Provider newsletter

Winter 2018

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Prior authorization requirements

Florida Medicaid and Healthy Kids Members

This is notification of a change in prior authorization requirements for the following procedures or DME. Effective March 15, 2018, prior authorization will be required. To check the authorization requirements for any service, you can access ProPat through our secure provider portal or directly at **aetnamedicaidportal.com/propat/Default**.

CPT/HCPCS Codes	DESCRIPTION
19328	REMOVAL INTACT MAMMARY IMPLANT
19330	REMOVAL MAMMARY IMPLANT MATERIAL
21243	ARTHRP TMPRMAND JOINT W/PROSTETHIC REPLACEMENT
27416	OSTEOCHRONDRAL AUTHOGRAFT KNEE OPEN MOSAICPLASTY
43631	GSTRCT PRTL DSTL W/GASTRODUODENOSTOMY

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FL-18-02-01

Prior Authorization Requirements

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CPT/HCPCS Codes	DESCRIPTION
43632	GSTRCT PRTL DISTL W/GASTROJEJUNOSTOMY
43633	GSTRCT PRTL DISTL W/ROUX-EN-Y RCNSTJ
43634	GSTRCT PRTL DISTL W/FRMJ INTSTINAL POUCH
69930	COCHLEAR DEVICE IMPLANTATION W/WO MASTOIDECTOMY
95807	SLEEP STD REC VNTJ RESPIR ECG/HRT RATE&O2 ATTN
97112	THER PX 1/GT AREAS EACH 15 MIN NEUROMUSC REEDUCA
99183	PHYS/QHP ATTN&SUPVJ HYPRBARIC OXYGEN TX/SESSION MEDICINE
E0424	STATION COMPRS GASOUS O2 SYS RENT;FLWMTR HUMIDFR
E0425	STATION COMPRS GAS SYS PURCH; FLWMTR HUMIDFR NEB
E0439	STATION LQD O2 SYS RENT; FLWMTR HUMIDFR NEBULIZR
E0440	STATION LQD O2 SYS PURCH;RESRVOR HUMIDFR NEBULZR
E0617	EXTERNAL DEFIB W/INTEGRATED ECG ANALY
E0618	APNEA MONITOR WITHOUT RECORDING FEATURE
E0619	APNEA MONITOR WITH RECORDING FEATURE
E1390	O2 CONC 1 DEL PORT 85PCT /GT 02 CONC AT PRSC FLW RATE
E1391	O2 CONC 2 DEL PORT 85PCT /GT O2 CONC PRSC FLW RATE EA
E1392	PORTABLE OXYGEN CONCENTRATOR RENTAL
E1831	STATIC PROGRESSIVE STRETCH TOE DEVICE
E2101	BLD GLU MONITOR W/INTEGRATED LANCING/BLD SAMPLE
G0177	TRN&ED REL CARE&TX PTS DISABL MENTL HLTH-SESS
K0065	SPOKE PROTECTORS EACH
K0073	CASTER PIN LOCK EACH
K0105	IV HANGER EACH

If you have questions, or require additional information please contact your Provider Relations Representative at **1-800-441-5501** (MMA) or **1-844-528-5815** (FHK). You can also reach us via email FLMedicaidProviderRelations@aetna.com or fax **1-844-235-1340**.

You're invited to attend our free HEDIS webinar series

The goal of the series is to:

- Educate on HEDIS measures
- Explore ways to cut down on the burden of medical record review- maximize administrative data capture.
- Present NCQA HEDIS reporting codes that will effectively capture care
- Discuss HEDIS measures applicable to certain populations
- Open discussion to see how other providers are addressing HEDIS and barriers to care
- Strategies for improvement
- Connect you with a single point of contact at the health plan for HEDIS/ Quality questions

- **February 2018:** HEDIS measures affecting 21 and older males
- **March 2018:** HEDIS measuring affecting 21 and older females
- **April 2018:** HEDIS measures focusing on members with serious and mental illness and chronic conditions
- **May 2018:** Why attend these Webinars and what exactly is a "point of contact" / HEDIS measures affecting 0-11 year olds including EPSDT
- **June 2018:** HEDIS measures affecting 12-21 year old members. A focus on administrative data capture vs medical record review
- **July 2018:** Maternity care / ONAF

Check your inbox for monthly invites and registration information.

Questions?

For HEDIS related questions email Michelle DelaRosa at DelaRosaM1@aetna.com. For non-HEDIS questions email FLMedicaidproviderrelations@aetna.com. Please cascade this information to other staff who may benefit from these free webinars.

