Early Intervention Services (EIS)

Provider Training

aetna®

Rev 02.2022

Aetna Way Values Wheel

Leading our industry with our core values and behaviors

The wheel was developed by colleagues representing all levels within Aetna to bring our core values to life.

The values and behaviors are our foundation. They inform and inspire everything we do as we work together to serve each other, our members, and our customers.

Building a healthier world begins with us.

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Early Intervention Services Program

What are Early Intervention Services (EIS)?

Early Intervention Services (EIS) provide for the early detection and treatment of recipients from 0-36 months of age who exhibit developmental delays or related conditions. EIS promotes a parent-coaching model intended to support the child in meeting certain developmental milestones.

Reimbursable services include:

- Screenings to identify the need for more intensive evaluation and assessment activities, if necessary
- Evaluations conducted by a multidisciplinary team to identify the presence of a developmental delay or disability
- Weekly individual or group EIS sessions that include:
  - Family and caregiver support and education
  - Parent training to implement intervention strategies

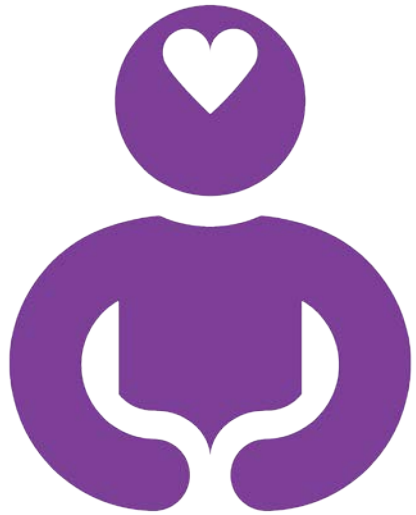
Who can receive EIS?

- Children ages 0-36 months of age enrolled in the Florida Department of Health's (DOH) Early Steps program.
- Anyone can refer a child to the Early Steps program; however, being referred does not necessarily mean that a child is eligible for EIS.
- An eligible member must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in Early Intervention Services Medicaid Policy.
- Provider(s) must verify each recipient's eligibility each time a service is rendered.

What are screenings, evaluations, and Individualized Family Support Plans?

Child undergoes a screening/evaluation determining the child's developmental status in one or more of the following domains:

- Physical: Moving, walking, grasping, and coordination (including hearing and vision)
- Cognitive: Thinking, learning, and problem solving
- Communication: Babbling, languages, speech, and conversation
- Social/Emotional: Playing and interacting with others
- Adaptive environment: Self-help skills (e.g., feeding, toileting, or dressing)



The initial evaluation must be completed within 45 days of a child's referral.

If a child is determined eligible, an Individualized Family Support Plan (IFSP) is created.

Services must be provided within 30 days from the date the family consents to the services listed in the IFSP.

Aetna Better Health's Responsibilities

Screening and Evaluation services

Screening and/or evaluation is an essential part of the process for determining if a child needs EIS.

Aetna Better Health will not require prior authorization or a prescription before a child can access EIS screening and/or evaluation services.

Multidisciplinary Team Meeting

Participation in the multidisciplinary team meetings where the IFSP is developed to facilitate quick and timely authorization of medically necessary services.

Service Delivery Model

Aetna Better Health will ensure that services are provided to the family and child where they live, learn, and play to enable the family to implement developmentally appropriate learning opportunities during every day activities and routines.

Aetna Better Health will work with the DOH Early Steps program to ascertain best practices and evidence-based guidelines that support the delivery of EIS when developing clinical protocols or service authorization criteria.

Service Authorization of EIS

Aetna Better Health of Florida does not require an authorization for the evaluation and management of therapies provided under the Early Steps program by approved providers participating in the program.

Aetna Better Health will accept the IFSP as the authorizing document to authorize therapies in lieu of having the provider go through a separate authorization process.

Please fax the current Individualized Family Support Plan to

1-860-607-8056.

Targeted Case Management /Care Coordination

Children receiving EIS are eligible for targeted case management (TCM) services.

Aetna Better Health is required to cover the TCM services for children receiving EIS using case managers who are certified by the DOH Early Steps program.

Provider Network and Reimbursement

Aetna Better Health will contract with EIS and TCM providers who are certified through the DOH Early Steps program, or its designee.

Single Care Agreements (SCA)

- Aetna Better Health will enter into single case agreements with existing providers to honor continuity of care requirements for any EIS member who was receiving EIS or TCM at the time of transition.
- A single case agreement is a contract between the health plan and an out-of-network provider for a specific service or patient, to ensure services are continued.

EIS and TCM services will be reimbursed at the current Medicaid rate.

Non-participating providers will be reimbursed at the rate they received for services rendered to the member immediately prior to the member transitioning to the plan for a minimum of 30 days.

