Provider newsletter

Winter 2023

Utilization management criteria, availability and decisions

Utilization management (UM) criteria and availability/UM decisions is a system for reviewing eligibility for benefits for the care that has been or will be provided to patients. The UM department includes:

- Preauthorization
- Concurrent review
- Case management

Medical necessity is based upon clinical standards and guidelines as well as clinical judgment. All clinical standards and guidelines used in the UM program have been reviewed and approved by practicing, participating physicians in our network. You can receive a copy of our clinical standards and guidelines by calling us at 1-800-441-5501 (TTY: 711), 8 AM to 7 PM ET.

The medical director makes all final decisions regarding the denial of coverage for services when the services are reviewed via our UM program. The provider is advised that the decision is a payment decision and not a denial of care. The responsibility for treatment remains with the attending

(continued on next page)

In this issue

Referrals 2

Pharmacy restrictions and drug formularies 3

Access to care and service standards 3

Second opinions 3

Member rights & responsibilities 4

Clinical practice guidelines 5

Keep your information current . . 5

Website new look! 6

Discharge planning coordination 7

Utilization management criteria, availability and decisions *(continued from previous page)*

physicians. The medical director is available to discuss denials with attending physicians and other providers during the decision process. Notification includes the criteria used and the clinical reason(s) for the adverse decision. It includes instructions on how to request reconsideration as well as a contact person's name, address, and phone number.

The policy on payment for services helps ensure that the UM decision-making process is based on consistent application of appropriate criteria and policies rather than financial incentives.

- UM decisions are based only on appropriateness of care and service and the existence of coverage.
- We do not reward practitioners, providers or other individuals conducting utilization review for issuing denials of coverage or service care.
- The compensation that we pay to practitioners, providers and staff assisting in utilization related decisions does not encourage decisions that result in underutilization or barriers to care or service.

The UM staff is available to discuss specific cases or UM questions by phone by calling 1-800-441-5501 (TTY: 711) (Medicaid), 1-844-645-7371 (TTY: 711) (Comprehensive Long-Term Care) or 1-844-528-5815 (TTY: 711) (Florida Healthy Kids), from 8 AM to 7 PM ET. UM staff is available on holidays and weekends by voice mail and fax.

Referrals

The primary care provider (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?

- Support coordination of care between PCP and specialist
- Promote the right care at the right time
- Ensure enrollees receive preventive, primary care services, not just specialty care

No PCP referral is required for the following direct-access services: chiropractic, dermatology (five visits/year), routine podiatric care, optometry, behavioral health, and OB/GYN. PCP referrals are required for all other specialist services.

Referrals can be made electronically via our secure portal at AetnaBetterHealth.com/Florida/providers/provider-portal. If a paper version is preferred, it can be downloaded and printed from our website under Authorizations at 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.

Pharmacy restrictions and drug formularies

You can access the Aetna Better Health of Florida formularies at AetnaBetterHealth.com/Florida under the "Providers site" tab, "Pharmacy benefits" and "Formulary/Preferred Drug List" areas (AetnaBetterHealth.com/Florida/providers/pharmacy.html).

You will find the Florida Medicaid preferred drug list (PDL) and the Florida Healthy Kids formulary search tool and formulary document.

If you have any questions regarding the formulary, contact us at the toll-free numbers below or visit our website.

- Medicaid Provider Relations: 1-800-441-5501 (TTY: 711)
- Florida Healthy Kids Provider Relations: 1-844-528-5815 (TTY: 711)

Access to care and service standards

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history.

Our Provider Relations Department will routinely monitor compliance and seek corrective action plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standard. Providers are contractually required to meet standards for timely access to care and services, considering the urgency of and the need for the services.

Providers shall offer appointments and access to members within the specified guidelines.

Review your provider manual for details online at AetnaBetterHealth.com/florida/providers/materials-forms.html.

Second opinions

A member may request a second opinion from a provider within our network. Providers should refer the member to another network provider within an applicable specialty for the second opinion.

Please note that there are no timeframes for referrals. If an Aetna Better Health of Florida provider is not available, Aetna Better Health will help the member get a second opinion from a nonparticipating provider at no cost to the member.

Member rights & responsibilities

We have adopted the Florida Member's Bill of Rights and Responsibilities. Members can request a copy of it from their doctor or from Member Services.

