Aetna Better Health® of Florida

Long Term Care Provider Training

aetna®

March 28, 2024

Agenda

- Long Term Care General Information
- Electronic Visit Verification (EVV)
- Clinical - CM, CC, UM
- Encounters & ALF Payments
- Home Health & Personal Care Services
- Best Ways To Connect with Us
- Availity Provider Portal
- Electronic Funds Transfers (EFT) & Electronic Remittance advise (ERA)
- Prior Authorization
- Timely Filing Requirements
- Grievance & Appeals
- Provider Manual, Newsletters and Notifications
- Monthly Provider Trainings Information

Long Term Care (LTC)
General Information

What is LTC/LTSS?

LTC = Long-term care LTSS = Long Term Services and Supports

LTC and LTSS are used interchangeably

Comprehensive = member has our MMA (managed medical assistance) and our LTC program

Why comprehensive? One medical plan to coordinate and monitor all services, integrated person-centered approach, minimize multiple handoffs and duplication of services, robust network of providers, better access to care.

LTC provides nursing facility services and home and community-based care to elders and adults (ages 18 yrs and older) with disabilities.

Home and community-based services (HCBS) are designed to delay or prevent nursing facility placement. Services such as meal prep, laundry, housekeeping, bathing, dressing, shopping and supervision are LTC services provided in the home. This includes services provide at assisted living facilities.

LTC pays for services that are provided at the nursing facility if the member lives there full-time.

Department Contacts

UM/Prior Authorization –

Use for Prior Authorization inquires for hospice, skilled services, and DME. Nurses/staff are assigned using the first letter of the member's last name.

UM Manager: Natasha Sealey
SealeyN@cvshealth.com

Service Authorization Team (SAT) – Service Authorization questions

FL_LTC_SAT@aetna.com

Care Management Associates (CMA) – 2515/2506 & enrollee eligibility questions

ABHLTC-CMA@AETNA.com

LTC Director/ Manager/ Supervisors

Director – Kelly Levy levyk@aetna.com

Senior Manager - Franceska Corentin corentinF@aetna.com

Reg 11 Ashley Bishop bishopa23@aetna.com

Reg 11 Ines Gonzalez GonzalezI5@aetna.com

Reg 11 Shameika Wallen wallens@aetna.com

Reg 6 Josephine Estevez EstevezJ1@aetna.com

Reg 6 & 7 Myrlene Warren warrenM3@aetna.com

Reg 7 Brittany Mathis MathisB@aetna.com

Clinical Team Melissa Walmsley WalmsleyM@aetna.com

SAT/CMA Teams Zully Taveras Taverasz@aetna.com

EVV

Electronic Visit Verification

Electronic Visit Verification (EVV)

Aetna Better Health of Florida is currently live with Netsmart for EVV. Netsmart offers EVV provider mobile platform.

Providers (Home Health Care) are required to verify delivery of services using EVV system (i.e., by having caregivers logging visits with EVV app to schedule/track appointments and bill their claims). 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.

If you have any Netsmart EVV system questions or concerns, please contact Netsmart at **1-800-842-1973** or **https://www.ntst.com/support/client-support**

Mobile Caregiver + EVV Support: 1-833-483-5587

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Clinical

Care Management, Case Coordination/UM

Care Management Service Levels/Care Management Colleagues

Intensive

Focus
Complex clinical care coordination
Biopsychosocial approach
Root cause resolution

Characteristics
- Behavioral & Physical Health Co-morbidities
- Higher risk, high cost (includes high risk pregnant members with significant co-occurring disorders)
- Chronic condition management incorporated
- Face-to-face visits offered
- Frequent member and care team contact
- Interdisciplinary care team coordination
- Smaller caseloads

Clinical Care Manager

Registered Nurse or Licensed Behavioral Health Clinician
Unencumbered clinical license in Florida, works with intensive members

Supportive

Focus
Problem and solution focused
Standard care coordination and planning

Characteristics
- Acute and Chronic Condition management
- Routine care coordination
- High risk pregnancies
- State mandated populations (e.g., lead-exposed children)
- Larger caseloads due to less frequent contact and coordination activities

Care Management Coordinator - CMC

Bachelor degree required. Degree / Relevant Experience in: Physical or Behavioral Health, Human Services e.g., psychology, social work, counseling etc. Works with supportive members only

Community Health Workers- CHW

High School/ GED at minimum required. Relevant Experience in: Community Resources, Health Care and Human Services, etc. Field based position

Encounters
&
ALF Payments

Encounters & ALF Payments

ALFs must submit the encounter claims for which capitated payments have been received within 30 days of date of service

- Assisted Living Facilities are paid through a capitation agreement for Aetna members residing in the facilities.
- Members are assigned to the ALF to ensure payments are processed and paid monthly.
- The monthly capitation is run on the 1st Sunday.
- LTSS check are date for the Thursday following the cap run
- Retro Cap Amounts will be reflected on monthly payments (positive or negative balances)

If you do not receive a payment for an Aetna member, please reach out to your assigned Network Consultant for assistance.

Home Health & Personal Care Services

Home Health & Personal Care Services – Billing Guidelines

When billing codes: S5130, S5135, S5170, S9122, or T1019, each date of service must be billed on a separate line. These codes cannot be billed with a date span.

HOME HEALTH & PERSONAL CARE SERVICES

BILLING CODES, FREQUENCY, AND COVERAGE

CODE	TYPE OF SERVICE	FREQUENCY	COVERAGE
S5130	HOMEMAKER SERVICE	PER 15 MINUTES	This procedure code does not allow for span dating
S5135	ADULT COMPANIONCARE	PER 15 MINUTES	This procedure code does not allow for span dating
S5170	HOME DELIVERED MEALS	PER MEAL	This procedure code does not allow for span dating
S9122	HOME HEALTH AIDE OR CERTIFIED NURSE ASSISTANT PROVIDING CARE IN THE HOME	PER HOUR	This procedure code does not allow for span dating
***T1019**	PERSONAL CARE SERVICES	PER 15 MINUTES	This procedure code does not allow for span dating

*T1019 is not for an inpatient or resident of a Hospital, Nursing Facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by Home Health Aide or Certified Nurse Assistant).

