Aetna Better Health of Florida

June Monthly Claims Training

Nazdar Shwani

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Learning objectives

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

- Discuss Telemedicine Guidelines
- Review Telemedicine Requirements
- Discuss Telemedicine Billing
- Inform Covid-19 Temporary Flexibilities Ending 7/1/2021
- Review Prior Authorization Requirements for J Codes
- Discuss Change Healthcare Web Connect Tool
- Introduce Availity- New Provider Web Portal
- Explain Timely Filling Guidelines
- Inform the importance of EFT/ERA Registration

Telemedicine Guidelines

Telemedicine Guidelines

Who can provide telemedicine?

- ✓ Practitioners, including MDs, DOs, and physician extenders (physician assistants and advanced practice nurses)
- ✓ Clinic providers (county health departments, rural health clinics, and federally qualified health clinics)
- ✓ Behavioral Health providers -Behavioral health providers should contact ABHFL's behavioral health subcontractor, Beacon Health Solutions at (844) 513-4954 for coverage and billing guidelines.

What services can be provided via telemedicine?

Covered medical services include evaluation, diagnostic, and treatment recommendations for services included on the Agency's practitioner fee schedule to the extent telemedicine is designated in the American Medical Association's Current Procedural Terminology (i.e., national coding standards). All service components included in the procedure code must be completed in order to be reimbursed.

ABHFL reimburses services using telemedicine at the same rate detailed on AHCA's practitioner fee schedule or contracted percentage thereof.

Providers must append the GT modifier to the procedure code in the fee-for-service delivery system.

Telemedicine Requirements

Telemedicine Requirements

As a participating Aetna Better Health of Florida provider offering Telemedicine, you must meet the following requirements:

- Ensure the services provided are medically necessary and performed in accordance with the applicable Medicaid service policy. Ensure the patient and parent or guardian, as applicable, are present for the duration of the service provided using telemedicine except when using store and forward modalities.
- Ensure telemedicine is not used if it may result in any reduction to the quality of care or if the service delivered through this modality could adversely impact the recipient.
- Include Documentation regarding the use of telemedicine in the progress notes for each encounter with a recipient. All other documentation requirements for the service must be met as described in the coverage policy.
- Comply with the Health Insurance Portability and Accountability Act (HIPAA) when providing services; all equipment and means of communication transmission must be HIPAA compliant.
- Ensure that the recipient has compatible equipment and the necessary connectivity in order to send and receive uninterrupted video. Telephone or electronic-based contact with a Florida Medicaid recipient without a video component is not permitted.

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Telemedicine Requirements

- Have Fraud, Waste and Abuse Policies and Procedures specific to telemedicine that address:
  - Authentication and authorization of users;
  - Authentication of the origin of the information;
  - The prevention of unauthorized access to the system or information;
  - System security, including the integrity of information that is collected, program integrity and system integrity; and
  - Maintenance of documentation about system and information usage.
- Have available Audio/Video Equipment (real time 2-way audio/video live communication only).
- Ensure equipment and operations comply with technical safeguards in 45 CFR 164.312.
- Provide training to clinical personnel on Telemedicine Requirements.
- Supervision requirements within a provider's scope of practice continue to apply for services provided through telehealth.

Providers are required to sign an attestation indicating all telemedicine requirements have been met.

The Telemedicine Requirements can be found in the provider manual at https://www.aetnabetterhealth.com/florida/providers/provider-manual

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Telemedicine Billing

Telemedicine Billing

ABHFL will reimburse each service once per day per recipient, as medically necessary, at the rates detailed in the table below or the contracted percentage thereof.

Service	Procedure Code	Modifier Required	Medicaid Reimbursement Rate	
			Maximum Fee*	Maximum Facility Fee**
Store-and-forward	G2010	CR	$7.69	$5.66
Telephone Communications - *Existing* Patients	99441	CR	$9.05	$8.05
	99442	CR	$17.65	$16.10
	99443	CR	$25.80	$23.94
Telephone Communications - *New* Patients	99441 CG	CR	$9.05	$8.05
	99442 CG	CR	$17.65	$16.10
	99443 CG	CR	$25.80	$23.94
Remote patient monitoring	99453	CR	$11.77	N/A
	99454	CR	$39.15	N/A
	99091	CR	$37.12	N/A
	99473	CR	$7.02	N/A
	99474	CR	$9.51	$5.44
	99457	CR	$32.36	$19.80
	99458	CR	$26.48	$19.80

On the AHCA practitioner fee schedule, this represents the fee schedule increase rate, which is the base Florida Medicaid rate with a 4% increase included for all ages. **The facility fee is the reimbursement rate for a practitioner performing services in one of the following places of service: outpatient hospital-off campus (19), inpatient hospital (21), outpatient hospital-on campus (22), emergency room hospital (23), or ambulatory surgical center (24), according to Medicare's designation.