Member rights

- Be treated with courtesy and respect.
- Always have your dignity and privacy considered and respected.
- Receive a quick and useful response to your questions and requests.
- Know who is providing medical services and who is responsible for your care
- Know what member services are available, including whether an interpreter is available if you do not speak English.
- Know what rules and laws apply to your conduct.
- Be given easy to follow information about your diagnosis, and openly discuss the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you.
- Participate in making choices with your provider about your health care, including the right to say no to any treatment, except as otherwise provided by law.
- Be given full information about other ways to help pay for your health care.
- Know if the provider or facility accepts the Medicare assignment rate.
- To be told prior to getting a service how much it may cost you.
- Get a copy of a bill and have the charges explained to you.
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any health emergency that will get worse if you do not get treatment.
- Know if medical treatment is for experimental research and to say yes or no to participating in such research.
- Make a complaint when your rights are not respected.
- Ask for another doctor when you do not agree with your doctor (second medical opinion).
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed.
- Have your medical records kept private and shared only when required by law or with your approval.
- Decide how you want medical decisions made if you can't make them yourself (advanced directive).
- To file a grievance about any matter other than a plan's decision about your services.
- To appeal a plan's decision about your services.
- Receive services from a provider that is not part of our plan (out-of-network) if we cannot find a provider for you that is part of our plan.
- Speak freely about your health care and concerns without any bad results.
- Freely exercise your rights without the plan or its network providers treating you badly.
- Get care without fear of any form of restraint or seclusion being used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of your medical records and ask that they be amended or corrected.
- Receive information on member's rights and responsibilities.
- To voice a complaint about care the organization provides.
- To make recommendations regarding the organization's member rights and responsibilities policy.

Member responsibilities

Aetna Better Health of Florida members, their families, or guardians are responsible for:

- Give accurate information about your health to your plan and providers.
- Tell your provider about unexpected changes in your health condition.
- Talk to your provider to make sure you understand a course of action and what is expected of you.
- Listen to your provider, ask questions and follow instructions for care you have agreed to with your practitioner.
- Keep your appointments and notify your provider if you will not be able to keep an appointment.
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions.
- Make sure payment is made for non-covered services you receive.
- Follow health care facility conduct rules & regulations.
- Treat health care staff & case manager with respect.
- Tell us if you have problems with any health care staff.
- Use the emergency room only for real emergencies.
- Notify your case manager if you have a change in information (address, phone number, etc.).
- Have a plan for emergencies and access this plan if necessary for your safety.
- Report fraud, abuse and overpayment.

Clinical practice guidelines

Aetna Better Health of Florida makes clinical decisions regarding members' health based on the most appropriate care and service available. We make these decisions based on appropriate clinical criteria. The criteria used in the decision-making process is provided upon request by calling Member Services at the number listed on the back of the member's ID card.

Criteria may be viewed on AetnaBetterHealth.com/Florida or a hard copy may be requested. We adopt evidence-based clinical practice guidelines (CPG) from national recognized sources. These guidelines have been adopted to promote consistent application of evidence-based treatment methodologies and made available to practitioners to facilitate improvement of health care and reduce unnecessary variations in care.

Aetna Better Health reviews the CPGs every two years or more frequently if national guidelines change within the two-year period. The CPGs that have been formally adopted can be found at AetnaBetterHealth.com/Florida.

The CPGs are provided for informational purposes only and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider's clinical judgment regarding the appropriate treatment of a patient in any given case.

Keep your information current

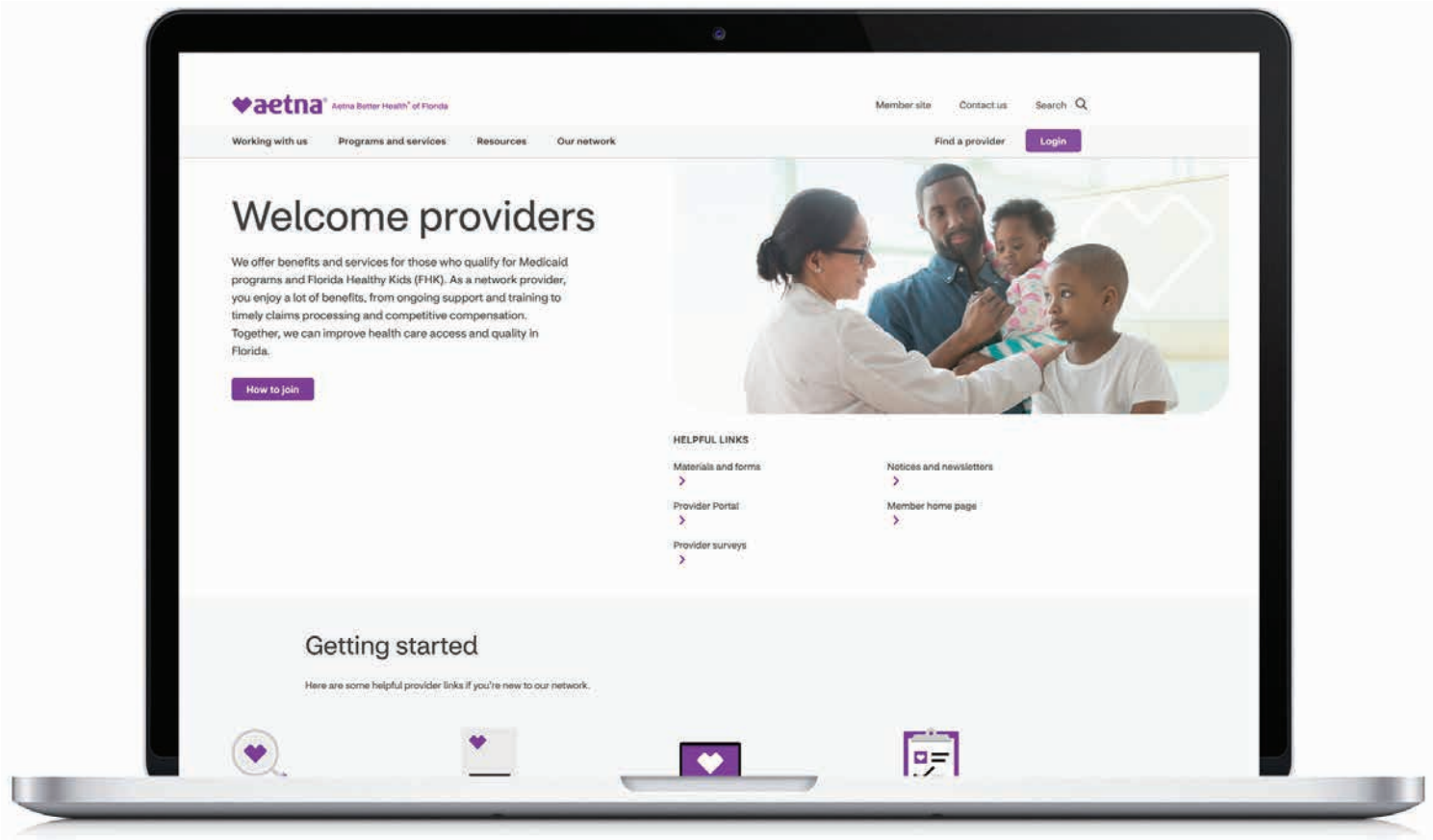
Keeping your details up to date in our directories helps members find the right information about you and your practice. This also helps ensure that you receive timely payment, communications, reminders and more.

