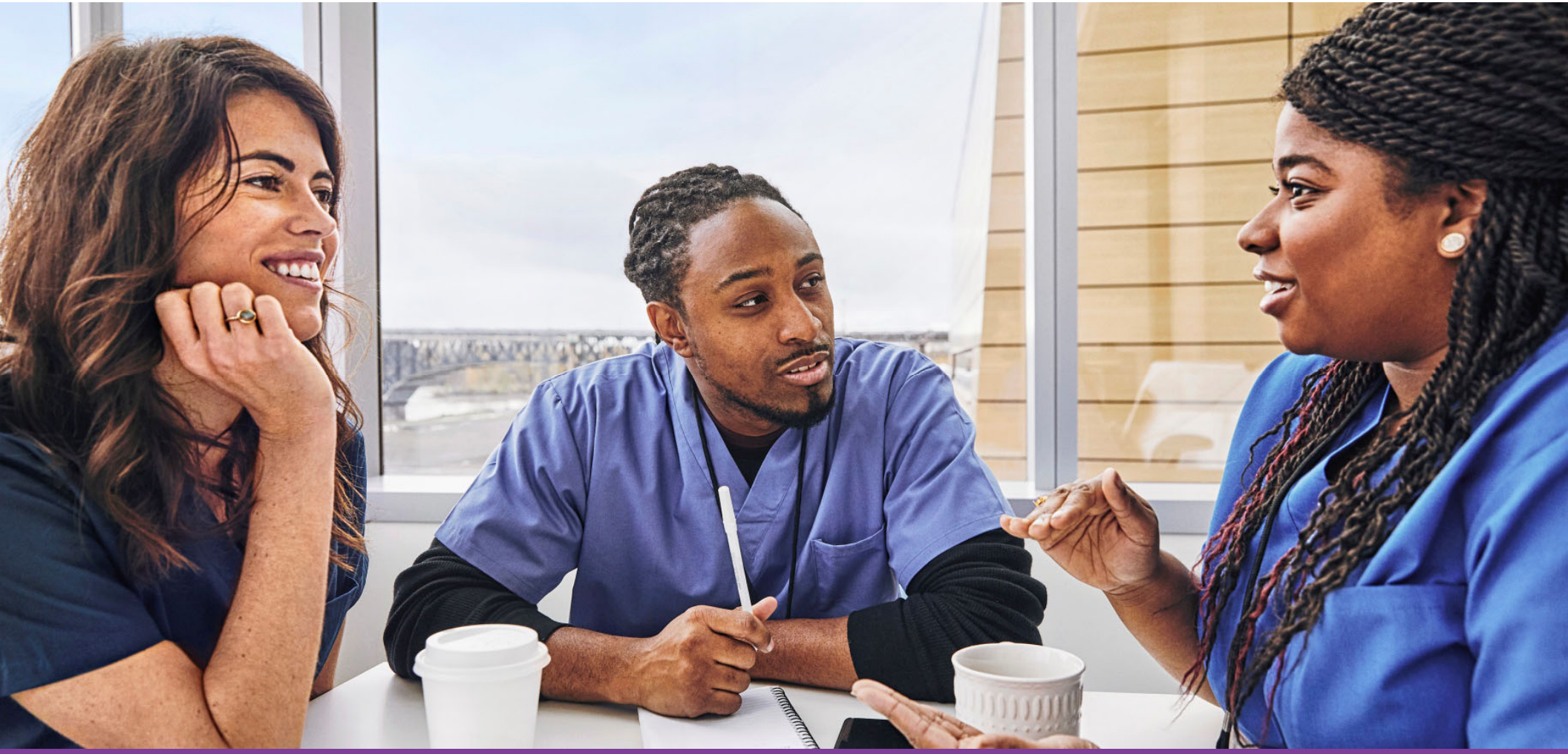

Aetna Better Health of Florida

Monthly Claims Training- February

Denise E. Castro

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February 24, 2021

Learning objectives

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

- Discuss EVV (electronic visit verification) submissions
- Review Co-Surgeon Modifier 62
- Review Billing with Manifestation Codes
- Inform on 835s and Remittance Advise Discrepancy Notice
- Discuss Change Healthcare Web Connect Tool
- Introduce Availity- New Provider Web Portal
- Explain Timely Filling Guidelines
- Inform the importance of EFT/ERA Registration

