Provider newsletter

Winter 2025

Utilization management criteria, availability, 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 too

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, 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 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

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Utilization management *(continued from previous page)*

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** (Medicaid), **1-844-645-7371** (Comprehensive Long-term Care) or **1-844-528-5815** (Florida Healthy Kids); (**TTY**: **711**), 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.

Provider notices and newsletters

Receiving updates that impact you and our members is very important!

How to stay informed: Our most updated information is always available on our **ABHFL Provider Page**.

Here are some important and helpful links

- **Provider site**
- **Provider notices, policy updates, newsletters**
- **Orientation and monthly webinar training**
- **Materials, authorizations, forms**
- **Provider manuals**
- **Provider portal**
- **Health equity**

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**)

Member rights and 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

1. Members have the right to have their privacy protected.
2. Members have the right to a response to questions and requests.
3. Members have the right to know who is providing services to them.
4. Members have the right to know the services that are available, including an interpreter if they don't speak English.
5. Members have the right to know the rules and regulations about their conduct.
6. Members have the right to be given information about their health.
7. Members have the right to get service from out-of-network providers for emergency services.
8. Members have the right to get family planning services from any participating Medicaid provider without prior authorization.
9. Members have the right to be given information and counseling on the financial resources for their care.
10. Members have the right to know if the provider or facility accepts the assignment rate.
11. Members have the right to receive an estimate of charges for their care.
12. Members have the right to receive a bill and to have the charges explained.
13. Members have the right to be treated regardless of race, national origin, religion, handicap or source of payment
14. Members have the right to be treated in an emergency.
15. Members have the right to know if medical treatment is for purposes of experimental research and to give their consent or refusal to participate in such research.
16. Members have the right to file a grievance if they think your rights have been violated.
17. Members have the right to information about our doctors.
18. Members have the right to be treated with respect and with due consideration for their dignity and privacy.
19. Members have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand.
20. Members have the right to participate in decisions regarding their health care, including the right to refuse treatment.
21. Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
22. Members have the right to request and receive a copy of their medical records and request that they be amended or corrected.
23. Members have the right to be provided health care services in accordance with federal and state regulations.
24. Members are free to exercise their rights, and the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat them.
25. Members have the right to make a complaint about the health plan or the care it provides.
26. Members have the right to file a grievance about any matter other than an adverse benefit determination.
27. Members have the right to appeal a decision the health plan makes.
28. Members have the right to make a recommendation regarding the health plan's member rights and responsibilities.

Member responsibilities

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

1. Members should provide accurate and complete information about their health.
2. Members should report unexpected changes in their condition.
3. Members should report that you understand your care and what is expected of them.
4. Members should follow the recommended treatment plan.
5. Members should keep appointments.
6. Members should follow their doctor's instructions.
7. Members should make sure their healthcare bills are paid.
8. Members should follow health care facility rules and regulations.
9. Members should understand their health problems and participate in starting equally agreed-upon treatment goals.

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. 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.

Aetna Better of Florida continues to require notification of admission/prior authorization for all inpatient hospital confinements. This requirement is inclusive of all maternity-related inpatient confinements. Please make sure that ALL inpatient confinements including short stays (1-2 days) have the required authorization or they will be subject to claims denial.

Depression screening (Florida Healthy Kids)

Aetna Better Health of Florida (ABHFL) has adopted nationally accepted evidence-based preventive services guidelines (PSG) from the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention (CDC). We did this to help improve health care. These guidelines are not meant to direct coverage or benefits determinations or treatment decisions.

Screening for depression is recommended in healthy children 12-17 year of age with normal risks. ABHFL has added two new HCPCS codes to report depression screening to comply with the Florida Healthy Kids (FHK) depression screening measurement requirements. Please reference the chart below when billing for routine preventive depressive screening for children 12-17 years old.

HCPCS Codes	Description	Reimbursement
G8431	Screening for depression is documented as being positive and a follow-up plan document is required	$18
G8510	Screening for depression is documented as negative, a follow-up plan is not required	$18

For specific coverage information, members should refer to their plan's evidence of coverage, contact their employer's benefits department or call us at the number on their plan member ID card.

For additional information regarding all of our preventive service guidelines please visit our **preventive services guidelines**.

ProgenyHealth

Supporting your maternity patients between office visits

- **Ongoing monitoring:** We screen members early and often to identify any changes throughout their pregnancy and the postpartum period that might indicate rising risk due to clinical factors, mental health issues or social determinants of health. Our nurse case managers and social workers provide personalized support to women with high and medium risk factors.
- **Care navigation:** ProgenyHealth's specialized team supports your patients by navigating health plan benefits, connecting them with providers or specialists and providing a mobile app for care right at their fingertips.
  - » **Health plan benefits:** Assistance in navigating programs for pregnant individuals that are already covered under their health insurance plan, such as access to mental health resources, coverage for durable medical equipment or helping to find in network providers and specialists.
  - » **Mobile app:** Provides curated articles on pregnancy and postpartum, parenting tips and a checklist of important to-do list items for each trimester.
  - » **NICU case management:** In the event of a NICU admission after birth, ProgenyHealth provides specialized NICU case management focused on care for both the baby and family.
- **Solving for social issues:** ProgenyHealth connects patients to trusted community-based programs that focus on maternal and infant health. We assist patients experiencing food and housing insecurity, support health literacy by offering prenatal and postpartum education and help with any roadblocks families face with access to care.