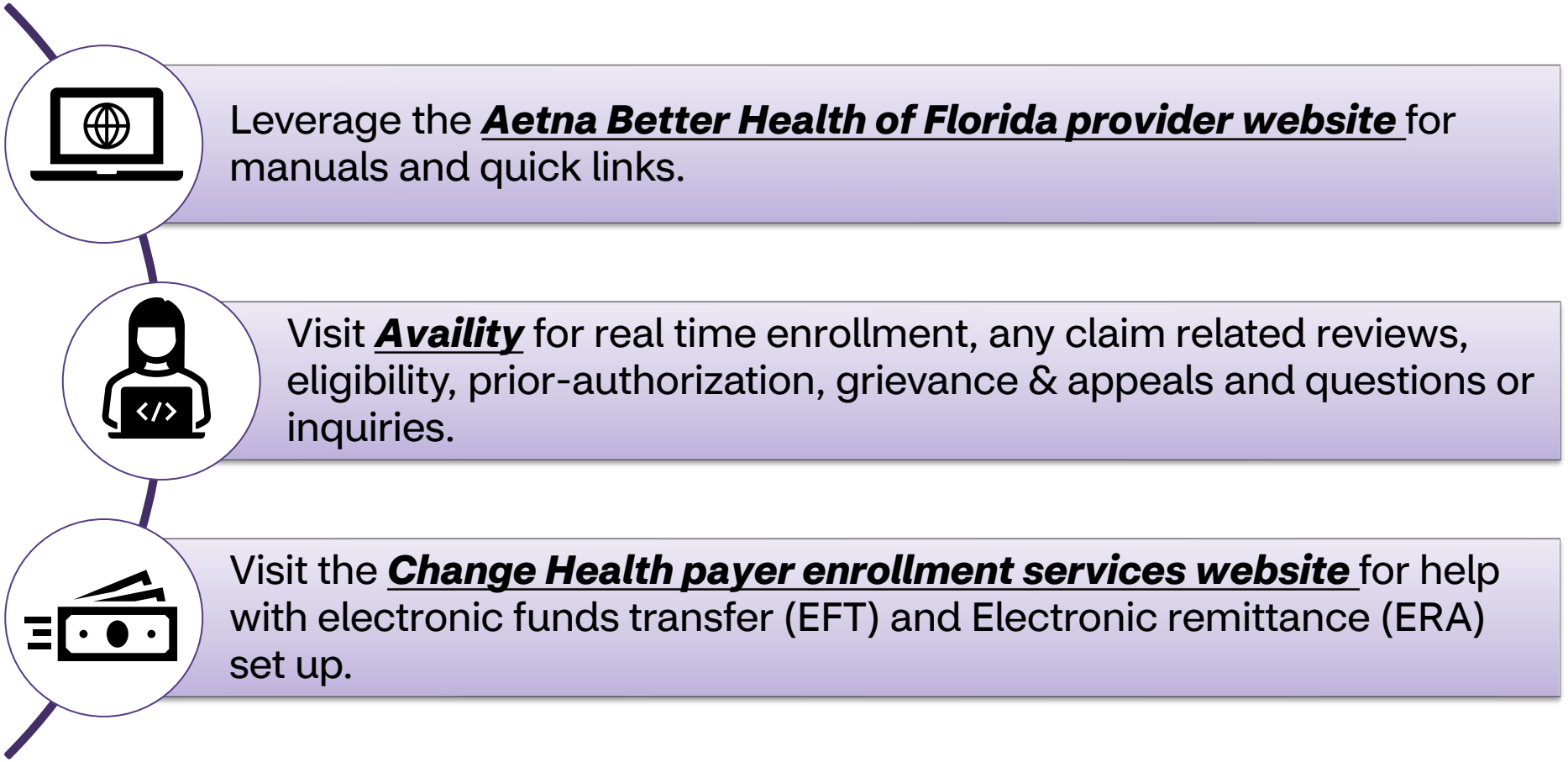
Reminder- Type of Service & Frequency determines the unit count to be billed:

- Per Hour – 1 hour = 1 Unit
- Per 15 Minutes – 1 hour = 4 Units

Best Ways to Connect with Us

Best Ways to Connect with Us

We want to make doing business with Aetna as easy as possible, and that includes getting in touch with us when you need support.

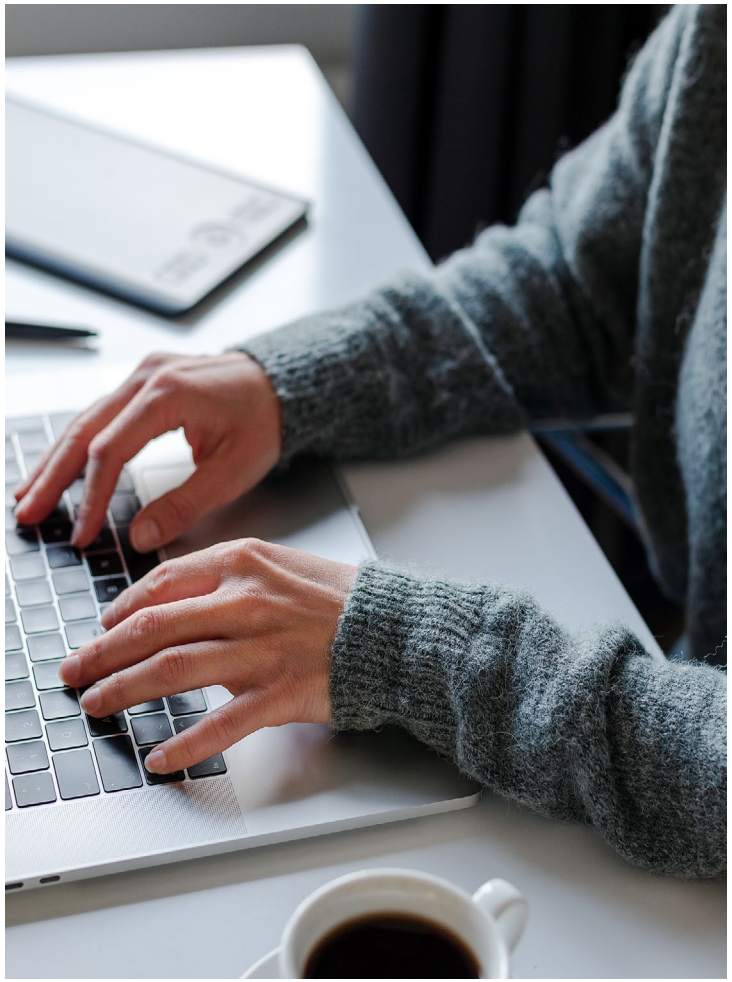


Leverage the ***Aetna Better Health of Florida provider website*** for manuals and quick links.

Visit ***Availity*** for real time enrollment, any claim related reviews, eligibility, prior-authorization, grievance & appeals and questions or inquiries.

Visit the ***Change Health payer enrollment services website*** for help with electronic funds transfer (EFT) and Electronic remittance (ERA) set up.

Best Ways to Connect with Us



Still Need Support?

Use our new provider contact us form to tell us more about your specific request or inquiry.

This form allows you to share the right information from the start, so you don't have to spend valuable time tracking down the help you need.

As an added benefit for us both, we have ensured that any request or inquiry made through this form is routed to the appropriate department.

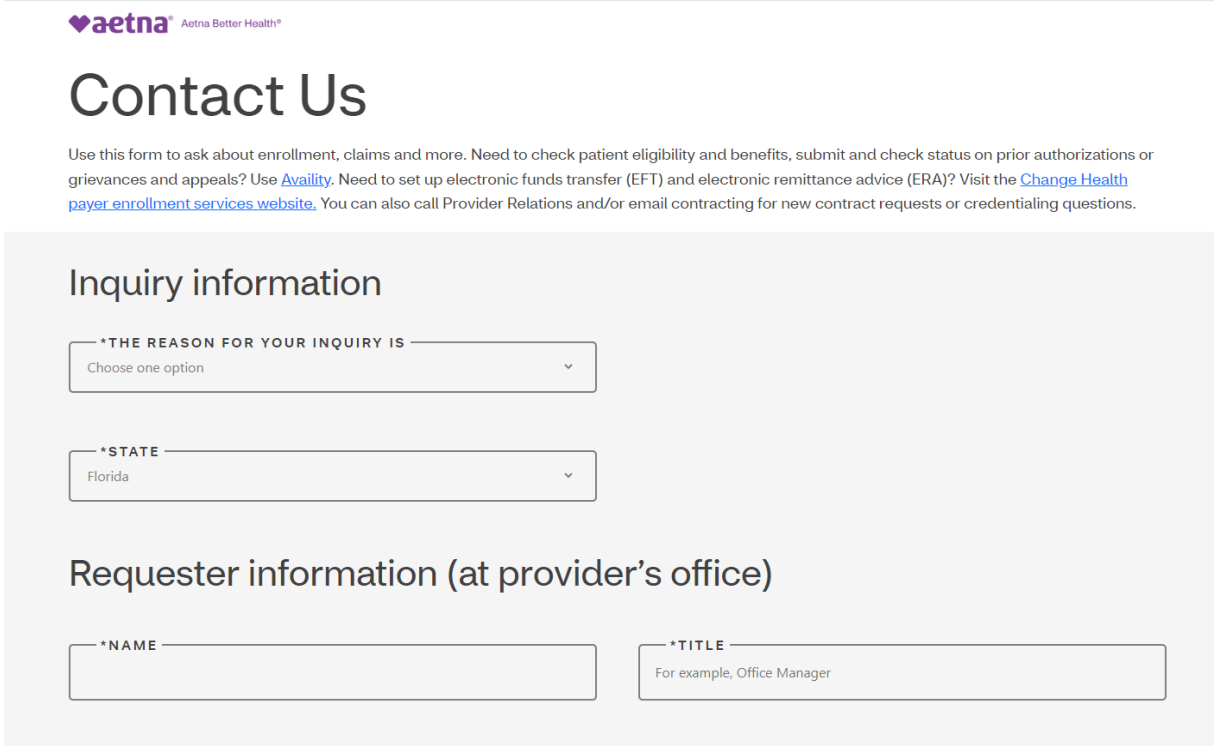
HOW IT WORKS !

