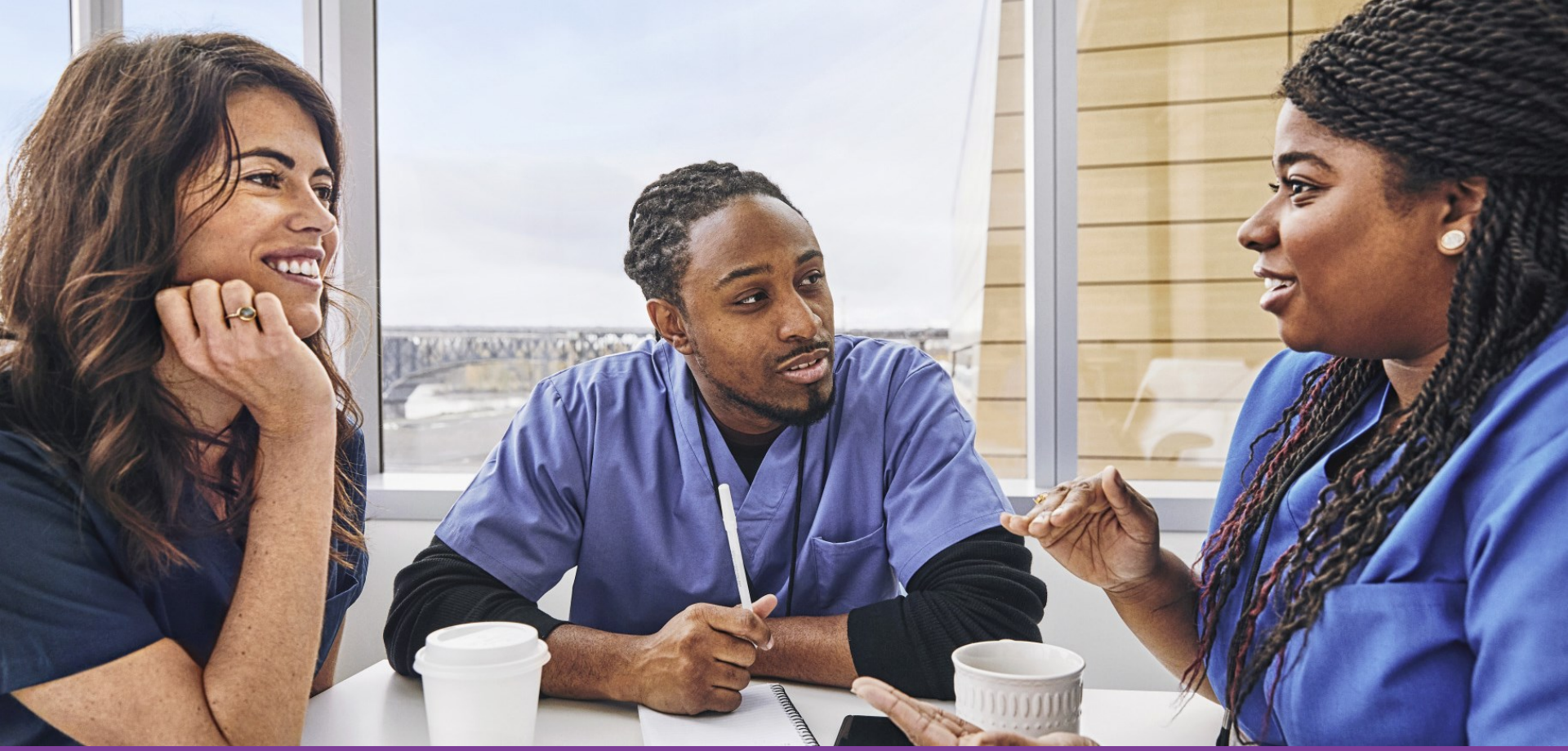

Aetna Better Health of Florida

Monthly Claims Training- December

Elba Tapanes

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December 17, 2020

Learning objectives

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

- Review FHK copay reinstatement
- Discuss electronic visit verification requirements
- Explain assisted living facility (ALF) encounter submission
- Discuss urgent care centers (Rev Code 516)
- Review authorization requirement for skilled nursing facilities (SNF) for Florida Medicaid
- Discuss timely filing requirements
- Review the importance of accurate provider demographics
- Discuss primary care physicians (PCP) member panels
- Explain well visit requirements and immunizations

