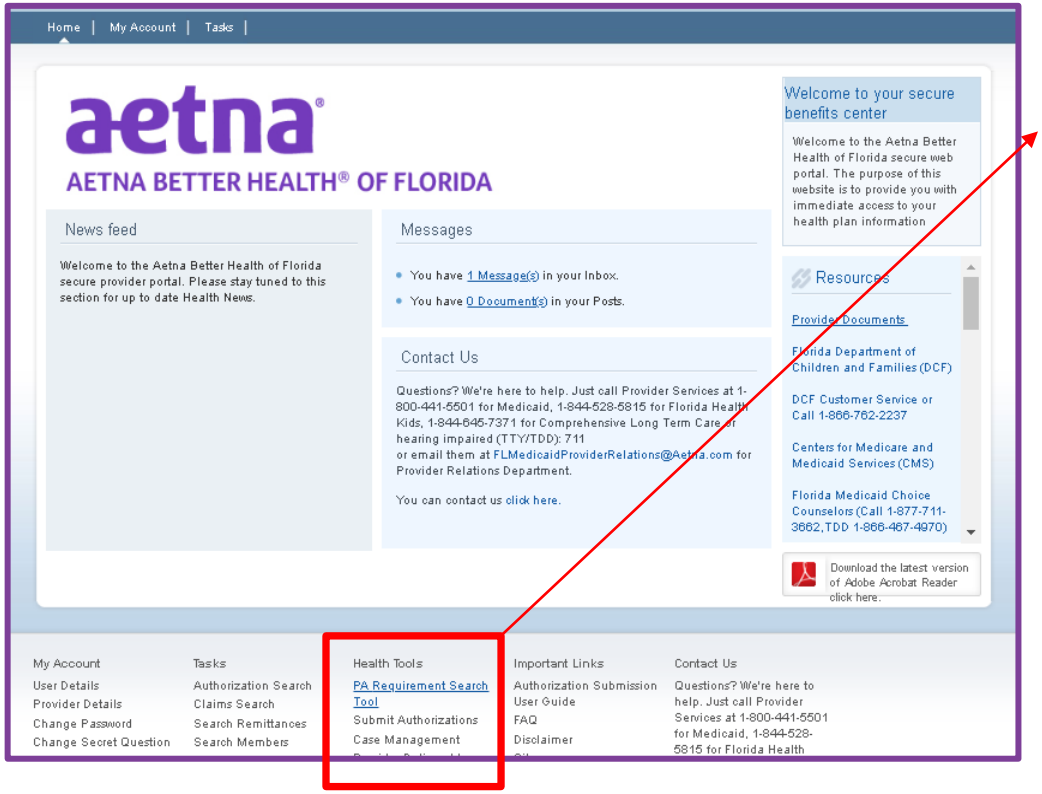
Insurance Verification

- ✓Eligibility
- ✓Benefits
- ✓Referral
- ✓**Prior Authorization**
- ✓Utilization Management
- ✓Copay

Prior Authorization

Under certain circumstances, a prior authorization must be obtained prior to rendering certain covered services.

Prior to submitting an auth request, use the **PA Requirement Search Tool** found as a link at the bottom of your *Provider Web Portal* screen to help you determine if an authorization is needed.



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General Information about Authorizations

- **Please remember that *emergencies do not require prior authorization***
- Urgent/expedited requests should be indicated on the Prior Authorization Form
- Turn around time for processing requests are as follows:

  ✓ Standard: 14 calendar days

  ✓ Urgent: 72 hours

  How to check the status of Prior Authorization: aetnabetterhealth-florida.aetna.com

- To determine which services require prior authorization use our ProPat Auth Lookup Tool through the Secure Web Portal **https://medicaidportal.aetna.com/sso/propat/Default.aspx**

For any questions about authorization requirements or assistance with the search tool, you may contact Aetna Better Health of Florida Provider Relations at **1-800-441-5501**