To access the form visit "Contact Us" provider web form.

Start by selecting the reason for your inquiry, then share the appropriate contact at your practice, and add essential information like your Tax ID, NPI and more.

You can also include up to 5 files with your inquiry if needed.

Best Ways to Connect with Us


aetna Aetna Better Health®

Contact Us

Use this form to ask about enrollment, claims and more. Need to check patient eligibility and benefits, submit and check status on prior authorizations or grievances and appeals? Use Availity. Need to set up electronic funds transfer (EFT) and electronic remittance advice (ERA)? Visit the Change Health payer enrollment services website. You can also call Provider Relations and/or email contracting for new contract requests or credentialing questions.

Inquiry information

*THE REASON FOR YOUR INQUIRY IS
Choose one option

*STATE
Florida

Requester information (at provider's office)

*NAME

*TITLE
For example, Office Manager

NOTE: Please make sure that you have your provider's office information handy while submitting the request as there are required fields to submit the inquiry/request. (Requestor's name, title, email, phone, provider's name, TIN, NPI)

Contact Us

Inquiry Reason - Options

- ✓ Claims Inquiry or Disputes
- ✓ Grievances & Appeals
- ✓ Delegated Group Updates
- ✓ New Contract Request
- ✓ Provider Enrollment or Adds to an Existing Par Group
- ✓ Provider Demographic Data Update
- ✓ Provider Terms, Leaving Practice, Retiring, Closing Practice
- ✓ Status Inquiry of previous email submission
- ✓ Other

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

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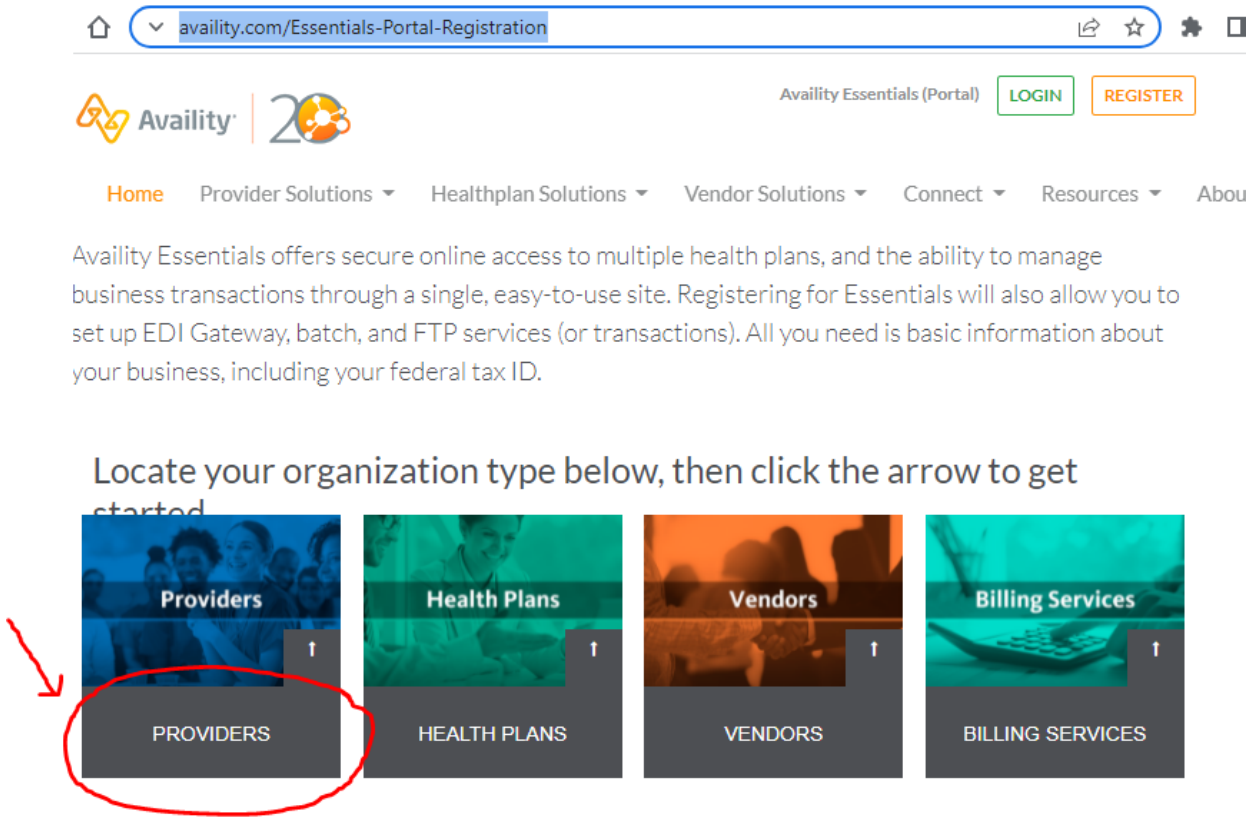
Availity

Availity Provider Portal

- 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 at:
- **https://availity.com/Essentials-Portal-Registration**

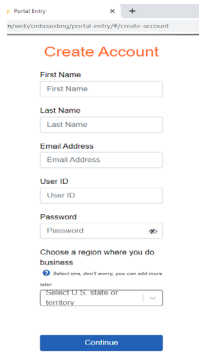
Click on the **Providers** button as indicated below in red to get stated.



Availity Provider Portal

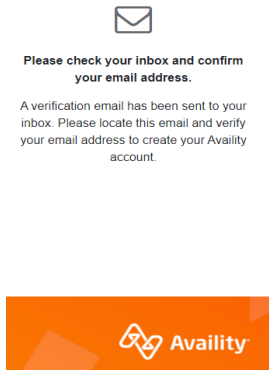
Create Account

- Click here to get started in creating an account
- Fill out all required fields



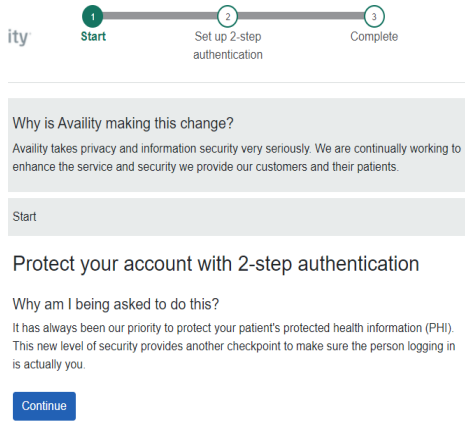
Check your email

- You will receive a verification email.
- Open email and click the link provided to verify the account.