Florida Healthy Kids Copay Reinstatement

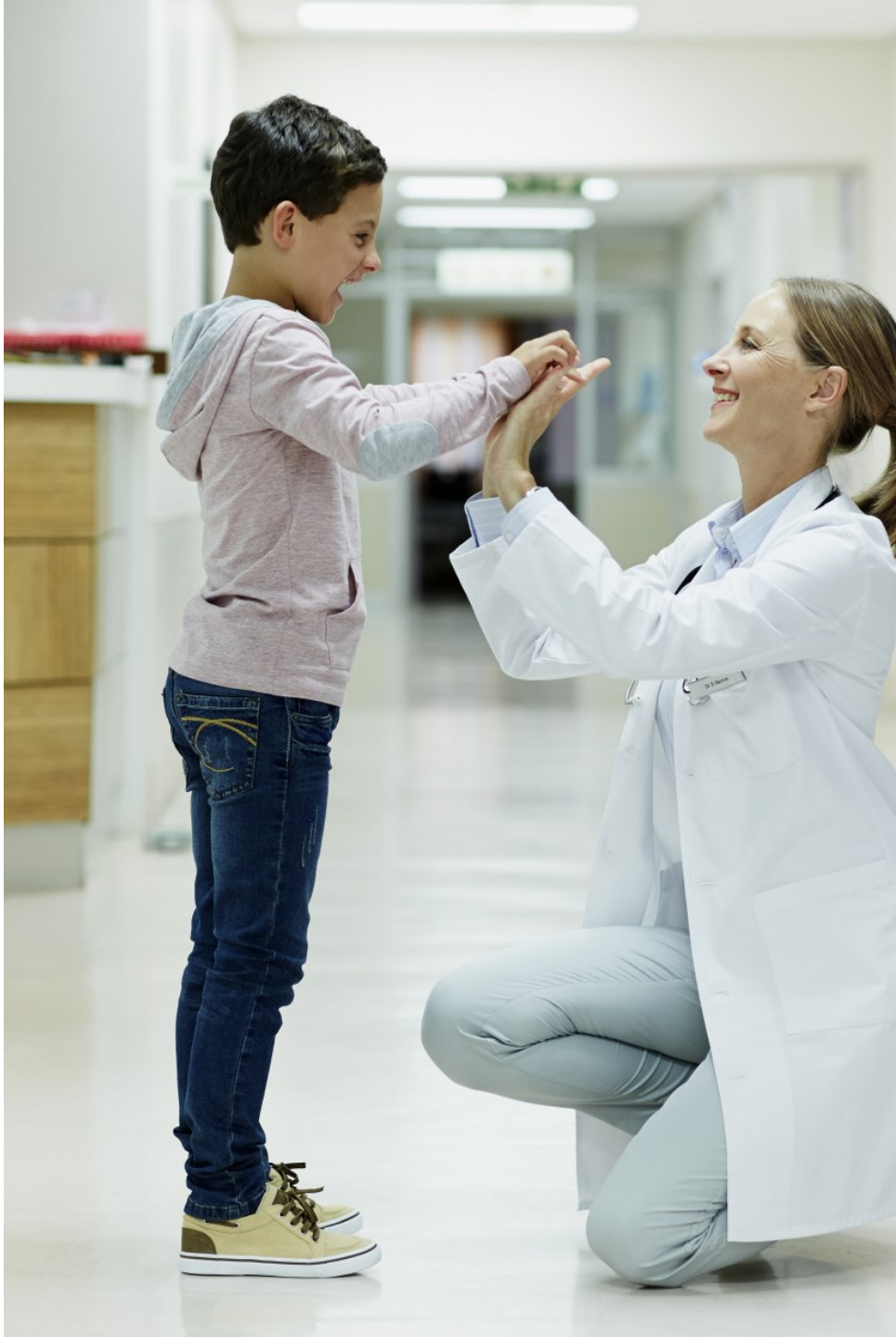
Waived Copayments

As a result of COVID-19, Aetna Better Health of Florida (ABHFL) will continue to waive copayments requirements through December 31, 2020 for Florida Health Kids.

Copayments for Florida Health Kids will resume on January 1, 2021.

For any questions regarding billing COVID-19 ICD-10, please refer to official diagnosis coding guidelines that have been published by the Centers for Disease Control (CDC).

