Monthly Provider Claims Training

July 2020

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Covid-19 Prior Authorization Reinstatement

COVID-19 Prior Authorization Reinstatement Requirements

In a recent Policy Transmittal (PT 2020-35 Prior Authorization Reinstatement), the Agency for Health Care Administration (AHCA) communicated the changes and details on the reinstatement of prior authorization for certain Medicaid-covered services.

In order to remain consistent with Phase 2 of Governor Ron DeSantis' Plan for Florida's Recovery and AHCA, Aetna Better Health of Florida (ABHFL) will follow the prior authorization reinstatements requirements.

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Prior Authorization Reinstatement Update

Effective June 19, 2020 Aetna Better Health of Florida (ABHFL) has reinstated prior authorization requirements for the following Florida Medicaid and Florida Healthy Kids services that were waived in response to COVID-19 (see Policy Transmittal: 2020-15):

- Hospital services (including long-term care hospitals)
- Nursing facility services
- Physician services
- Advanced practice registered nursing services
- Physician assistant services
- Home health services
- Ambulance transportation
- Durable medical equipment and supplies

This change applies in both:

1. The fee-for-service and
2. The managed care delivery systems

Prior Authorization Reinstatement Update

Behavioral Health Exception
ABHFL will continue to waive prior authorization requirements and services limits (frequency and duration) for Medicaid-covered behavioral health services covered. This includes community behavioral health services, inpatient behavioral health services, and targeted case management services. ABHFL will continue this flexibility until further notice.

Florida Healthy Kids Exception
ABFHL will continue to waive copayments through July 31, 2020.

Additional Resources
Additional information regarding COVID-19 updates, changes and new process can be located on our Aetna Better Health of Florida website under the resources page, "COVID-19 Information":

https://www.aetnabetterhealth.com/florida/providers/resources/covid-19

In Office Labs

In- Office Labs

Providers must utilize a participating laboratory for laboratory and pathology services (ex. clinical labs, nonclinical labs, pathology, dermatology, etc.) to be covered by Aetna Better Health of Florida.

Aetna Better Health of Florida is currently contracted with LabCorp and Quest to provide outpatient lab services to our members.

Providers may bill and receive reimbursement for laboratory and pathology procedures in urgent situations where lab work is necessary to make a diagnosis or to treat the member while in the provider's office.

All laboratory and Pathology codes/procedures covered in the provider's office are listed in the provider manual available at

https://www.aetnabetterhealth.com/florida/providers/provider-manual

Urgent Care Billing

Hospital-Based Urgent Care Services

Aetna Better Health of Florida will process claims for Hospital-Based Urgent Care Services billed on the CMS-1450/UB-04 or its electronic equivalent the 837I based on the current EAPG calculators.

Hospital-Based Urgent Care Services should be billed on the CMS-1500 professional claims form or its electronic equivalent the 837P, using the appropriate 5-digit CPT or HCPCS procedure codes covered under the Medicaid Physician Services program.

Since revenue code 0516 is no longer covered, facility providers will receive claim denials for these services.

To prevent denials, please submit urgent care claims on a CMS 1500 or its electronic equivalent the 837P.

Anesthesia Billing

Anesthesia Billing

Aetna Better Health of Florida will require the appropriate anesthesia modifier be filed on anesthesia services.

- Each provider should use the appropriate modifier.
- An anesthesiologist, CRNA or Anesthesiology Assistant (AA) can provide anesthesia services.
- The anesthesiologist, CRNA or AA can bill separately for anesthesia services personally performed.
- When an anesthesiologist provides medical direction to a CRNA or AA, both the anesthesiologist and the CRNA/AA should bill for the appropriate component of the procedure performed.

Anesthesia Modifiers -Appropriate Anesthesia Coding

REQUIRED MODIFIERS		
Modifier Information Billed by an Anesthesiologist	AA	Anesthesia services personally performed by the anesthesiologist
	AD	Supervision, more than four procedures
	QK	Medical Direction of two, three or four concurrent anesthesia procedures
	QY	Medical Direction of one CRNA by an anesthesiologist
Modifier Information Billed by a CRNA or Anesthesiology Assistant	QX	Anesthesia, CRNA or Anesthesiology Assistant, medically directed
	QZ	Certified Registered Nurse Anesthetists (CRNA) without medical direction by a physician

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Anesthesia Modifiers -Appropriate Anesthesia Coding

AS APPROPRIATE MODIFIERS	
QS	Monitored anesthesiology care services
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure
G9	Monitored anesthesia care (MAC) for patient who has history of severe cardiopulmonary condition
78	Unplanned return to the operating room, related procedure

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Anesthesia Modifiers -Appropriate Anesthesia Coding

INFORMATIONAL MODIFIERS			
			Unit Value(s)
Physical Status Modifiers – to be billed by anesthesiologist, CRNA, or Anesthesiology Assistant	P1	A normal healthy person	0
	P2	A patient with mild systemic disease	0
	P3	A patient with severe systemic disease	1
	P4	A patient with severe systemic disease that is a constant threat to life	2
	P5	A moribund patient who is not expected to survive without the operation	3
	P6	A declared brain dead patient whose organs are being removed for donor purposes	0

Vaccines- Billing with SL modifier

Vaccines- Modifier SL

Florida Medicaid providers must be registered with the Vaccines for Children (VFC) program.

This program supplies providers with vaccines for children 0-21 years of age. Aetna Better Health of Florida.

ABHFL covers the administrative fee for these vaccines.

Providers must bill the vaccine itself with a modifier of "SL" and the applicable administrative service code in order to get reimbursed for the administration of these vaccines.

This modifier indicates that the vaccine is state supplied. This requirement is in compliance with national correct coding guidelines.

It is critical for providers to add this modifier to get properly reimbursed and for ABHF to count the administration of vaccines in our HEDIS and quality measures.

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Modifier 25

Modifier 25

Modifier 25 is defined as a significant, separately identifiable E/M (evaluation and management) service by the same physician of other health qualified health care professional on the same day of a procedure or other service.

- This modifier may be appended to evaluation and management codes (99201-99499) to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service.
- Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.
- Medical records must reflect appropriate use of the modifier.

Preventive Visits

- Providers must use modifier 25 to describe circumstances in which an acute care E/M visit was provided at the same time as a checkup.
- Providers must submit modifier 25 with the E/M procedure code when the rendered services are distinct and provided for a different diagnosis.

Prescribed Drug Services - National Drug Code (NDC)

HCPCS Codes for Drugs and National Drug Code (NDC) Requirements:

Providers who bill HCPCS codes for drugs must enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug in the shaded area of item 24.

- Begin entering the information above 24 A. Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units
- The NDC is required on claims for drugs, including Medicare-Medicaid crossover claims for drugs
- The NDC must be entered with 11 digits in a 5-4-2-digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and the last two digits are the package size

HCPCS Codes for Drugs and National Drug Code (NDC) Requirements:

Aetna Better Health recommends using the NDC number on the box (outer packaging) if the medication comes in a box with multiple vials.

If you are given an NDC that is less than 11 digits, add the missing digits as follows:

- For a 4-4-2-digit number, add a 0 to the beginning
- For a 5-3-2-digit number, add a 0 as the sixth digit
- For a 5-4-1-digit number, add a 0 as the tenth digit

Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point.

The Unit Qualifiers are:

- F2 – International Unit
- GR – Gram
- ML – Milliliter
- UN – Unit

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

Thank you.

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