Login

- Now you will need to login using the username/password created.
- Set up your 2-step authentication



Note: For registration, login or technical issues please contact Availity Client Services at 1-800-282-4548

Availity Provider Portal

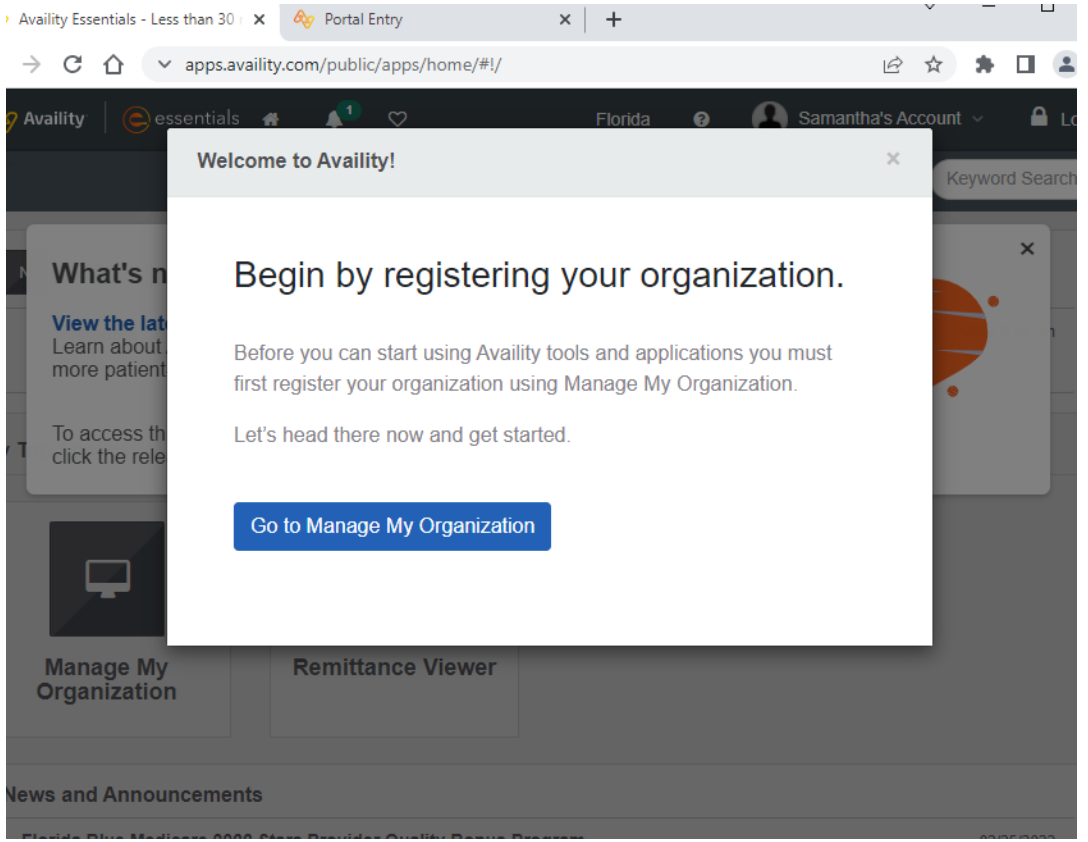
In order to start using Availity tools and applications you must first **register your organization.**

Additional Availity Essentials Resources

The resources below will take you to guides that will visually walk you through the steps needed to complete the registration process.

- Infographic for New Users Who Register with Availity(opens in a new tab)(opens in a new tab)
- Infographic for Availity Essentials Login Process and Your Data Privacy(opens in a new tab)(opens in a new tab)
- Infographic for Availity Essentials Login Process for Primary Admins

Click the button "Go to Manage My Organization" and follow the prompts to complete the process.



Availity Provider Portal

Providers support capabilities offered through Availity include the ability for providers to:

- **Claim Submissions**
- **Claim Status Inquiries**
- **Payer Space**
- **Contact Us Messaging**
- **Appeals & Grievance**
- **Appeals & Grievance Status**
- **Panel Rosters**
- **Specialty Pharmacy Prior Authorization**
- **Prior Authorization Submission**
- **Prior Authorization Status**
- **Eligibility and Benefits**
- **Reports & PDM**

Availity allows providers to directly communicate with Aetna's clinical and administrative staff through the Contact Us application.

Availity Provider Portal

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

Availity & Helpful Links:

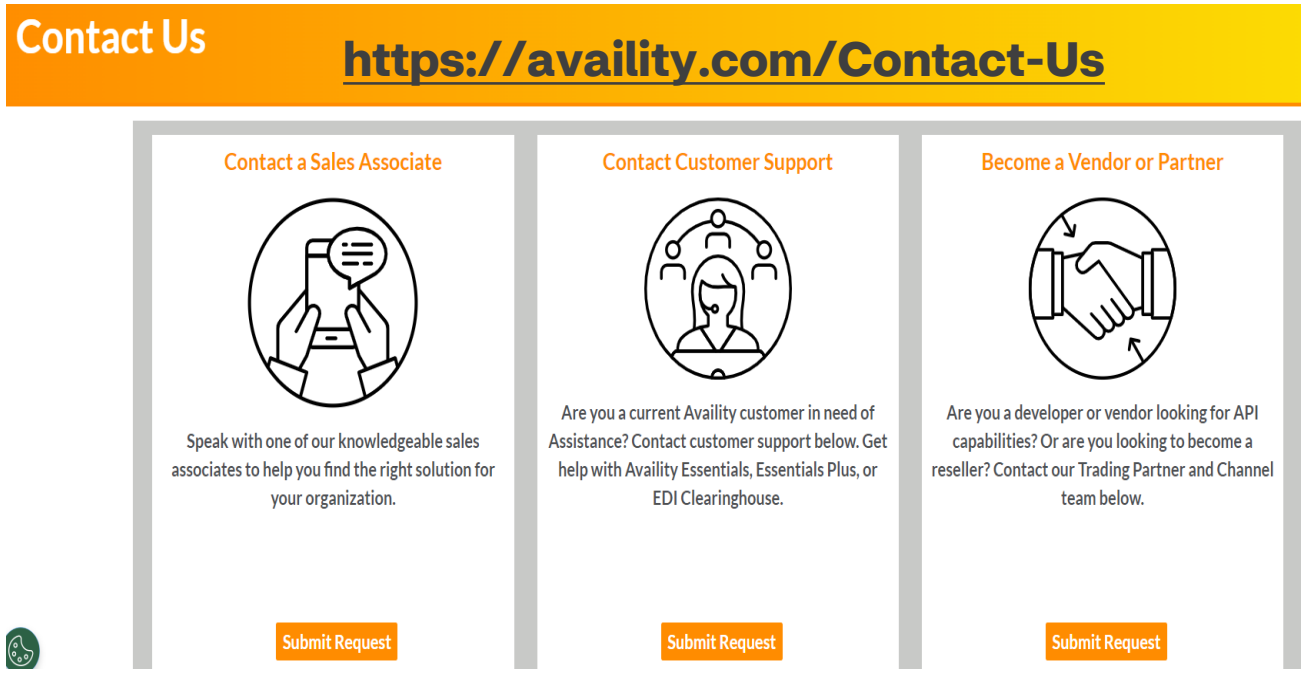
- Availity Main Page
- Availity Provider Portal
- Availity Portal-Registration
- Availity Get Started
- Availity Log In
- Availity Training-and-Education

Availity Provider Portal

Help is available! Any issues related to Availity you can 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.



Electronic Funds Transfers (EFT)
Electronic Remittance Advice (ERA)

Electronic Funds Transfers (EFT)
Electronic Remittance Advice (ERA)

Effective February 1, 2023, all **ABHFL EFT/ERA Registration Services (EERS)** are managed by **Change Healthcare**. EERS gives payees multiple ways to set up EFT and ERA in order to receive transactions from multiple payers.

Electronic funds transfer (EFT)

EFT makes it possible for us to deposit electronic payments directly into your bank account. Some benefits of setting up an EFT include:

- Improved payment consistency
- Fast, accurate and secure transactions

Electronic remittance advice (ERA)

ERA is an electronic file that contains claim payment and remittance info sent to your office. The benefits of an ERA include:

- Reduced manual posting of claim payment info, which saves you time and money, while improving efficiency
- No need for paper Explanation of Benefits (EOB) statements

For more information, visit our ABHFL website provider bulletin distributed on 01/30/2023:

- https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/florida/provider/pdf/abhfl_eft_era_registration_services_eers_provider_communication.pdf

Electronic Funds Transfers (EFT)
Electronic Remittance Advice (ERA)

How to enroll

To enroll in EFT/ERA Registration Services (EERS) visit
Change Health payer enrollment services website

- Create your enrollment by filling out the Provider Information, Contact Information, Bank Information (only if adding EFT enrollment(s)), and Enrollment Information.
- Submit your enrollment(s) and you will receive an email notification confirming submission to Change Healthcare.
- Log in to the Provider Portal to check the status of your enrollment(s).