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- Claim Submissions

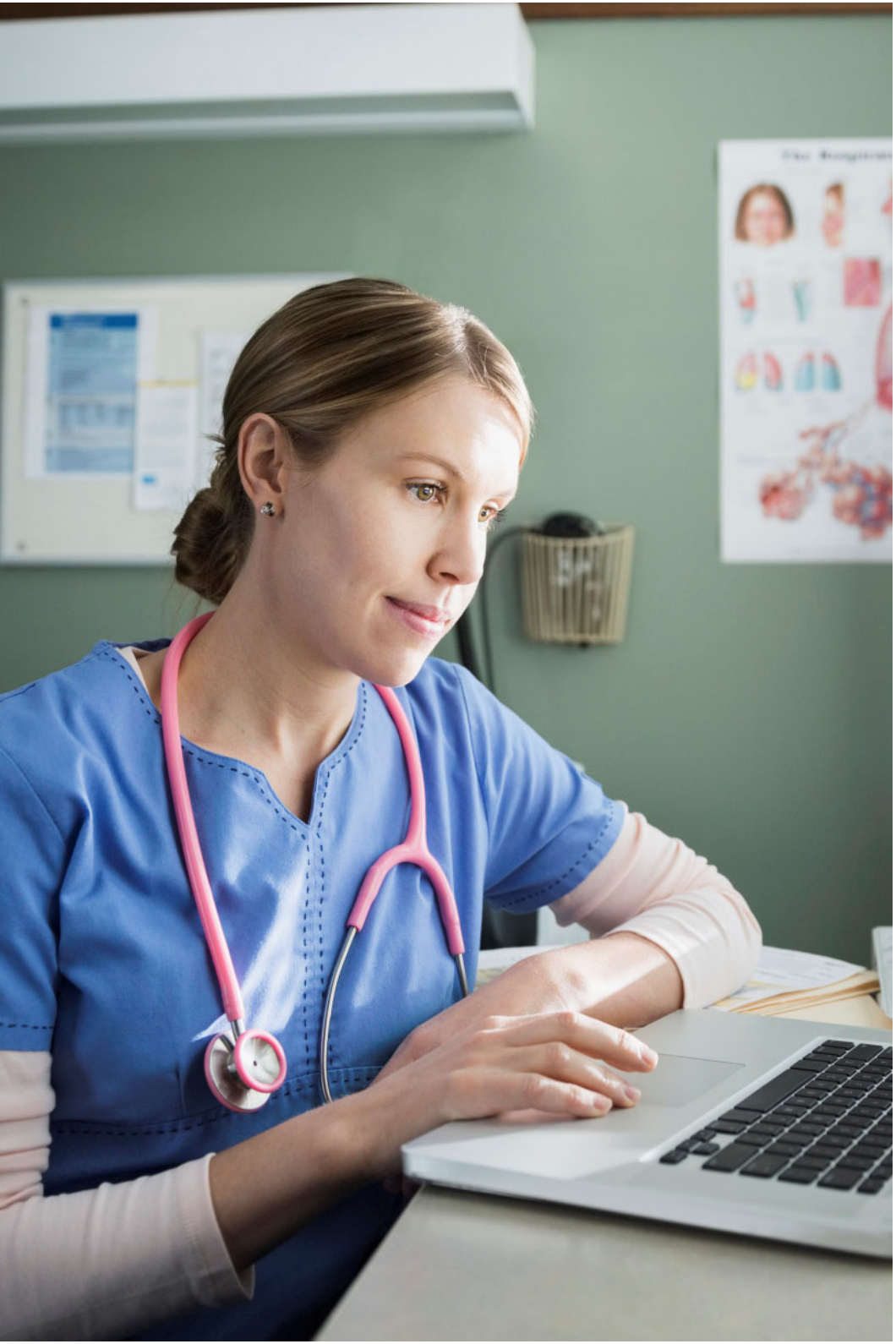
As an interim step towards full compliance with the 21st Century Cures Act, effective for dates of service As of December 4, 2020, Aetna Better Health of Florida will require claims for Personal Care Services and Home Health Services to be submitted through Tellus, our EVV vendor.