Key Reminders

- Place of Service = always use 02
- Modifiers= Use CR for phone only, Use GT for phone and video.
- Claim Service Location (Box 32- CMS 1500 Form)
  - PCPs that have multiple service locations should list the location that the member is assigned to.

Covid-19 Flexibilities

Covid-19 Flexibilities Ending

Reinstatement of Preadmission Screening and Resident Review (PASRR) Requirements:

All required PASRR processes are reinstated effective with any admission on or after July 1, 2021. Retroactively performed screenings or resident reviews must document the reason for the delay in the completion of PASRR requirements. Aetna Better Health of Florida may deny payment based upon the lack of completion of PASRR requirements for new admissions to a nursing facility with an admission date on or after July 1, 2021.

Reinstatement of Interfacility Transfer Prior Authorization Requirements

On July 14, 2020, Aetna Better Health of Florida waived service authorization requirements prior to admission for hospital transfers, including:

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

Prior authorization requirements for the services listed above are reinstated for dates of service on or after July 1, 2021.

This guidance does not apply to prior authorization and service limit flexibilities put in place to appropriately evaluate and treat individuals diagnosed with COVID-19.

Covid-19 Flexibilities Ending

Reinstatement of Prior Authorization and Service Limits for Behavioral Health Services

Aetna Better Health of Florida waived Medicaid prior authorization requirements and service limits (frequency and duration) for behavioral health services (this includes targeted case management services) on May 5, 2020 and on June 12, 2020.

- Prior authorization requirements must be reinstated for dates of services on or after July 15,2021,
- Service limits must be reinstated for dates of service on or after July 1, 2021 .

As prior authorizations and service limits are reinstated, Aetna Better Health of Florida will work closely with providers to ensure continuity of care for medically necessary courses of treatment

Florida Healthy Kids ONLY:

Effective July 1st, 2021, Aetna Better Health of Florida will reinstate all co-payments.

Covid-19 Flexibilities Ending

Ending Provisional Provider Enrollment:

Aetna Better Health of Florida allowed provisional enrollment for in-state and out-of-state providers to address potential workforce shortages on March 18, 2020.

The availability of provisional enrollment ends on July 1, 2021, prohibiting providers from enrolling through that provisional enrollment process effective July 1, 2021.

Providers currently enrolled through the provisional enrollment process have through December 31, 2021, to enroll in Medicaid. Providers who do not complete the enrollment process by that date will be terminated from Florida Medicaid.

Ending Temporary Expansion of LTC Service Providers:

Aetna Better Health of Florida provided the temporary expansion of LTC provider qualifications and temporary modification to services during the state of emergency through on March 20, 2020. Aetna Better Health of Florida will no longer enroll any new LTC service providers under this temporary expansion during the state of emergency effective July 1, 2021.

Reinstating L TC Face-to-Face Case Management Requirements:

Aetna Better Health of Florida waived all face-to-face case management requirements for LTC enrollees, allowing virtual visits or telephonic contact instead during the pandemic on March 12, 2020. Starting October 1, 2021, Aetna Better Health of Florida will reinstate face-to face visits for new enrollees, annual assessments, and for any enrollee experiencing a significant change.

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J Codes Prior Authorization

J Codes and Prior Authorization

Effective July 1st, 2021, Aetna Better Health of Florida (ABHFL) will require prior authorization (PA) for the following codes: J0717, J3380, J0178.

CODE	DESCRIPTION
J0717	Injection, certolizumab pegol, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J3380	Injection, vedolizumab, 1 mg
J0178	Injection, aflibercept, 1 mg

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.

Sign up and get started TODAY!

You will be able to setup a new account in just seconds. Once you have received your new credentials, you may immediately begin checking eligibility.

Claim submission will be available to you within one business day of setting up your account. Be sure to bookmark the new login page: https://physician.connectcenter.changehealthcare.com/#/site/home?payer=214558

Link: https://physician.connectcenter.changehealthcare.com/#/register/step1/PQCGR5mGCwgELkrDndrXQaA6NIakfqyNVLp3Qt-1Q-sI6IP6mLTz8Qf_jaeJUM9-

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.

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Questions? We've got answers.

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

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