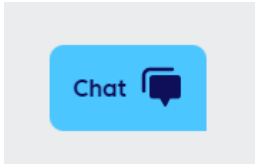
Electronic Funds Transfers (EFT) Electronic Remittance Advice (ERA)

Change Healthcare's Payer Enrollment Services FAQ's

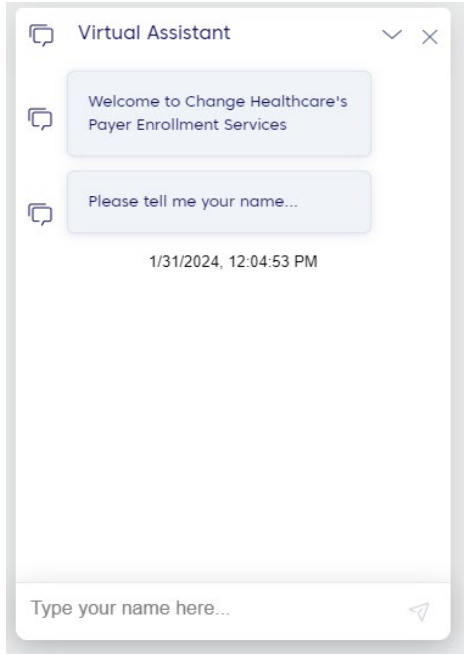
- What is Payer Enrollment Services (PES)?
- How do I log in?
- How do I submit an enrollment?
- How do I check the status of the enrollments that I submitted?
- How do I know when my enrollment(s) were successfully approved by the payer?
- Where can I submit new enrollments?
- How do I withdraw an enrollment?
- Who can I contact for help?
- What do the statuses in Provider Portal mean?
- Which payer(s) can I submit EFT and/or ERA enrollments to using PES?

Support Team

Change Healthcare Support Team can be contacted at 1-800-956-5190 Monday through Friday 8:00AM – 5:00PM CST



Virtual Assistance is also available!



Prior Authorization

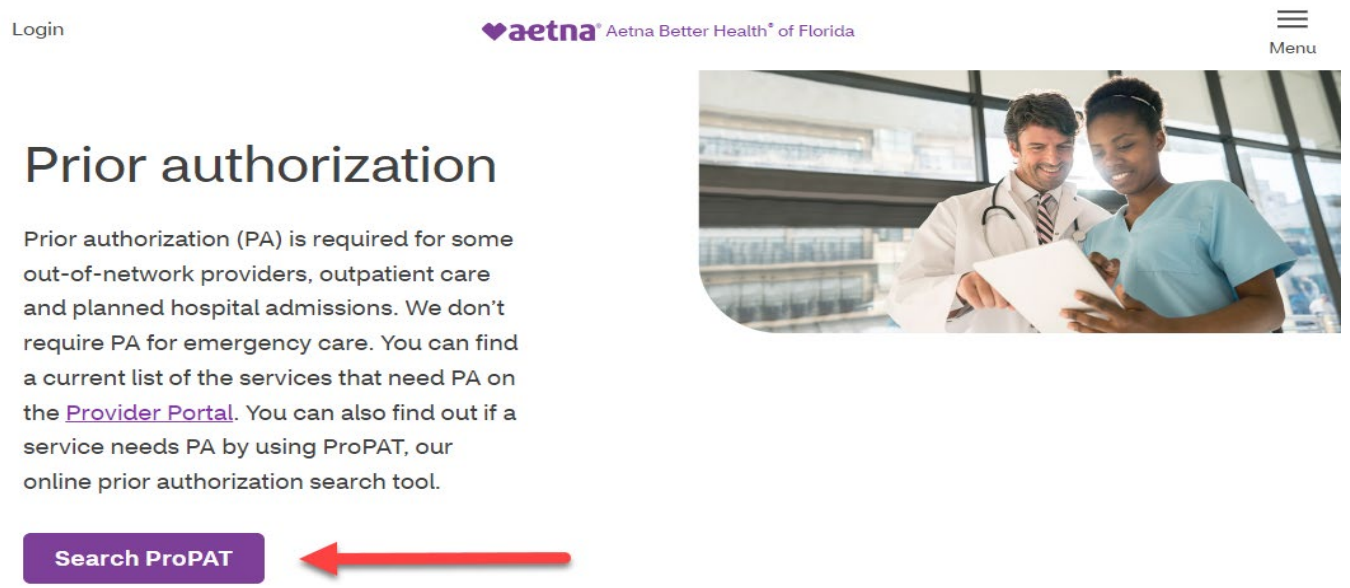
Prior Authorization

Prior authorization (PA) is required for some out-of-network providers, outpatient care and planned hospital admissions.

We don't require PA for emergency care. You can find a current list of the services that need PA on the Provider Portal.

You can also find out if a service needs PA by using ProPAT, our online prior authorization search tool.

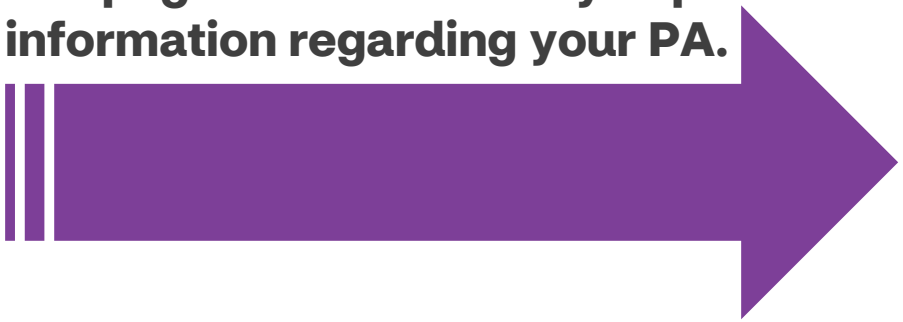
Propat Link: **Search ProPAT**



Prior Authorization

ProPAT is ABHFL Participating Provider Prior Authorization Requirement Search Tool.

We highly recommend that you READ all the exception details that are outlined on this page. It contains very important information regarding your PA.



Participating Providers: To determine if prior authorization (PA) is required, enter up to six Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes or a CPT group and select SEARCH. Search result definitions:

YES - Prior authorization request is required for this service.

NO - Health plan does not require a prior authorization request for this service.

NON-COV - CPT or HCPCS code entered is not a covered benefit by health plan.

INVALID - CPT or HCPCS code entered was invalid, not found.

EXPIRED - CPT or HCPCS code entered is no longer valid for use by health plan providers.

Exception Detail, Svc Partner Detail - When the symbol is displayed for the code, place your cursor over the symbol to review additional information regarding PA submission or service partner requirements.

General Information/Code Search:

- The term Prior Authorization (PA) is the utilization review process used to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage.
- The five character codes included in the Aetna Medicaid PA Requirement Search Tool are obtained from Current Procedural Terminology (CPT), by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five-character identifying codes and modifiers for reporting medical services and procedures performed by physicians.
- Benefit coverage may vary by plan or may be subject to special conditions. For additional information regarding benefit coverage click here or call your provider services representative for Aetna Better Health of Florida at 1-844-645-7371, TTY 711, for Comprehensive, 1-800-441-5501 for Medicaid and 1-844-528-5815 for Florida Healthy Kids.
- PA requirement results are valid as of today's date only. Future changes to CPT or Healthcare Common Procedure Coding System (HCPCS) codes that require PA will be communicated by Aetna Better Health of Florida in writing and on the home page of Aetna Better Health of Florida's secure web portal.

For Aetna Better Health of Florida – Comprehensive

- If you have any questions about authorization requirements or need help with the search tool, please contact Aetna Better Health of Florida – Comprehensive Provider Relations at 1-844-645-7371, TTY 711.
- Emergent and Urgent Care services do not require PA.
- Search results are not a guarantee of claim payment.

For Aetna Better Health of Florida for Medicaid and Florida Healthy Kids

Exception Detail, Svc Partner Detail - When the symbol is displayed for the code, place your cursor over the symbol to review additional information regarding PA submission or service partner requirements.