Lab services

In order for laboratory and pathology services (e.G., clinical labs, nonclinical labs, pathology, dermatology) to be covered by Aetna Better Health of Florida, the provider must utilize a participating laboratory. Currently Aetna Better Health of Florida is contracted with LabCorp only to provide outpatient lab services to Aetna Better Health of Florida members.

It is imperative that only LabCorp is used for laboratory and pathology services. If laboratory and pathology services are provided by an outside reference lab other than LabCorp, the services will not be covered by Aetna Better Health of Florida, which may cause the member to be billed.

There are some instances where in urgent situations lab work is necessary to make a diagnosis or to treat the member while in the provider's office, and when this situation occurs the provider may bill and receive reimbursement for "Stat Lab" procedures according to the list provided in the Provider Manual available at aetnabetterhealth.com/fl.

If you have questions or require additional information, please contact Provider Relation's Customer Service at **1-800-441-5501**, e-mail FLMedicaidProviderRelations@aetna.com, or fax **1-844-235-1340**.

Healthy behaviors programs

We offer programs to our members who want to stop smoking, lose weight or address any substance use problems. We also offer prenatal and after-delivery programs. We reward members who join and meet certain goals. Members who participate and meet certain goals can earn gift cards. Members are not required to join the Healthy Behaviors program. To learn more about the healthy behaviors program, call us at **1-800-441-5501**.

Advance directives

Advance directives help members be prepared when things happen suddenly. Advance directives are instructions about their medical care if they are not able to make those decisions. Advance directives can also say who makes medical decisions for them when they can't make the decisions for themselves.

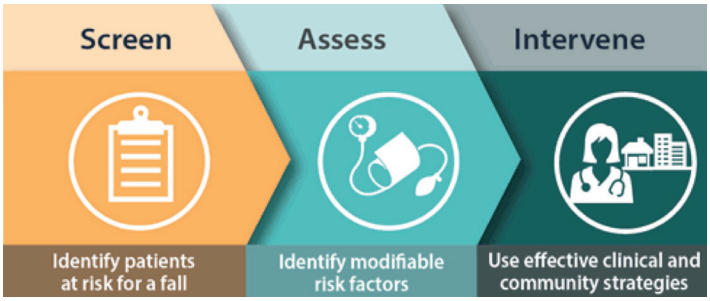
There are two kinds of advance directives:

- A living will is a document that says what medical care they want or don't want. It is used in the event that they are not able to speak for themselves.
- A health care power of attorney is a legal document that says who can make medical decisions for them. It is also used when they are not able to speak for themselves.

Providers must document whether or not a member executed advance directive(s) in a prominent part of the member's medical record. Providers shall certify if a member cannot implement an advance directive on grounds of conscience as permitted by state law.

STEADI - Stopping Elderly Accidents, Deaths & Injuries

STEADI Stopping Elderly Accidents, Deaths & Injuries



Falls are not an inevitable part of aging. As a healthcare provider, you are already aware that falls are a serious threat to the health and well-being of your older patients. You play an important role in caring for older adults, and you can help reduce these devastating injuries. There are specific things that you, as their health care provider, can do to reduce their chances of falling. STEADI's tools and educational materials will help you to:

- Identify patients at low, moderate, and high risk for a fall;
- Identify modifiable risk factors; and
- Offer effective interventions.

3 questions to ask your older adult patients

When you see patients 65 and older, make these three questions a routine part of your exam:

1. Have you fallen in the past year?
2. Do you feel unsteady when standing or walking?
3. Do you worry about falling?

If your patient answers "yes" to any of these key screening questions, they are considered at increased risk of falling. Further assessment is recommended.

For more information about STEADI go to: **www.cdc.gov/steadi/**

Source: Centers for Disease Control and Prevention

Empowerment through our integrated care management programs

Aetna Better Health of Florida offers an evidence-based care management programs to help our members improve their health and access the services they need. Care managers typically are nurses, counselors, or social workers. These professionals create comprehensive care plans that help members meet specific health goals, as well as support psychosocial needs.

Integrated Care Management (ICM)

Members voluntarily agree to enroll in the program. All members are stratified and assigned to a level of care management. The amount of care management a member receives is based upon an individual member's needs. Some of the reasons you may want to ask the health plan to have a case manager contact the member are:

- Does the member frequently use the emergency room instead of visiting your office for ongoing issues?
- Has the member recently had multiple hospitalizations?
- Is the member having difficulty obtaining medical benefits ordered by providers?
- Has the member been diagnosed with diabetes, asthma, or depression, yet does not comply with the recommended treatment regimen?
- Does the member have HIV?
- Is the member pregnant with high-risk conditions?
- Does the member need information on available community services and resources not covered by Medicaid (e.g. energy assistance, SNAP, housing assistance)?