Prior Authorization Options

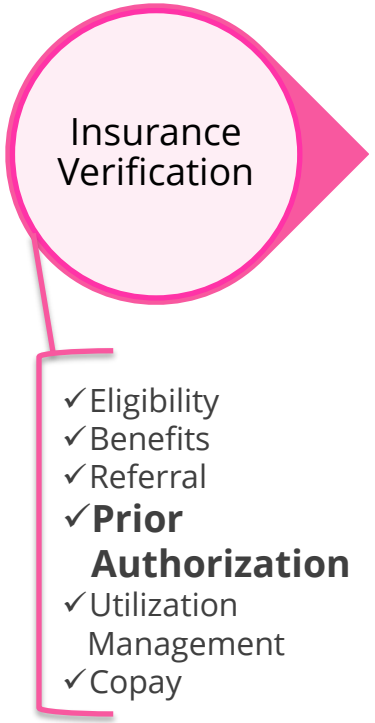
Providers can request prior authorizations for medically necessary services for members in the following ways:

- Authorization Department at
  - Medicaid 1-800-441-5501
  - Comprehensive Long-Term Care 1-800-645-7371
- Fax 1-860-607-8056
- Provider Secure Web Portal: aetnabetterhealth-florida.aetna.com

If you are submitting a request with clinical information attached, you will need to fax your request to:

- Medical Prior Authorization Fax 1-860-607-8056
- Obstetrics Prior Authorization Fax 1-860-607-8726
- Pharmacy Prior Authorization Fax 1-855-799-2554
- Long-Term Care Prior Authorization Fax 1-844-404-5455

- Prior authorizations for MRI, PET, CT, Nuclear Medicine and Interventional Pain Management are managed by eviCore and can be requested via phone, fax or web portal:
  - Phone 1-888-693-3211
  - Fax 1-844-822-3862
  - Web www.eviCore.com



Requesting Prior Authorization

Prior authorizations can be obtained two ways:

Online	Paper
Through the Secure Web Portal at aetnabetterhealth-florida.aetna.com	Print the Prior Auth form online at https://www.aetnabetterhealth.com/florida/providers/provider-auth

*Submit PA to the address indicated on the top of the printed form.

Authorization status can be obtained via the secure portal or by calling 1-800-441-5501.

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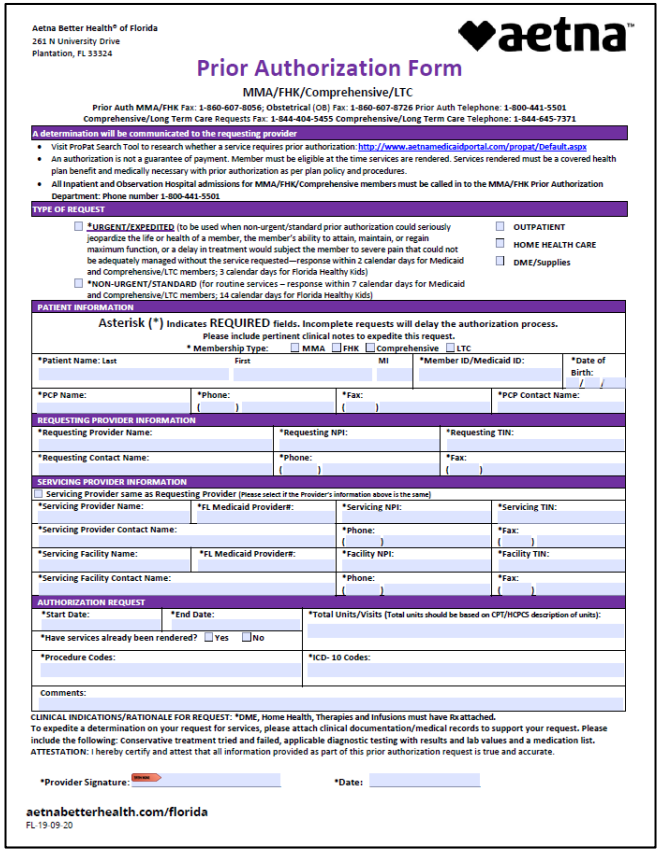
Prior Authorization Form

- Providers will only need to submit one form for all lines of business. The PA Authorization form can be found at: https://www.aetnabetterhealth.com/florida/assets/pdf/provider/Revised%20PA%20Form%20Final%20v.7%20Oct21_2019.pdf

- Providers are required to complete the Prior Authorization Form in its entirety to avoid delays in the authorization process.