Continuity of Care (COC)

Ongoing treatment that was authorized prior to the recipient's enrollment into the plan will be honored for up to 60 days after the roll-out date in each region.

Providers should continue providing any services that were previously authorized, regardless of whether the provider is participating in the plan's network.

Providers will be reimbursed at the rate previously received for up to 30 days.

Aetna Better Health will enter into single case agreements with existing providers to honor continuity of care requirements for any EIS member who was receiving EIS or TCM at the time of transition.

Member and Provider Resources

Member Services and Contact Information

- **Member Services can help with:**
  - Eligibility and benefits
  - Assisting members with available programs and resources
  - Assisting members in finding providers
  - Assisting members in filing grievances or appeals
  - Provide general information regarding benefits
  - Request replacement ID cards
- Contact Member Services at **1-800-441-5501.**

Contact Information

Aetna Better Health of Florida - Medicaid

261 N. University Drive

Sunrise, FL 33324

Hours: Monday – Friday, 8 a.m. – 7 p.m. ET

Toll Free Number: 1-800-441-5501

Provider Services Fax: 1-844-235-1340

Prior Authorizations Fax: 1-860-607-8056

Provider Services Email Address:

FLMedicaidProviderRelations@aetna.com

EIS Contact Person:

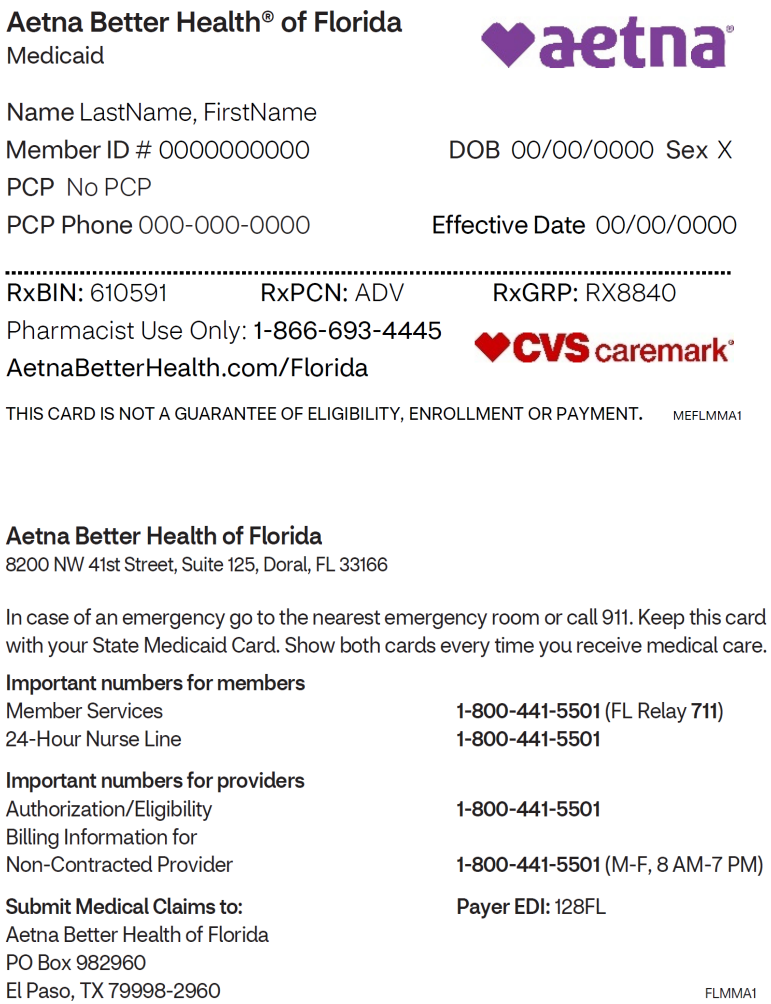
Kimberley Bygrave

Email: BygraveK@aetna.com

Phone: 561-517-7591

Member Identification Card

- The Member ID number on the Aetna Better Health ID card is the member's current Medicaid ID number.
- If the member does not have his/her new ID card, providers can verify enrollment via the Aetna Secure Web Portal at www.aetnabetterhealth.com/florida
- A temporary ID card can be faxed to a provider's office by calling our Member Services department at **1-800-441-5501.**
- Members can request a copy of their ID card anytime from Member Services.



Aetna Better Health® of Florida
Medicaid

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Name LastName, FirstName
Member ID # 0000000000 DOB 00/00/0000 Sex X
PCP No PCP
PCP Phone 000-000-0000 Effective Date 00/00/0000

RxBIN: 610591 RxPCN: ADV RxGRP: RX8840
Pharmacist Use Only: 1-866-693-4445
AetnaBetterHealth.com/Florida

CVS caremark

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEFLMMA1

Aetna Better Health of Florida
8200 NW 41st Street, Suite 125, Doral, FL 33166

In case of an emergency go to the nearest emergency room or call 911. Keep this card with your State Medicaid Card. Show both cards every time you receive medical care.