ProgenyHealth serves a diverse array of women, infants, families and physician teams to drive positive outcomes related to maternal and infant health before, during and after pregnancy.

Recent success story: Marta, 32 years old

Issue: During hurricane disaster outreach, Progeny-Health case managers discovered that Marta and her newborn needed to evacuate but had nowhere to go and had no identification documentation required for a traditional shelter.

Intervention: A ProgenyHealth case manager made numerous calls to local emergency shelters to find one where Marta would not be denied entry based on her lack of identification documentation. The case manager also confirmed that the shelters were medically equipped to help support Marta's newborn baby.

Outcome: Marta confirmed with the ProgenyHealth case manager that she was able to seek emergency shelter to keep her baby and herself safe and was able to return home after the storm.

Referring your patients is simple

- **Review the Program:** Learn more about the ProgenyHealth Maternity Program.
- **Encourage Patient Engagement:** Hand out member flyers, encouraging them to download the app.
- **Submit the Florida Medicaid Pregnancy Notification Form:** Send a completed Florida Medicaid pregnancy notification form via sFax to **1-860-607-8726**.
- Give us a call at **1-855-231-4730** or send an email to **maternity@progenyhealth.com**

Together, we can provide exceptional care and support for expectant mothers throughout their pregnancy and postpartum journey.

Family home health aid services fee schedule

All fee schedules are updated by Aetna Better Health of Florida within **90 days of the state release**.

To ensure that all changes are updated in our systems accordingly, all changes go through the following process:

1. The fee schedule updates are configured in all systems accordingly.
2. Retro claims queries are identified for all claims on file affected by the fee schedule updates.
3. Once all retro claims are identified a project is sent for claims to be reprocessed.
4. All claims payments are revised by the new fee schedule within 90 days.

Family home health aid visit fee schedule updates were processed in November 2024.

For more information, a provider bulletin was distributed by AHCA in October 2024. Click **here** to view the provider bulletin.

Family home health aid services

Code	Modifier 1	Modifier 2	Coverage	Hourly
S9122	SK		Family home health aide visit (up to 8 hours per day)	$45/hour
S9122	SK	TT	Family home health aide visit (up to 8 hours per day) provided to more than one recipient in the same setting*	$45/hour
S9122	SK	UF	Family home health aide visit (up to 8 hours per day) provided by more than one provider in the same setting**	$45/hour
	TT	UF	Family home health aide visit (up to 8 hours per day) provided to more than one recipient by more than one provider in the same setting***	$45/hour
			Any portion of the hour that exceeds 30 minutes may be rounded up to the next hour, but the total may not exceed the daily authorized number of hours. *The provider should bill using the TT modifier on all cases but should reduce their billing for each as indicated in policy for subsequent cases within the same residence. **The home health provider must add a UF modifier to the home health service procedure code to identify that services are being coordinated with another home health provider. ***Per provider	

Diabetic supplies – pharmacy services

On October 2024, a provider notification was sent out via fax blast to all providers advising the all the diabetic supplies changes. Click **here** for details if you missed the notification.

As of 10/1/2024, the Agency for Healthcare Administration (AHCA) requires diabetic supplies to be processed through the pharmacy benefit for FL Medicaid members. This change applies to members who have Medicaid as primary insurance. Duals members and Florida Healthy Kids members are excluded.

Diabetic supplies that are submitted by a provider through DME will be subject of rejection and would need to be resubmitted through a pharmacy.

Transition of diabetic supplies
(from durable medical equipment (DME) benefit to the pharmacy benefit)

- All Aetna Better Health of FL Members with a diabetes diagnosis and a prescription for insulin to treat their diabetes are eligible for items included on the Florida Medicaid preferred product list (PPL).
- All diabetic supplies prescriptions shall be submitted to an enrolled pharmacy provider for dispensation.
- Effective January 1, 2025, members eligible for diabetic supply services may no longer receive their diabetic supplies through the DME benefits. Members are required to fill diabetic supplies at the pharmacy.

Continuity of care (COC)

Aetna Better Health of Florida maintained coverage for existing eligible utilizers through the DME benefit to ensure sufficient transition time is available to prevent disruption of care. The continuity of care timeframe was effective October 1, 2024, through December 31, 2024.

Member collaboration

To keep our members informed and make sure that there is minimal to no interruption in their diabetic supplies, we count on you to assist us in providing the most updated information available to our members. We understand that this is new process and members may have questions regarding the changes and we have got you covered.

> Please review and share the **Diabetic Frequently Asked Questions (FAQs)** document with our members to assist our members understand the new process.

It is imperative that your office is making sure that all diabetic supplies for your members eligible for the services are being transitioned accordingly to receive their diabetes supplies through a pharmacy.

Any new members that qualify to receive diabetic supplies are to be referred through a pharmacy with no exceptions. We understand that this is new process and members may have questions regarding the changes.