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advicecoronavirus-feb-20-2020.pd



EVV- Electronic Visit Verification

EVV- Electronic Visit Verification

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.

EVV- Electronic Visit Verification Compliance

Effective for dates of service beginning December 4, 2020, Aetna Better Health of Florida will require claims for personal care services and Home Health services to be submitted through Tellus, our EVV vendor.

Provider claims for Home Health and Personal Care Services may be processed outside ABHFL care plan system for dates of service through December 3, 2020.

Claims will deny with dates of service on or after December 4, 2020, that are submitted outside of the Tellus EVV system by providers who are submitting less than 25 percent of Personal Care Services or Home Health Services claims through the Tellus EVV system.

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

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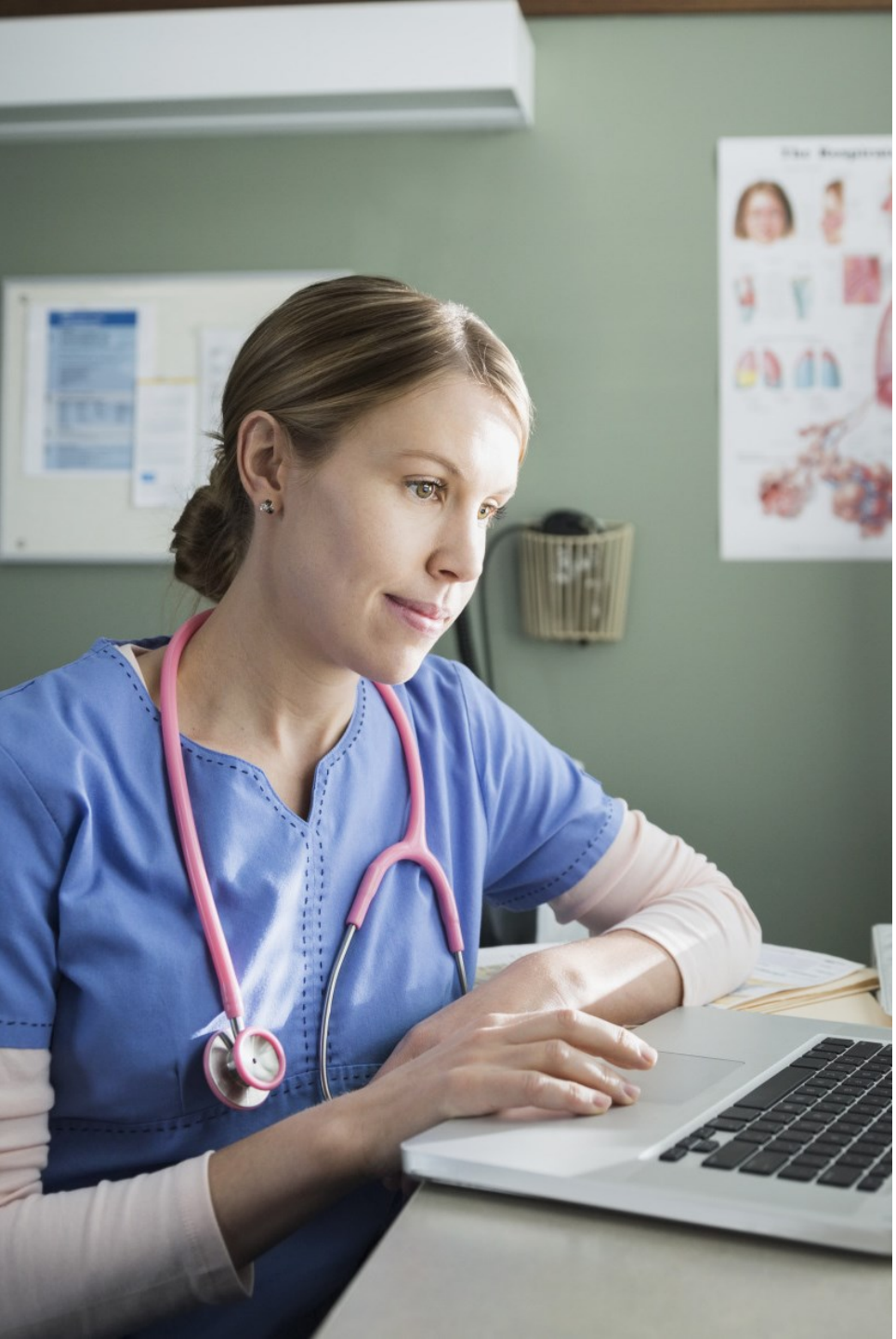
Assisted Living Facility (ALF) Claim Submission



ALF Claim Submissions

Assisted Living Facilities (ALF) are required to submit claims on a monthly basis for members residing in their facility. The HCPC code use to bill these services is T2030.