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

Aetna Better Health of Florida will deny any claims with dates of service on or after December 4, 2020, that are submitted to us 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.

Co-Surgeon Modifier 62



Co- Surgeon Modifier 62

Aetna Better Health of Florida (ABHFL) would like to remind you of the importance of accurate claim submission, when applying Co-surgeon modifier 62.

Modifier 62 is appended to surgical claims to report the need for the skills of two surgeons (co-surgeons) to perform a procedure, with each surgeon performing a distinct part of the same procedure, during the same surgical session.

When submitting claims with Modifier 62, the medical records submitted must support the details performed by each physician on the operative notes, detailing what portion of the procedure he or she performed, how much work was involved, how long the procedure took, etc.

When billing Co-surgeon modifier 62 claims, ABHFL requires medical records to be submitted for review.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Aetna Better Health of Florida may:

- Reject or deny the claim
- Recover and/or recoup claim payment

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Billing with Manifestation Codes

Manifestation Billing Codes

Aetna Better Health of Florida (ABHFL) promotes correct claims coding, including the appropriate use of manifestation codes. Manifestation codes describe the manifestation of an underlying disease, not the disease itself.

When choosing and assigning diagnosis codes, it's important to choose the correct codes to make sure your claims process efficiently and without any issues.

Per our policy, which is based on ICD Manual guidelines, certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD Manual coding guidelines have established a coding convention that requires the underlying condition to be sequenced first followed by the manifestation. Based on this guideline, a manifestation code cannot be the only diagnosis on the claim.

Manifestation Code Examples	
Code	***Description***
D63.1	Anemia in chronic kidney disease
E08.9	Diabetes mellitus due to underlying condition without complications
M63.80	Disorders of muscle in diseases classified elsewhere, unspecified site
G05.4	Myelitis in diseases classified elsewhere

Note: *Manifestation codes are backed by blue highlights in the ICD-10-CM Manual*

When billing Manifestation Codes:

- Do not report a manifestation code as the only diagnosis
- Do not report a manifestation code as a first-listed or principal diagnosis
- Code the underlying disease/condition as the primary diagnosis

835s Remittance Advise

Change Healthcare- 835 Remittance Advise

Change Healthcare made updates to their system in order to improve and streamline the payment and remittances process.

This update impacted multiple 835's and Remittance Advices from October 26, 2020 through November 6, 2020.

For those impacted, the payments/EFTs did not match the information within the 835/Remittance Advice, however, we assure you that payments were not affected.

The issue has been resolved as of Friday November 6, 2020.

If you have been affected, you should have received a corrected 835/Remittance Advice in order to reflect the correct inf.ormation for your records