Diabetic supply list(s)

We ask that you review the diabetic supply list accordingly as there are separate diabetic supply lists (Medicaid and Florida Healthy Kids) and this change applies only to Medicaid. The preferred product lists for both MMA and FHK can be found on our website under the “Diabetic Supplies” section at Medications we cover | Aetna Medicaid Florida (aetnabetterhealth.com).

Covered diabetic supply products list

Please review the **Covered Diabetic Supply Products List**. Products not listed may still be available but will require prior authorization.

Additional resources

- **AHCA Pharmacy Policy Page**
- **Diabetic Supply Services Page**
- **Florida Medicaid Diabetic Supply Services Coverage Policy**

Availity provider portal

The Availity provider portal gives you the info, tools and resources you need to support the day-to-day needs of your patients and office. **Access the provider portal here**

Availity Essentials is our preferred and trusted source for payer information. If your organization isn't registered with Availity, we strongly recommend that you get started **today by clicking here.**

You can also call Availity for assistance at **1-800-282-4548**.

Live webinars are available for Availity portal users!
Once you're registered, sign in at **Apps.availity.com/availity/web/public.elegant.login**. The Availity Learning Team offers regularly scheduled live webinars on a variety of topics.

Explore the training site to register for a live webinar session, review recording and access additional resources: **Availity Essentials – Live Webinars**

Help is available!
Any issues related to Availity contact them directly via the **Contact-Us button** on the website or by calling one of the phone numbers below depending on your question/inquiry/issue.

Availity Essentials, Essentials Plus or EDI Clearinghouse customers:
If you have an Availity Essentials, Essentials Plus or EDI Clearinghouse account and cannot log in to submit a ticket, call **1-800-282-4548** for support.

Availity Essentials PRO (RCM) customers:
If you have an Availity Essentials Pro account and cannot log in to submit a ticket, call **1-877-927-8000** for support.

Availity helpful links:

- **Availity main page**
- **Availity provider portal**
- **Availity portal registration**
- **Availity get started**
- **Availity log in**

Pharmacy restrictions and preferences, how to access our preferred drug list (PDL) and formularies

You can access our preferred drug list and formularies at **AetnaBetterHealth.com/Florida**. Information on the PDL and formularies can be found under the "For Providers" tab, "Pharmacy" subtab, "Preferred Drug List and Formulary" drop-down.

Direct link. Provides access to the Florida Medicaid preferred drug list (PDL) and the Florida Healthy Kids formulary search tool and formulary document.

Please note, the formulary can change at any time, due to the ever-changing world of medicine.

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

- Medicaid / LTSS Provider Relations: **1-800-441-5501**
- Florida Healthy Kids Provider Relations: **1-844-528-5815**

Quest Analytics/BetterDoctor partnership

We are excited to announce that Aetna Better Health of Florida has partnered with Quest Analytics/ BetterDoctor to assist with ensuring the accuracy of our Medicaid provider directories.

Quest provides a range of tools to ensure that payers have the most up-to-date data in our directories, ensuring patients have clear access to care. Quest Analytics provider data verification and validation solutions make it easy for providers to reduce the amount of time spent administering directory data, allowing more time to focus on providing care for your patients.

Quest is in the process of sending out communications to all providers on next steps to validate and update your practice information. We look forward to your engagement and we appreciate your commitment to our members and their health care needs.

If you have any questions, please call Provider Services at 1-800-441-5501 (TTY: 711).

Contact Us

You can call Provider Engagement with any questions/inquiries regarding enrollment, joining our network/ credentialing, claims, PA and more.

Managed Medical Assistance (MMA)
Call 1-800-441-5501 (TTY: 711), 8 AM to 7 PM, Monday through Friday.

Florida Healthy Kids (FHK)
Call 1-844-528-5815 (TTY: 711), 7:30 AM to 7:30 PM, Monday through Friday.

Long-Term Care
Call 1-844-645-7371 (TTY: 711), 8 AM to 7 PM, Monday through Friday.

Email:
FLProviderEngagement@aetna.com

Mail:
Aetna Better Health of Florida
Attn: Provider Relations
261 N. University Drive
Plantation, FL 33324

Online Form
The contact us form allows you to add the proper/ required information from the start, so you don't have to spend valuable time tracking down the help you need. **Direct link**

As an added benefit, we have ensured that any request or inquiry made through this form is routed to the appropriate department depending on the reason of the inquiry. You can also include up to 5 files with your inquiry if needed.

Inquiry reason – options

- Claims inquiry or disputes
- Grievances and appeals
- Delegated group updates
- New contract request
- Provider enrollment or adds to an existing group
- Provider demographic data update
- Provider terms, leaving/retiring/closing practice
- Status inquiry of previous email submission
- Other

Additional options will be added as we work through this new process!

What happens after I submit a request?

- Once the form is submitted an email confirmation will be generated with all the details about your request.
- Within 48 hours a case number will be assigned.
- Inquiries will be answered as quickly as possible by our support teams.

When should I use this form?

Demographic changes, updates or terms; new provider adds to existing group contracts; terming providers due to office closures, retirement and leaving medical group; large add/change/term files; W-9 submissions.