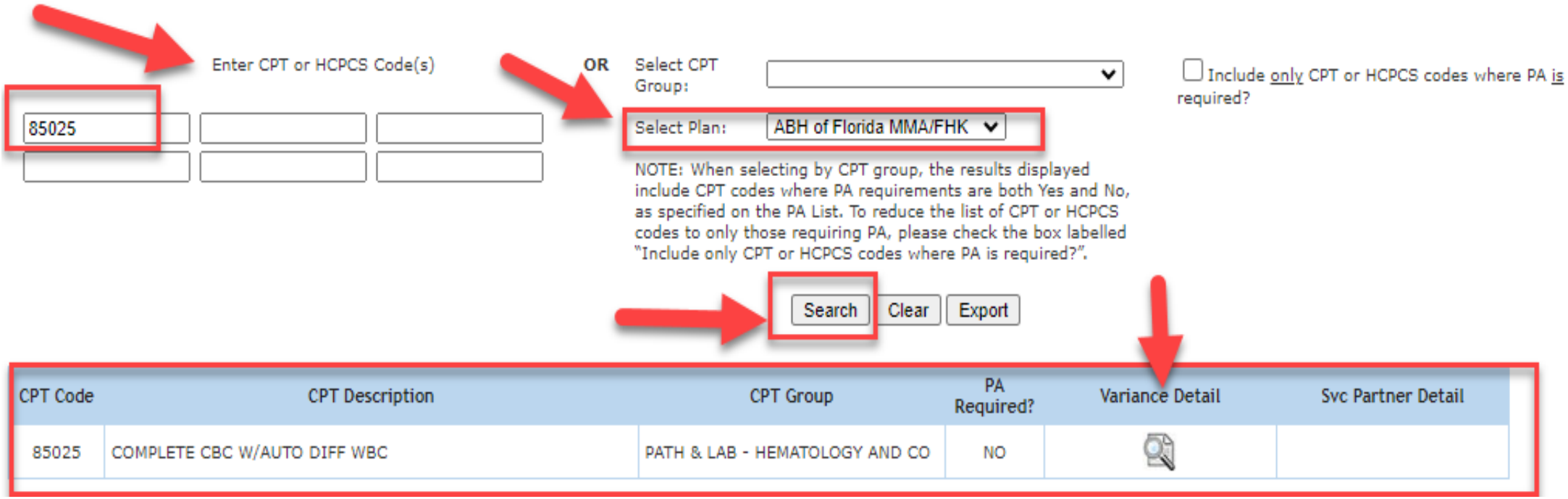
- If you have any questions about authorization requirements or need help with the search tool, contact Aetna Better Health of Florida Provider Relations at 1-800-441-5501 for Medicaid and 1-844-528-5815 for Florida Healthy Kids.
- For Dental benefits and prior authorization, please contact the member's Dental vendor.
- All inpatient hospital confinements require PA.
- Effective 4/1/2020, all Observation Level of Care authorizations will be waived. ABHFL will pay a maximum of 48 hours of Observation.
- Effective 4/1/2022, Outpatient Hospital Services rendered in place of service 19/22 or with Bill Type 130-138 require authorization based on the procedure code billed. Authorization requirements can be found in the code lookup tool.
- Usually ALL services provided by non-participating providers require PA except Professional Component (i.e.: RADIOLOGY, PATHOLOGY, ANESTHESIOLOGY, and LABORATORY) of Facility (hospital) based services, Urgent Care Services, and Emergency Ambulance Service.
- Home health, infusion, and enteral feeding services require prior authorization.
- All wound care requires prior authorization.
- The following DME, Medical Supplies, Prosthetics & Orthotics require authorization:
  - Any item listed on the fee schedule greater than $500 allowable
  - Any item not on the DME fee schedule
  - All DME rentals
  - DME items listed as requiring authorization.
- Transplant services (including evaluation) require prior authorization.
- Hospice services require prior authorization.
- All laboratory services related to genetic testing, regardless of place of service, require prior authorization.
- Search results, as well as authorization, are not a guarantee of claim payment.
- eviCore (formerly MedSolutions) performs Utilization Management services on behalf of Aetna Better Health of Florida for High Tech Imaging and Interventional Pain Management. Please submit your prior authorization request directly to evicore at www.evicore.com or you may call 1-888-693-3211 or fax 1-888-693-3210
- The following ancillary providers perform clinical review services on behalf of Aetna Better Health of Florida. Please contact these providers for clinical review and benefit information:

Prior Authorization

The ProPAT tool allows providers to:

- Enter CPT or HCPCS Code(s)
- Select Plan
- Search if PA is required or not for service(s)
- Review “Variance Detail” tab

*This tab provides additional detailed information related to the code that was searched. (ex: lab or path service to be sent to Quest or Labcorp).



Tips for requesting PA

A request for PA doesn't guarantee payment	We can't reimburse you for unauthorized services. You can make requesting PA easier with these tips: **Register for Availity** if you haven't already. Verify member eligibility before providing services. Based on the type of request, complete and submit the PA request form. Attach supporting documents when you submit the form.
TYPES OF PA REQUEST FORMS	These forms apply to all plans. **Physical health PA request form (PDF)** **Behavioral health PA request form (PDF)** **Obstetrical notification form (PDF)**
MORE HELPFUL RESOURCES	**Prior authorization rules for Medicaid and Florida Healthy Kids (PDF)** **Quick reference guide — vendor list (PDF)**

How to request PA

Online

Ask for PA through our Provider Portal.

Visit the Provider Portal

By phone

Ask for PA by calling us:

- Medicaid Managed Medical Assistance:

  1-800-441-5501 (TTY: 711)

- Florida Healthy Kids:

  1-844-528-5815 (TTY: 711)

By Fax

Download and complete the PA request form based on the type of request. Add any supporting materials for the review. Then, fax it to us.

Fax numbers for PA request forms

- Physical health PA request form fax: 1-860-607-8056
- Behavioral health PA request form fax (Medicaid Managed Medical Assistance): 1-833-365-2474
- Behavioral health PA request form fax (Florida Healthy Kids): 1-833-365-2493

Incorrect Authorizations

RECIEIVING INCORRECT AUTHORIZATION

If you have received an incorrect authorization, such as:

- units
- hours
- CPT code
- Dates of Service

NEXT STEPS:

Please notify us as soon as possible by sending us an email at:

FL_LTC_SAT@Aetna.com

Memory Care Authorizations

If members are moved to Memory Care, the ALF needs to notify the CM immediately.

If CM is not notified timely this will cause rejections & denials for Memory Care ALF services due to services not authorized on the member's plan of care.

Timely Filing Requirements

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 (**see guideline chart on your right).**

For more information visit our **ABHFL Complaints and appeals** page.

Guidelines Chart

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)

Grievance & Appeals

Grievance & Appeals Summary

Provider Appeals = Request to review the denial of or payment on a claim

NOTE: When submitting pre-service requests on behalf of a member you must have written consent. These requests are processed as a member appeals and subject to member appeal timeframes and processes.

Complaints/Grievances = Dissatisfaction with anything else not related to a claim

Interfiling vs. Bundling

Interfiled = submitting multiple unrelated claim denials for appeal in one packet.

Bundling = a submission of multiple claims with the same denial reason as one appeal. For example, code XXXX denies every time you submit a claim, or all claims for Jane Doe are denied.

Claim Resubmissions

Resubmitted claims = claims that are being resubmitted for reprocessing, including but not limited to corrected claims, hard copy claims that were denied due to missing information

Appeals Submissions

If you are submitting an interfiled appeal request (multiple unrelated claims) in one mailing you must use physical barriers (elastic, paper clip, binder clip, blank sheet of colored paper etc.) for each claim in the submission.