Encounter claims may be submitted electronically or on a CMS 1500 form.

Aetna Better Health of Florida highly encourages electronic claim submission.

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

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Urgent Care Center Billing- Rev Code 516

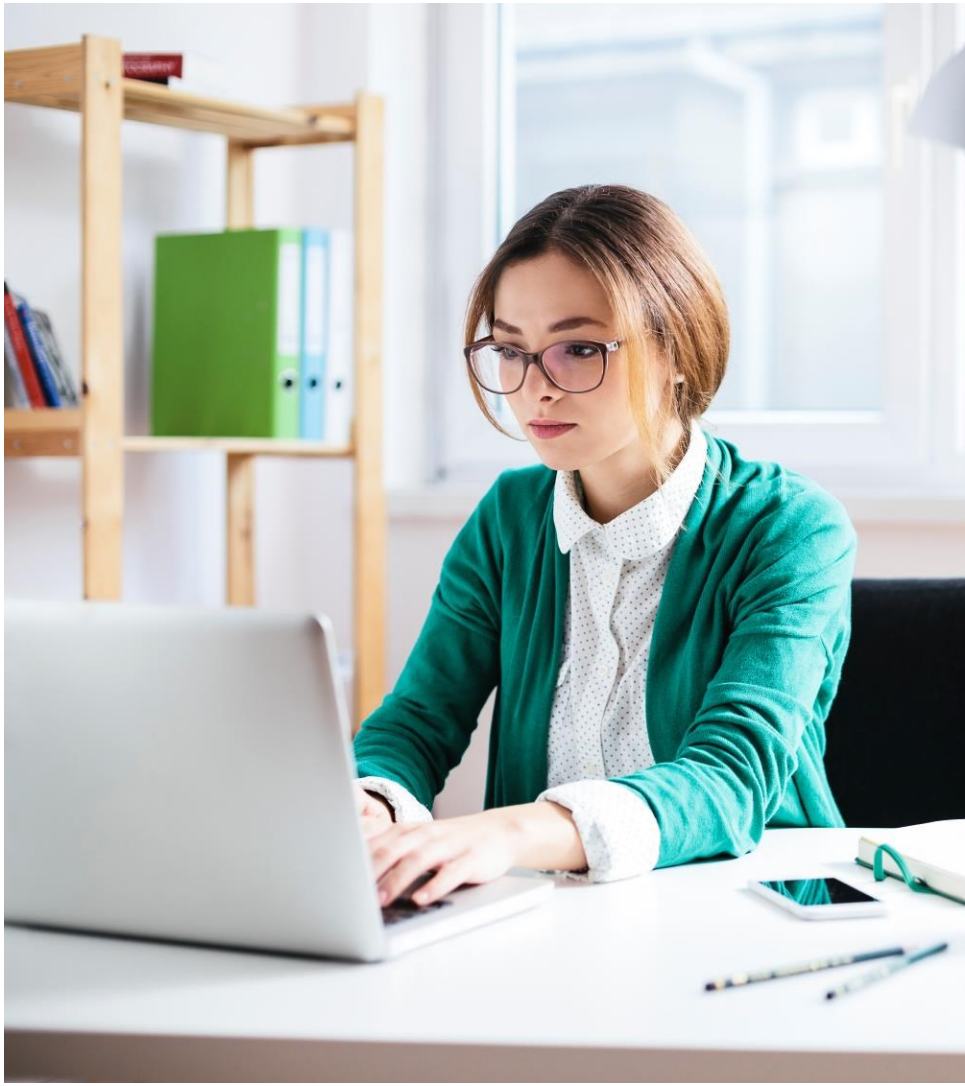
Hospital-Based Urgent Care Services

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



Skilled Nursing Facility Authorization Requirement

Custodial Care Authorizations

Custodial Care Authorizations -this is applicable to members who are not receiving skilled services and are waiting for LTC benefits.