Change Healthcare Web Connect Tool

Web Connect Tool

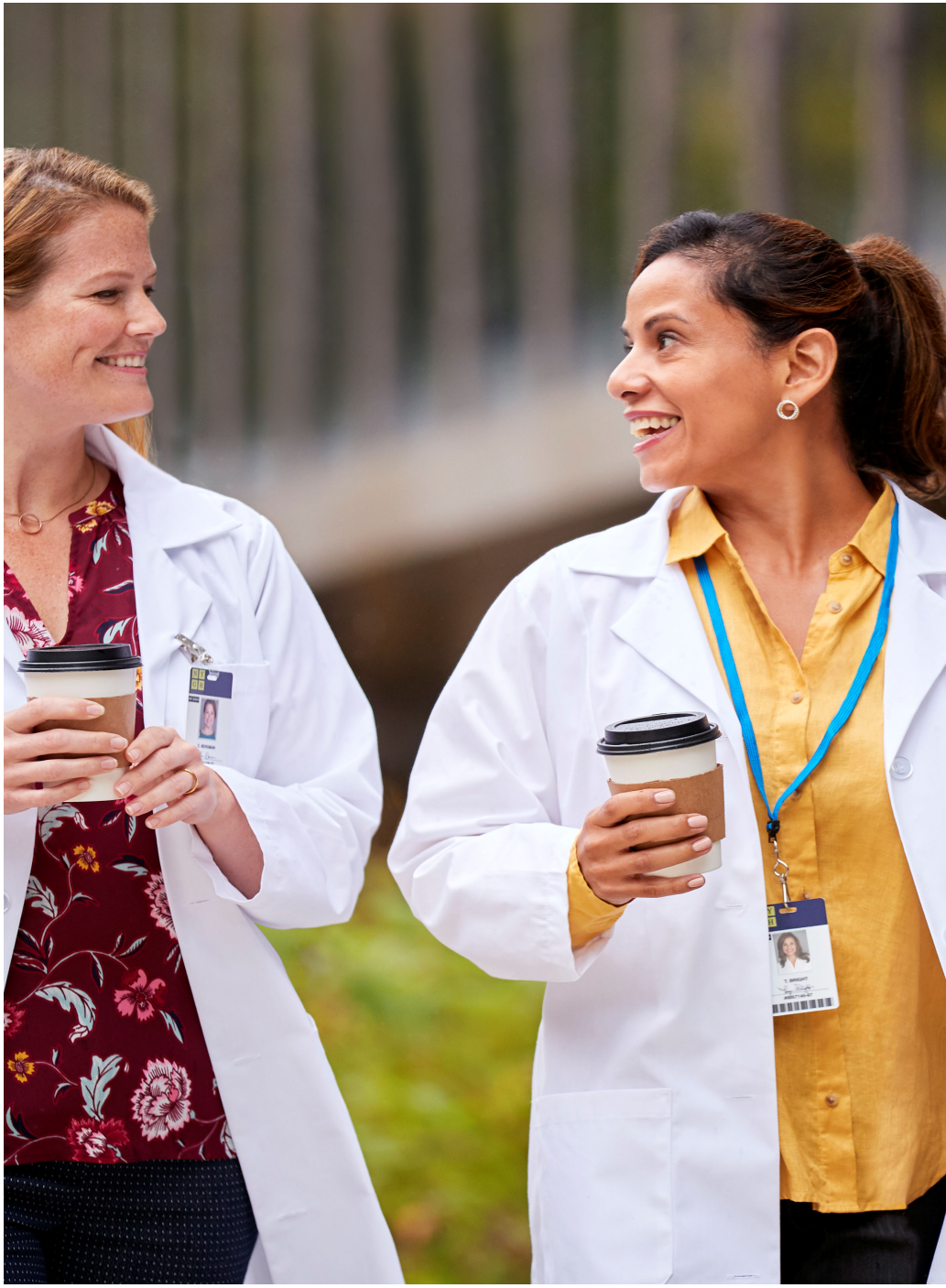
We are pleased to announce the availability of our new and improved solution for verifying member information and submitting claims to Aetna Better Health.

Within the next two months, ConnectCenter will replace Emdeon Office, giving you a more reliable, more complete way to submit claims, all at no cost to you. You will be able to use your ConnectCenter and Emdeon Office accounts at the same time until 4/30/2021.

Here are a few of the improvements you can look forward to with ConnectCenter:

- Claims users no longer need to choose between data entry of claims and upload of 837 files. All users may do both.
- Secondary and tertiary claims can be submitted.
- Institutional claims are supported
- Claims created online are fully validated in real-time so that you can correct them in real-time
- Whether you upload your claims or create them online, your claim reports are integrated with the claim correction screen for ease in follow-up
- Dashboard and work list views makes managing your billing to-do list a snap
- On-shore customer support available through online chat (as well as by phone)

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.

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.

Questions? We've got answers.

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

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