It is important to Aetna Better Health of Florida and your patients that your provider directory demographics are accurate. In support of NCQA, federal, and CMS regulations and standards, Aetna Better Health of Florida requires participating providers to visit our Provider Online Directory at AetnaBetterHealth.com/florida/find-provider each calendar quarter to validate the accuracy of your practice information.

Actively managing the accuracy of provider data is critical to ensuring our members can access medical care. Incorrect information within provider directories can lead to confusion and frustration for members and providers. Without consistently checking the information through provider data validation, inaccuracies can grow, and this can become a significant barrier in accessing care.

For more information, visit our website on how to make changes: AetnaBetterHealth.com/florida/providers/stay-current.html.

Need to update your information? Just email Provider Relations (FLMedicaidProviderRelations@aetna.com) to let us know about the requested change or complete our ABH FL Provider Data Change Form.



Website new look!

New look, same login, easier to navigate and more helpful information added!

We recently changed the look of our website AetnaBetterHealth.com/Florida to make it more user friendly for providers and our members.

Here are some important & helpful links:

- Provider Site: AetnaBetterHealth.com/florida/providers/index.html
- Provider notices, policy updates, newsletters: AetnaBetterHealth.com/florida/providers/notices-newsletters.html
- Orientation and monthly webinar training: AetnaBetterHealth.com/florida/providers/training-orientation.html
- Materials, authorizations, forms: AetnaBetterHealth.com/florida/providers/materials-forms.html
- Provider manual: AetnaBetterHealth.com/florida/providers/materials-forms.html
- Provider portal: AetnaBetterHealth.com/florida/providers/portal.html
- Health equity: AetnaBetterHealth.com/florida/providers/health-equity.html

Questions?

Just call Provider Relations. We're here to help.

- Medicaid MMA: 1-800-441-5501 (TTY: 711)
- Florida Healthy Kids: 1-844-528-5815 (TTY: 711)
- Long Term Care: 1-844-645-7371 (TTY: 711)

Discharge planning coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and for involving the member and family in implementing the plan.

Our concurrent review nurse (CRN) and transition of care clinician works with the hospital discharge team and attending physicians to verify that cost-effective and quality services are provided at the appropriate level of care.

This may include, but is not limited to:

- Assuring early discharge planning
- Facilitating or attending discharge planning meetings for members with complex and multiple discharge needs
- Providing hospital staff and attending physician with names of network providers (i.e., home health agencies, durable medical equipment (DME)/medical supply companies and other outpatient providers)
- Informing hospital staff and attending physician of covered benefits as indicated
- Seven-day and 30-day follow-up after discharge from hospital (or ER) with mental health DX or substance abuse

Discharge from a skilled nursing facility (SNF)

All discharges from a SNF must be coordinated with the member's case manager. In accordance with Section 83 of Title 42 of the Code of Federal Regulations, resident rights, any discharge or transfer of a member must be based on a medical reason, for his or her welfare, for the welfare of other patients, or for nonpayment (except as prohibited by Medicare (Title XVIII) or Medicaid (XIX) of the Social Security Act). Regardless of the reason, the member, his or her representative, and the member's case manager must be involved in discharge planning.