To make referrals for care management consideration, please call Member Services. A care manager will review and respond to your request within 3-7 business days.

Disease management

A component of Integrated Care Management (ICM) that is offered in each service level is assistance with the management of chronic conditions. Our ICM program provides an integrated treatment approach that includes the collaboration and coordination of patient care delivery systems. It focuses on measurably improving clinical outcomes for a particular medical condition. This is accomplished through the use of appropriate clinical resources such as:

- Preventive care
- Treatment guidelines
- Patient education
- Outpatient care

It includes evaluation of the appropriateness of the scope, setting, and level of care in relation to clinical outcomes and cost of a particular condition.

Chronic conditions available to members include:

- Asthma
- Diabetes
- Depression

For our pediatric Medicaid members, we developed disease specific assessments for children with asthma and diabetes. If you have a member who has one of the above listed chronic conditions, you or your staff can make a referral to our ICM Program at any time.

To make a referral, please call Member Services and ask for a care manager.

We provide clinical practice guidelines for asthma, diabetes and depression. You can get a copy of the guidelines through our web portal at **aetnabetterhealth.com/fl**.

Help us stop fraud

We urge you to remember that it is your responsibility as a Medicaid program provider to report suspected fraud and abuse. There are various ways to report suspected or confirmed fraud, waste or abuse:

- Aetna Alert Line: **1-888-891-8910**
- Special Investigation Unit (SIU) Hotline: **1-866-806-7020**
- E-mail the SIU: **FL-FraudandAbuse@Aetna.com**
- Fax the SIU: **1-724-778-6827**
- FL Medicaid Program Integrity Office: **1-888-419-3456**
- AHCA OIG Complaint Form: **apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx**
- FL Attorney General's Office: **1-866-966-7226**
- Florida Medicaid Compliance: **1-954-858-3672**

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (**1-866-866-7226** or **1-850-414-3990**). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General's Office about keeping your identity confidential and protected. Thank you for your continued support!

New policy updates: Clinical payment, coding and policy changes

We take great pride in our network of physicians and related professionals who serve our members with the highest level of quality care and service. We are committed to making sure our providers receive the best possible and latest information, technology and tools available to ensure their success and their ability to provide for clients.

Please review the changes that will take effect beginning January 30, 2018.

- We appreciate your continued service to our members. Contact us:
- E-mail: **FLMedicaidProviderRelations@aetna.com**
- Fax: **1-844-235-1340**
- Speak to a provider relations representative: **1-800-441-5501** (MMA), **1-844-645-7371** (LTC), or **1-844-528-5815** (FHK)

Bundled Facility Payment Policy-Pre-Admission Outpatient Services Treated as Inpatient Services:

According to CMS policy, outpatient services provided on the date of inpatient admission are included in the Inpatient Prospective Payment System (IPPS) payment when provided by the same admitting hospital. This includes all services with the exception of ambulance.

Bundled Facility Payment Policy-Outpatient Services Treated as Inpatient Services:

According to CMS policy, services provided by an outpatient hospital during an inpatient admission are not separately billable as they are included in the inpatient facility payment.

Bundled Services Policy- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Bundled to the Inpatient Admission:

According to CMS policy, Durable Medical equipment/supply items are for use by a member in his or her home. No separate payment will be made to a professional provider for DME items for a member's use in an inpatient institution. The institution is expected to provide all medically necessary DME items during a member's stay.

Evaluation and Management Services Policy-Observation Services:

Observation Discharge- According to the AMA CPT Manual, an observation care discharge code is to be utilized for discharge of a patient when the discharge is on a day other than the initial day of observation status. A qualifying observation care admission code/subsequent observation care code should be reported prior to the observation discharge care date of service.

Initial/Subsequent Observation Services for the Same Date of Service:

According to CMS policy, the initial observation care may only be billed by the physician who ordered the hospital outpatient observation services and was responsible for the patient during his/her observation care. Payment for an initial observation care code is for all the care rendered by the ordering physician on the date the patient is in an observation status and may only be billed once per day.

Additional observation services cannot be reported by the same physician for the same date of service.

In addition, other physicians who may contribute to the care of the patient cannot report observation services for the same date of service. (The care rendered by a physician other than the ordering physician should be reported with the appropriate outpatient E/M codes.)

Evaluation and Management Services Policy- New Patient Visits:

According to the AMA CPT Manual and CMS policy, a new patient is one who has not received any professional services from the physician or another physician of the same specialty and subspecialty who belongs to the same group practice, within the past three years.