Aetna Better Health of Florida Medicaid requires that you complete the attached Prior Authorization form and fax along with the PASRR, DCF 2506a, ACHA 3008, and Cares Assessment forms to 1-860-607-8056

- Authorization requests may be approved for 1 month at a time, up to 120 days, provided that the requested documentation is submitted, and the nursing facility is actively working with the member and state to obtain LTC
- All authorization requests must be for continuous dates unless there is a reasonable explanation for a gap, such as the member being hospitalized
- The date of admission and prior coverage payer information are required
- Retrospective requests must be submitted to the Health Plan within 90 days of initial service date (start date); if you do not submit your request within 90 days, you will need to submit with the claim and complete clinical records
- Aetna Better Health will respond with a determination as quickly as possible, however the turnaround time for a Standard Determination is 7 calendar days and for Retrospective Requests, 30 calendar days

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Skilled SNF/Rehabilitation Authorizations

- All requests for a SNF for rehabilitation (skilled) admissions must be called into Aetna at 1-800-441-5501. Choose the Provider option to be routed to Prior Authorization
- Aetna Better Health requires an initial telephone notification so that we can expedite your request.
- Members should not be transferred to a skilled facility for rehabilitation without prior authorization from the health plan.
- Upon call in, you will be asked to fax clinical documentation and the PASSR to Concurrent Review for an expedited review, 1-844-878-3583
- Aetna will make every effort to return a determination within 24 hours of your request for authorization.

COVID-19 Prior Authorization Requirements for Hospital Transfers

To facilitate prompt hospital discharges and to ensure adequate inpatient hospital capacity in response to COVID-19, Aetna Better Health of Florida is waiving service authorization requirements prior to admission for hospital transfers, including

- Inter-facility transfers: o transfers to a long-term care hospital; and
- Transfers to a nursing facility

This applies when the receiving facility is a participating provider or non-participating provider in ABHFL network.

Aetna Better Health of Florida requires the receiving facility to notify us of the admission within forty-eight (48) hours of the admission.

- At that point, Aetna Better Health of Florida may request additional clinical information to begin concurrent/continued stay reviews to facilitate care coordination and discharge planning.

For more information regarding COVID-19 Prior Authorization Requirements for Hospital Transfers please refer to the provider notice distributed on July 14, 2020.

- COVID-19 Waiver of Prior Authorization Requirements for Hospital Transfers

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Timely Filing Requirements

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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Provider Demographics

Provider Demographics

Has your information changed?

Please notify the plan in writing within sixty (60) days or in accordance with your agreement of any additions, deletions or changes to the topics listed below.

Our phone number is 1-800-441-5501 or
or you can fax us at 1-844-235-1340.

Failure to notify the Plan timely could negatively impact claims processing.

- Tax identification number (submission of W-9 required). Changing a tax identification number will require a new agreement with the new tax identification number)
- Office or billing address
- Telephone or fax number
- Specialty (may require additional credentialing)
- New physician additions to the practice (please allow time for credentialing)
- Licensure (DEA, state licensure or malpractice insurance)
- Group affiliation
- Hospital privileges

PCP Member Panel

Membership assigned to PCPs

Members may choose a PCP from the Provider Directory. Every month, PCPs receive a membership listing of the members that have chosen them as their PCP.

PCPs shall contact any new Medicaid members within 30 days of being assigned to their panel to ask if they need any assistance or to schedule an office visit for continued medical care.

Each PCP office shall designate an encounter/referral coordinator to ensure that encounters and referrals are completed and submitted to the Plan and/or the member.

Encounters may be submitted electronically or on a CMS 1500 form

Our secure Web Portal has access to a real-time listing of your patients.

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Well Visits and Immunizations