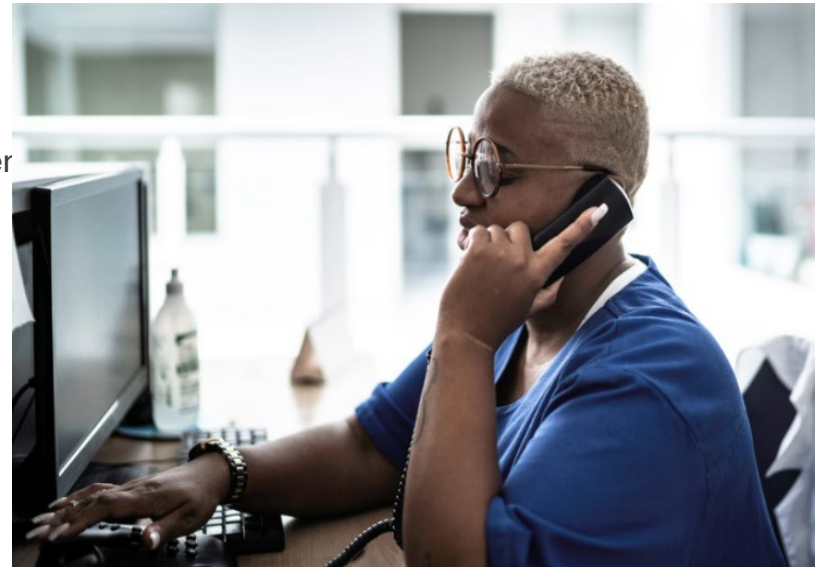
Appeals, Complaints and Grievances

1. **ELECTRONIC:** Whenever possible please submit your appeal, complaint or grievance electronically.
   - ➢ It is preferred that you submit through the Availity provider portal using the direct application for Appeals, Complaints and Grievances: **Availity Provider Portal**
   - ➢ You may submit by fax to **1-860-607-7894**

2. **TELEPHONE:** You can also call us with your complaint or appeal:
   - Medicaid Managed Medical Assistance: 1-800-441-5501 (TTY: 711)
   - Long-Term Care: 1-844-645-7371 (TTY: 711)
   - Florida Healthy Kids: 1-844-528-5815 (TTY: 711)

3. **MAIL:** If you prefer to mail hard copy requests for an appeal, complaint or grievance, they must be ser

Aetna Better Health of Florida
PO Box 81040
5801 Postal Road
Cleveland, OH 44181



Complaints/Grievances may be submitted at any time.

Medical necessity claim appeals must be submitted within sixty (60) calendar days from the claim denial or the resubmission denial

Provider Manual
Newsletters and Notifications

Provider Manual and Newsletters

ABHFL regularly updates and uploads Provider Bulletins, Provider Manual and Provider Newsletters on our ABHFL website for easy access.

To stay informed with the most updated information please visit our ABHFL under the provider tab: ABHFL Provider Page

Provider Manual (s)

- Florida Healthy Kids Provider Manual
- Medicaid and Comprehensive Long Term Care Provider Manual

Newsletters

- Provider newsletter - Winter 2024
- Coming soon (May 2024)

Provider newsletter

Winter 2024

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

(continued on next page)

In this issue

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Note: Provider Newsletters are issued 2 times a year. (Summer & Winter).

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Provider Notifications (Fax blasts)

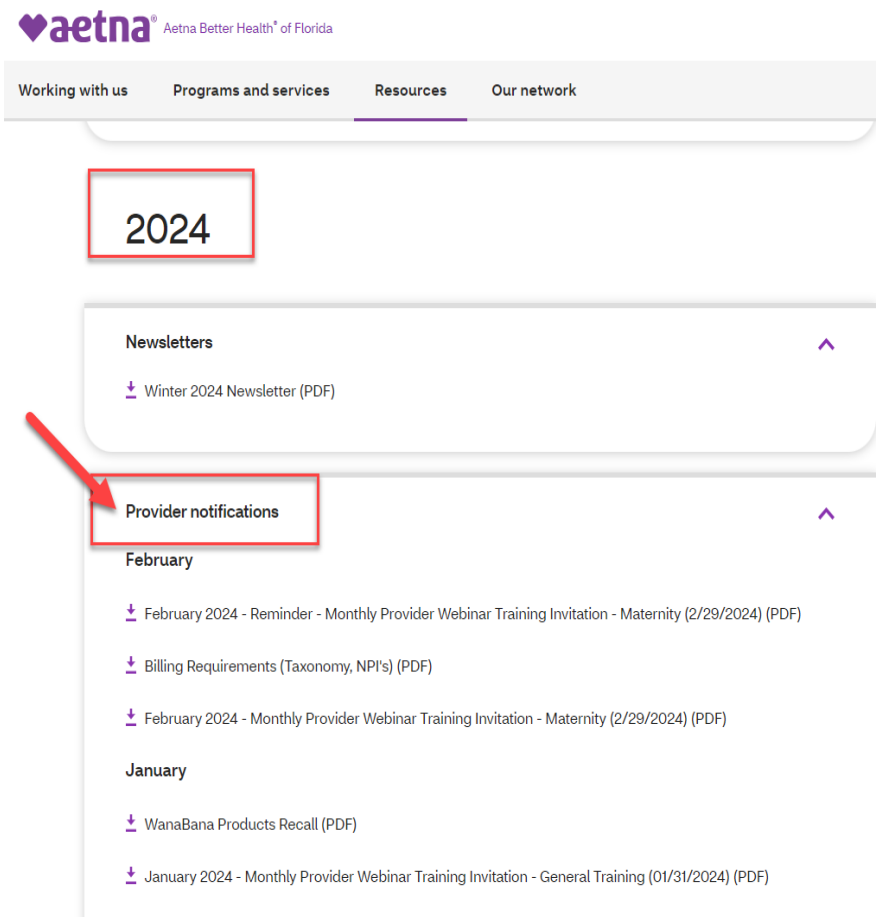
To stay informed with the most updated information please visit our ABHFL under the provider tab: ABHFL Provider Page

January 2024

- WanaBana Products Recall (PDF)
- January 2024 - Monthly Provider Webinar Training Invitation - General Training (01/31/2024) (PDF)
- Best Ways to Connect with Us (PDF)
- ProgenyHealth's Maternity Case Management Program (PDF)
- Durable Medicaid Equipment (DME) and Medical Supply Services Coverage Policies Update - Effective 01/10/2024 (PDF)

February 2024

- February 2024 - Reminder - Monthly Provider Webinar Training Invitation - Maternity (2/29/2024) (PDF)
- Billing Requirements (Taxonomy, NPI's) (PDF)
- February 2024 - Monthly Provider Webinar Training Invitation - Maternity (2/29/2024) (PDF)



Monthly Provider Trainings

Monthly Provider Trainings

Monthly Provider Training Invitations are sent to providers via fax and via email. We also upload the invitation on our ABHFL website for your convenience.

It is important that we have your most updated fax and email information on file in order for you to receive Monthly Provider Trainings and all of our communications timely.

Need to update your information?

1. Contact our provider relations department via email **FLProviderEngagement@aetna.com**
2. Complete the ABHFL Provider Data Change Form : **https://www.surveymonkey.com/r/AETPDCF**
3. Call us!
   - MMA: 1-800-441-5501 TTY (711)
   - LTC: 1-844-645-7371 TTY (711)
   - FHK: 1-844-528-5815 TTY (711)