- Fields marked with an asterisk (*) indicate required fields to process the request. Please include pertinent clinical notes and prescriptions to expedite requests. If you are attaching clinicals or scripts, **please fax your request to:**

  - **Medical 1-860-607-8056.**
  - **Long-Term Care 1-844-404-5455**



Aetna Better Health® of Florida
261 N University Drive
Plantation, FL 33324

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Prior Authorization Form

MMA/FHK/Comprehensive/LTC

Prior Auth MMA/FHK Fax: 1-860-607-8056; Obstetrical (OB) Fax: 1-860-607-8726 Prior Auth Telephone: 1-800-441-5501
Comprehensive/Long Term Care Requests Fax: 1-844-404-5455 Comprehensive/Long Term Care Telephone: 1-844-645-7371

A determination will be communicated to the requesting provider

- Visit ProPat Search Tool to research whether a service requires prior authorization: http://www.aetnamedicaidportal.com/propat/Default.aspx
- An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services rendered must be a covered health plan benefit and medically necessary with prior authorization as per plan policy and procedures.
- All Inpatient and Observation Hospital admissions for MMA/FHK/Comprehensive members must be called in to the MMA/FHK Prior Authorization Department: Phone number 1-800-441-5501

TYPE OF REQUEST

☐ *URGENT/EXPEDITED (to be used when non-urgent/standard prior authorization could seriously jeopardize the life or health of a member, the member's ability to attain, maintain, or regain maximum function, or a delay in treatment would subject the member to severe pain that could not be adequately managed without the service requested—response within 2 calendar days for Medicaid and Comprehensive/LTC members; 3 calendar days for Florida Healthy Kids)
☐ *NON-URGENT/STANDARD (for routine services – response within 7 calendar days for Medicaid and Comprehensive/LTC members; 14 calendar days for Florida Healthy Kids)

☐ OUTPATIENT
☐ HOME HEALTH CARE
☐ DME/Supplies

PATIENT INFORMATION

Asterisk (*) indicates REQUIRED fields. Incomplete requests will delay the authorization process.
Please include pertinent clinical notes to expedite this request.
* Membership Type: ☐ MMA ☐ FHK ☐ Comprehensive ☐ LTC

*Patient Name: Last	First	MI	*Member ID/Medicaid ID:	*Date of Birth:
				/ /

*PCP Name:	*Phone:	*Fax:	*PCP Contact Name:
	( )	( )	

REQUESTING PROVIDER INFORMATION

*Requesting Provider Name:	*Requesting NPI:	*Requesting TIN:
*Requesting Contact Name:	*Phone: ( )	*Fax: ( )

SERVICING PROVIDER INFORMATION

☐ Servicing Provider same as Requesting Provider [Please select if the Provider's information above is the same]

*Servicing Provider Name:	*FL Medicaid Provider#:	*Servicing NPI:	*Servicing TIN:
*Servicing Provider Contact Name:		*Phone: ( )	*Fax: ( )
*Servicing Facility Name:	*FL Medicaid Provider#:	*Facility NPI:	*Facility TIN:
*Servicing Facility Contact Name:		*Phone: ( )	*Fax: ( )

AUTHORIZATION REQUEST

*Start Date:	*End Date:	*Total Units/Visits (Total units should be based on CPT/HCPCS description of units):
*Have services already been rendered? ☐ Yes ☐ No		
*Procedure Codes:		*ICD- 10 Codes:

Comments:

CLINICAL INDICATIONS/RATIONALE FOR REQUEST: *DME, Home Health, Therapies and Infusions must have Rx attached.
To expedite a determination on your request for services, please attach clinical documentation/medical records to support your request. Please include the following: Conservative treatment tried and failed, applicable diagnostic testing with results and lab values and a medication list.
ATTESTATION: I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

*Provider Signature: *Date:

aetnabetterhealth.com/florida
FL-19-09-20

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Referrals

The 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?

✓ Supports coordination of care between PCP and specialist
✓ Promotes the right care at the right time
✓ Ensures enrollees receive preventive, primary care services, not just specialty care

- No PCP referral is required for the following Direct Access services: Chiropractic, Dermatology (5 visits/year), routine Podiatric care, Optometry, Behavioral Health, OB/GYN

- **PCP referral is required for all other specialist services**

- Referrals can be done electronically via our secure portal at **https://www.aetnabetterhealth.com/florida/providers/provider-portal .** If a paper version is preferred, it can be downloaded and printed from the Aetna Better Health of Florida website under Authorizations at www.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

Insurance Verification

- ✓Eligibility
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- ✓**Utilization Management**
- ✓Copay

Utilization Management

Utilization management (UM) is a system for reviewing eligibility for benefits for the care that has been or will be provided to patients. The UM department is composed of:

- Preauthorization
- Concurrent review
- Case management

When the services are reviewed via our UM program, the medical director makes all final decisions regarding the denial of coverage for services .