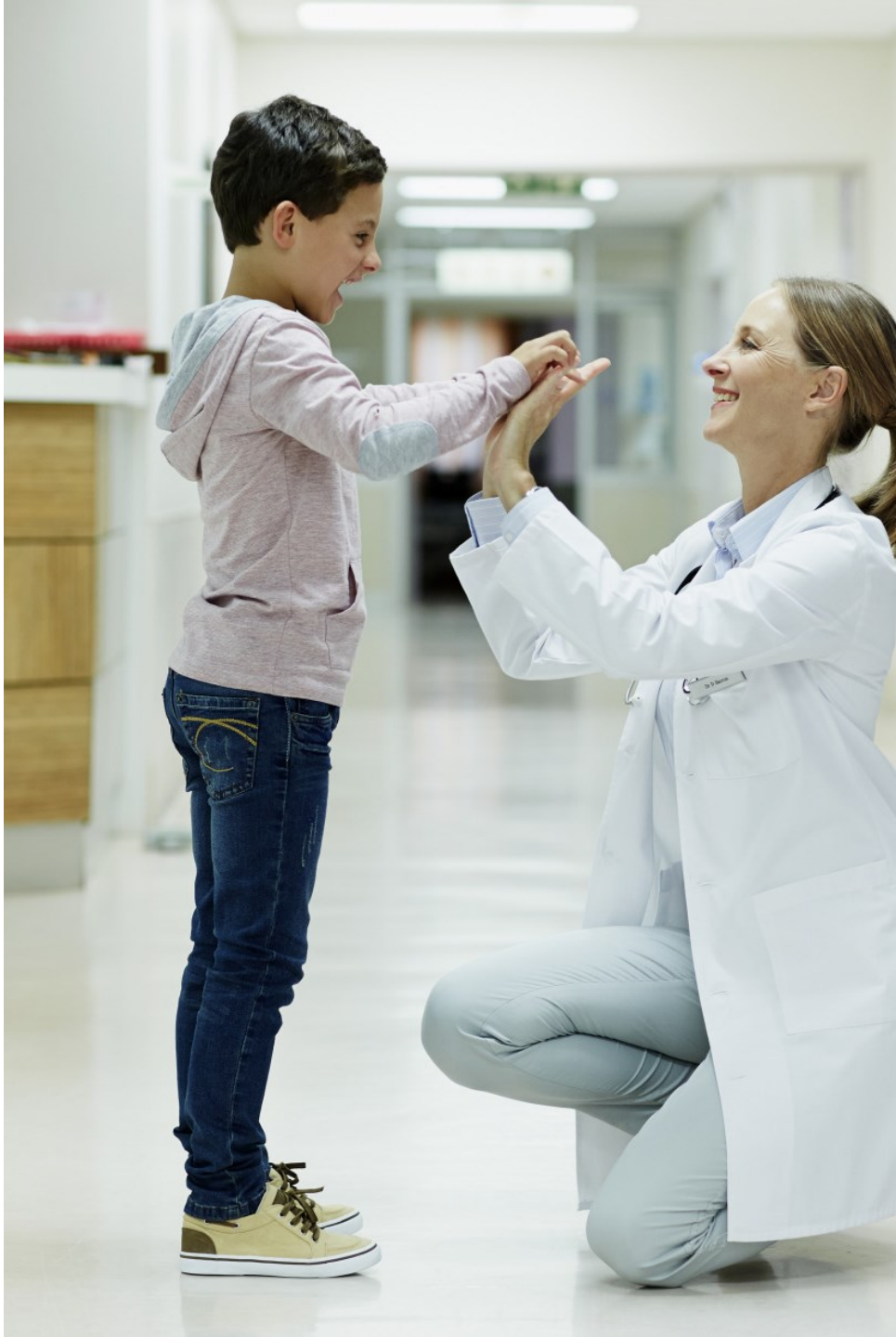
Well Visits and Vaccines

Aetna Better Health of Florida has initiated an outreach campaign to primary care physicians (PCPs) for missed services specific to well visits and vaccines.

PCPs are urged to reach out to members to schedule well visits and vaccines to their assigned members.

Provider should :

- Submit all claims for well visits as required to avoid untimely filing denials
- Bill the correct CPT code for well visits
- Coding for these preventive services would include: CPT: 99381-99385; 99391-99395 & 99461
- Append Modifier 25 to the applicable Evaluation & Management (E/M) code for the allowed sick visit when billing well visit for the same day
- Include Diagnosis Codes: V20.2 (Routine infant or child health check)



Provider News

Medicaid Availity Implementation

Aetna Better Health of Florida will be transitioning to Availity effective 1/19/2021.

As Availity is brought online for the upcoming year, it will be important that providers are aware of the options available to them through the new portal.

To support the success of Availity's transition, providers who are not already registered Availity should submit their email address to

FLMedicaidProviderRelations@aetna.com

For any questions, please reach out to call our Provider Services Department at 1-844-528-5815

Questions? We've got answers.

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

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