Given this definition, if a physician bills a new patient visit and the same physician or a physician from the same group practice with the same specialty and subspecialty has performed any other face-to-face service in the previous three years an established patient E&M should be reported. This includes professional services billed by a certified nurse midwife, clinical nurse specialist, nurse practitioner, or physician assistant as well; if any face-to-face services have been billed in the previous three years by the same Tax ID and any specialty.

Neurology Policy: Ambulatory or 24-hour EEG Monitoring:

According to CMS policy, ambulatory or 24-hour EEG monitoring (95950, 95951, 95953 or 95956) is appropriate for diagnoses such as seizure disorders, meningococcal encephalitis or unspecified coma.

Neurophysiology Evoked Potential (NEP) Studies-Brainstem Auditory Evoked Potentials and Responses (BAEPs/BAERs):

BAEPs/BAERs use an acoustic transducer inside an earphone or headphones to measure the brain wave activity from the ears through the brain stem that occurs in response to clicks or certain tones.

According to CMS policy, brainstem auditory evoked potential and response (BAEP/BAER) testing should be reported with an appropriate diagnosis (for example, evaluation of acoustic neuroma or unilateral tinnitus).

EEG-Frequency Limitations:

According to CMS policy, it would not be expected to see more than three EEG services billed in most circumstances within a one-year period.

EEG In the Evaluation of Headache or Migraine:

According to the American Academy of Neurology, no study has consistently demonstrated that an EEG improves diagnostic accuracy for the headache sufferer. An EEG has not been convincingly shown to identify headache subtypes, nor has it been shown to be an effective screening tool for structural causes of headache. Therefore, EEGs would not be expected to be performed for a diagnosis of headache or migraine.

Polysomnography and Sleep Studies:

According to our policy, which is based on CMS Policy, providers should not submit two separate claims if they perform a split-night service on a single night.

Place of Service Policy- Mutually Exclusive Places of Service:

According to CMS policy, the place of service (POS) code used should indicate the setting in which the patient received a face-to-face encounter or where the technical component of a service was rendered, in the case of an interpretation. However, when a patient is in a registered inpatient status, all services billed by all providers should reflect and acknowledge the patient's inpatient status. When a physician/practitioner/supplier furnishes services to a registered inpatient, payment is made under the Medicare Physician Fee Schedule at the facility rate. A physician/practitioner/supplier furnishing services to a patient who is a registered inpatient shall, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter.

Quick reference guide

Effective July 2017

Health plan main office	Provider & member services phone numbers
1340 Concord Terrace Sunrise, FL 33323	MMA **1-800-441-5501** LTC **1-844-645-7371** FHK **1-844-528-5815**
Hours of operation	**Provider & member services fax numbers**
Monday through Friday 8 a.m. to 7 p.m. EST	Provider services fax: **1-844-235-1340** Member services fax: **1-877-542-6958**
Claims/billing address	**To file a provider appeal**
Aetna Better Health of Florida P.O. Box 63578 Phoenix, AZ 85082-1925	Aetna Better Health of Florida Attn: Medicaid Appeals Coordinator 1340 Concord Terrace Sunrise, FL 33323
Claims payer ID for EDI	**Real time payer ID**
128FL	ABHFL
Claim timely filing – initial & corrected claims	**Claims inquiry / claims research (CICR)**
180 days from date of service or date of discharge	**1-800-441-5501** or **1-844-528-5815**
Fraud & abuse hotline	**Nurse line**
1-888-891-8910	MMA **1-800-441-5501** FHK **1-844-528-5815**
Provider services email address	**CVS mail order phone number**
FLMedicaidProviderRelations@aetna.com	**1-855-271-6603**
Pharmacy helpdesk number	**Web portal**
1-866-693-4445	aetnabetterhealth-florida.aetna.com
Prior authorization phone numbers	**Prior authorization fax numbers**
MMA **1-800-441-5501** LTC **1-844-645-7371** FHK **1-844-528-5815**	MMA, LTC, FHK (general svervices) Fax: **1-860-607-8056** Obstetrics fax: **1-860-607-8726** Pharmacy fax: **1-855-799-2554**
Vendor phone numbers	
eviCore (radiology, pain management, cardio) **1-888-693-3211** HearX Hearing **1-800-731-3277** iCare Vision **1-866-770-8170** MCNA Dental (MMA & LTC only) **1-800-494-6262**	NCH Oncology (MMA only) **1-877-624-8601** Beacon/PsychCare Behavioral Health **1-800-221-5487** Acess2Care (MMA only) **1-866-201-9972** Logisticare Transportation (LTC only) **1-866-799-4463**