If you have any questions or need to discuss a specific case, the UM staff is available at:

Program	Phone	Fax
Medicaid	1-800-441-5501	1-860-607-8056
Comprehensive LTC	1-844-645-7371	1-860-607-8726
Florida Healthy Kids	1-844-528-5815	1-844-404-5455

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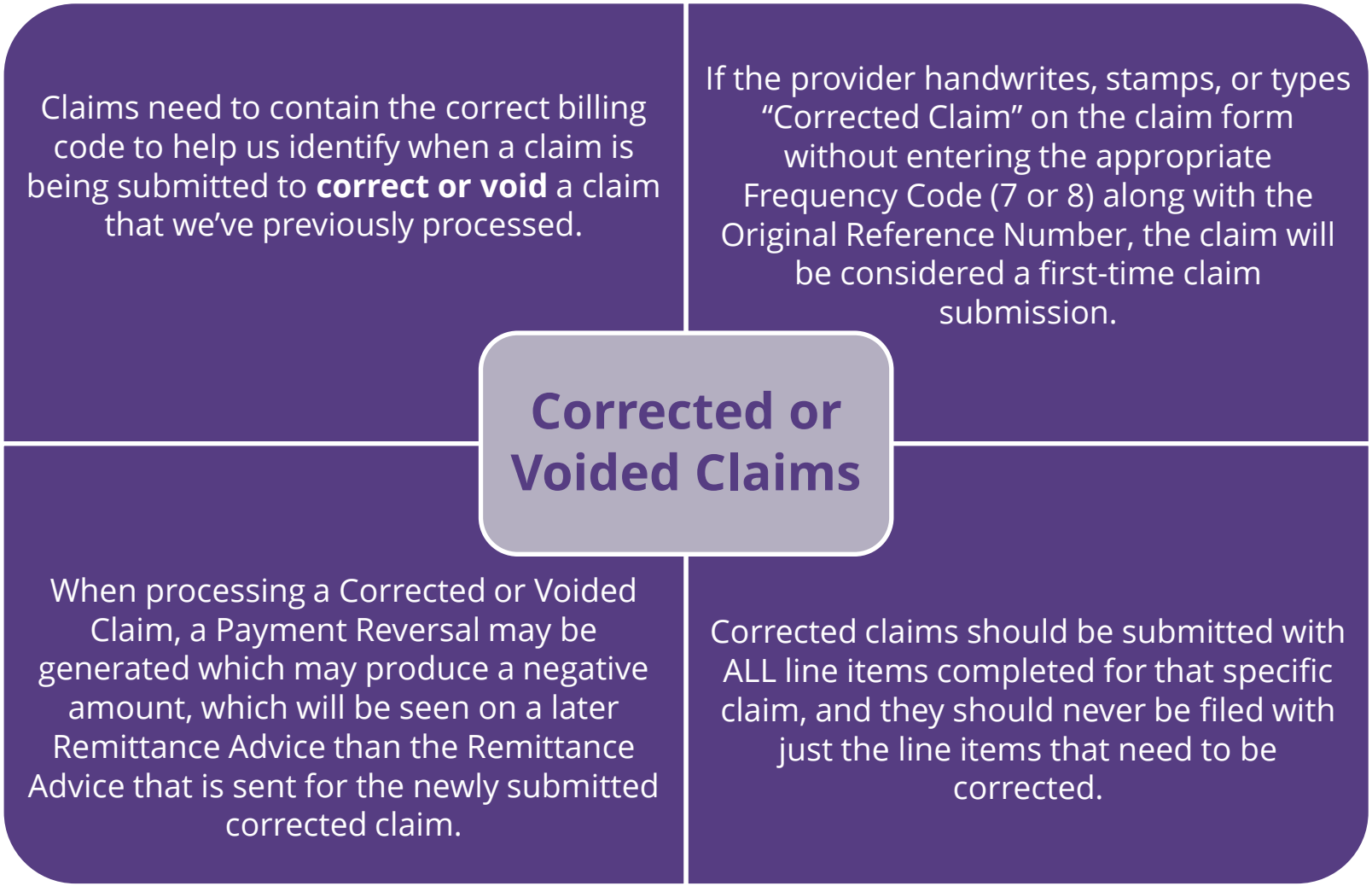
Corrected Claim Submission

Claim Submission

- All claims should be submitted on the most current claim forms.
- Claims must be legible and suitable for imaging and microfilming for permanent record retention.
- Complete ALL required fields and include additional documentation when necessary.
- The claim form may be returned unprocessed (unaccepted) if illegible or poor-quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.