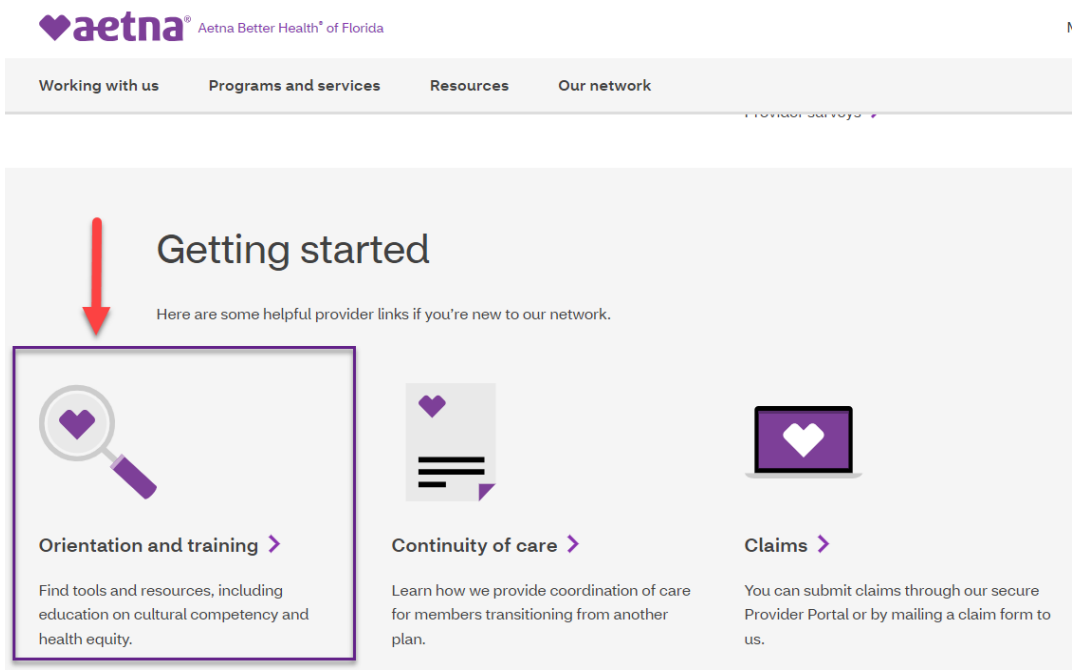
Monthly Provider Trainings

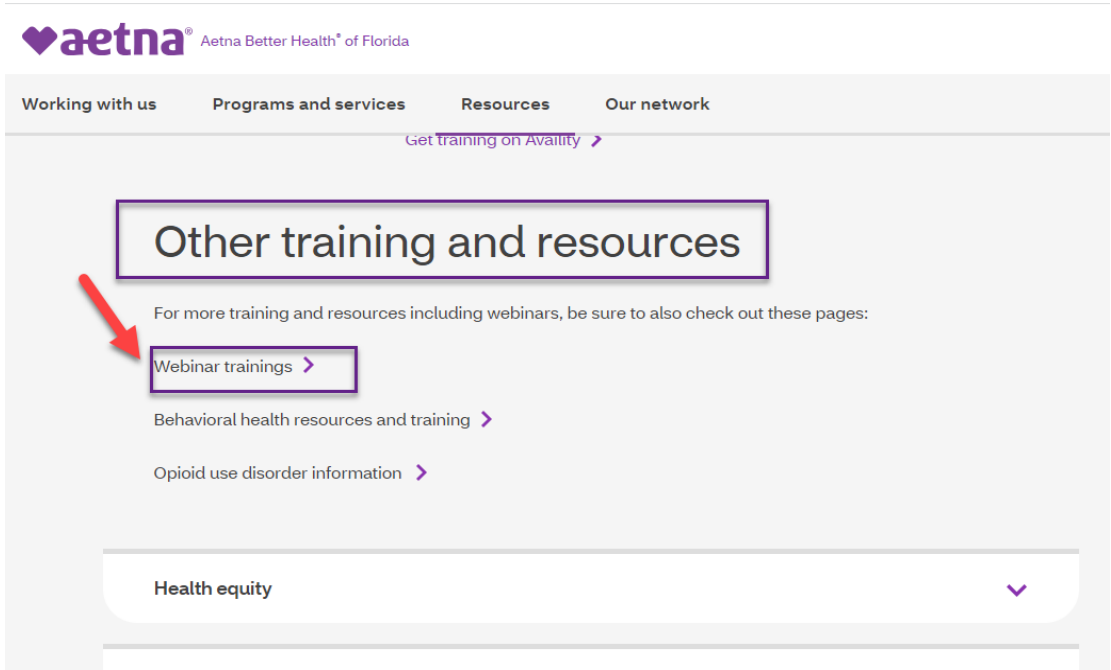
Missed a provider training? No problem!

Our provider trainings are uploaded on our website on a monthly basis.

Visit our ABHFL website under the Provider Site and you will find all of our trainings!

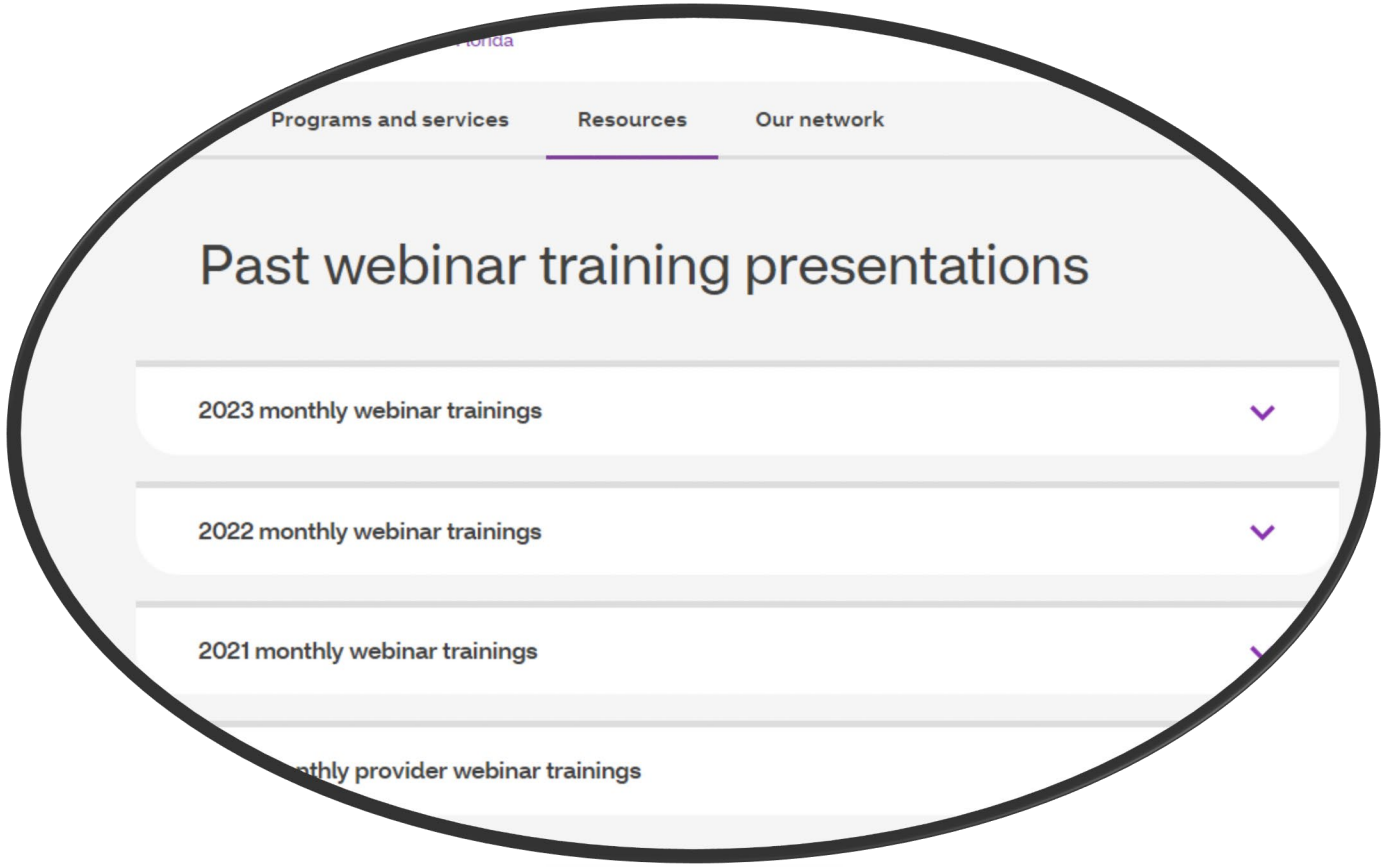
- https://www.aetnabetterhealth.com/florida/providers/materials-forms.html





Monthly Provider Trainings

https://www.aetnabetterhealth.com/florida/providers/webinar-trainings.html

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Questions?

We have answers!

Contact our Provider Services Department

Phone: 1-844-528-5815 (TTY: 711)

Email: FLProviderEngagement@aetna.com

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