EDI – Change Healthcare (Emdeon)
Claims/billing Address
Aetna Better Health of Florida **P.O. Box 63578** **Phoenix, AZ 85082-1925**
Claims payer ID for EDI
128FL
Real time payer ID
ABHFL

Corrected or Voided Claims- Important Information



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Submitting Corrected or Voided Claims – **Electronically**

To submit a Corrected or Voided Claim electronically:

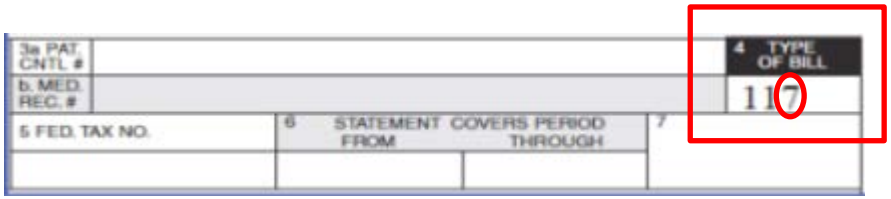
Loop 2300 Segment CLM composite element CLM05-3 should be ‘7’ or ‘8’ – indicating to replace ‘7’ or void ‘8’
Loop 2300 Segment REF element REF01 should be ‘F8’ indicating the following number is the control number assigned to the original bill (original claim reference number)
Loop 2300 Segment REF element 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.)

Submitting Corrected or Voided Claims – **via Paper**

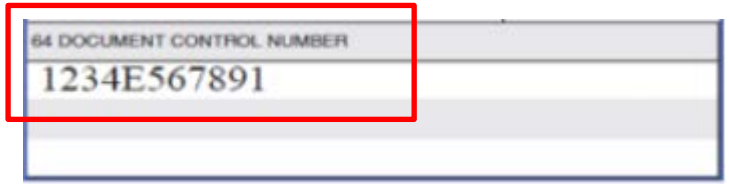
Provider must include the original Aetna Better Health of Florida claim number and bill frequency code (7 for corrected, 8 for void) per billing standards.

Institutional Claims Example:

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:



Professional Claims example:

Box 22 – Enter the appropriate bill frequency code (7 or 8) left adjusted in the left side of box and the original claim number on the right side.

Timely Filing Guidelines

Timely Filing Guidelines

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	Timely Filing 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.
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.
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.
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.
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.
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.

Overpayment Recovery

Overpayment Recovery

Providers are required to return any overpayment amount to the plan within 60 calendar days after the date in which the overpayment was identified.

Payment must be returned to the address below, along with written notice explaining the reason for the return of payment.

If the plan identifies that a claim is overpaid, the provider will receive a letter via U.S. mail from the plan requesting the return of monies paid in error in accordance with Florida statute.

- Providers are able to access and view their overpayment recovery detail through our secure portal at https://www.aetnabetterhealth.com/florida/providers/provider-portal under the "Tasks' section."

- If there are any questions about the information in the notice, on the website or concerns about an explanation of payment entry for a negative amount, please email the Plan's Provider Relations Department at FLMedicaidProviderRelations@aetna.com or via mail to:

Aetna Better Health of Florida
Provider Finance Department
4500 E Cotton Center Blvd
Phoenix, AZ 85040

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Member Billing

Balance Billing

- Providers shall accept payment from Aetna Better Health of Florida for Covered Services provided to our Members in accordance with the reimbursement terms outlined in the Agreement.
- Payment made to providers constitutes payment in full, with the exception of Member Expenses.
- For Covered Services, providers shall not balance bill Members any amount in excess of the contracted amount in the Agreement.
- An adjustment in payment as a result of Aetna Better Health of Florida's claims policies and/or procedures does not indicate that the service provided is a non-Covered Service, and Members are to be held harmless for Covered Services.
- For more information on balance billing, refer to the Florida Statutes 641.3154 and 641.3155 (5)a.(8).
- Additionally, Providers shall not charge Members for missed appointments.

For more information please contact your Network Relations Consultant or a Provider Services Representative.

Thank you.

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