Important numbers for members
Member Services **1-800-441-5501** (FL Relay **711**)
24-Hour Nurse Line **1-800-441-5501**

Important numbers for providers
Authorization/Eligibility **1-800-441-5501**
Billing Information for
Non-Contracted Provider **1-800-441-5501** (M-F, 8 AM-7 PM)

Submit Medical Claims to: **Payer EDI:** 128FL
Aetna Better Health of Florida
PO Box 982960
El Paso, TX 79998-2960

FLMMA1

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Aetna Better Health of Florida Public Website

Members and providers can access the Aetna Better Health of Florida website at www.aetnabetterhealth.com/florida

Through the website, providers will be able to access:

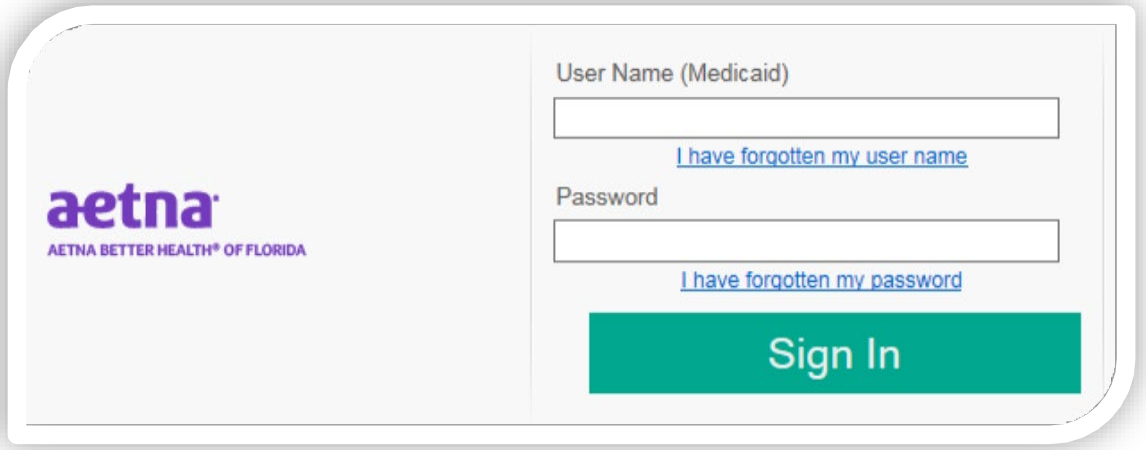
- The secure provider web portal
- Our provider manual, communications and newsletters
- A searchable provider directory
- A Reconsideration form

Provider Secure Web Portal Registration

Providers are encouraged to register for the provider web portal by doing the following:

- Complete the web portal registration form and submit to Provider Relations
- Review the provider web portal navigation guide
- Each TIN will have one account, with a primary administrator.
- The primary representative can add authorized representatives within their office to their account

For help registering or a live demonstration, contact Provider Relations at 1-888-441-5501.

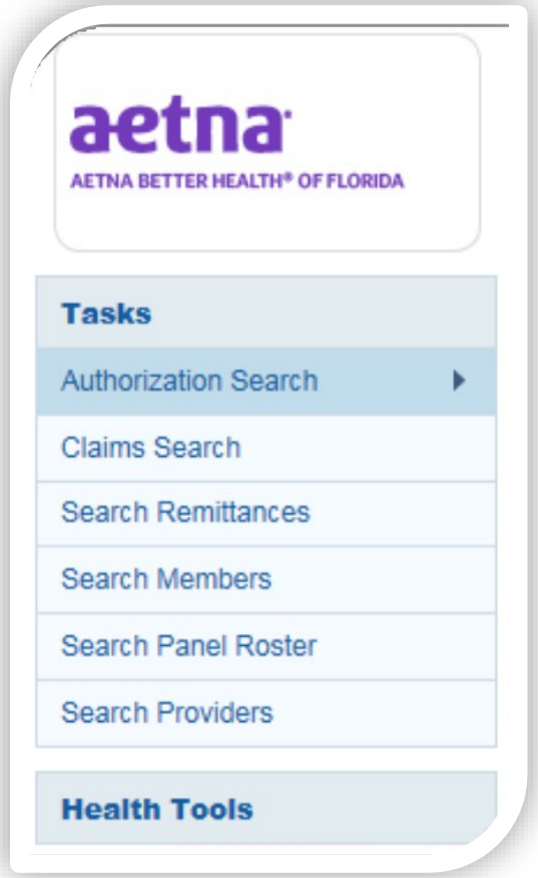


Provider Secure Web Portal

The Secure provider web portal will allow Aetna Better Health of Florida providers to:

- Search member eligibility, verify enrollment and recertification dates
- Search and initiate authorizations
- View claims status, claim detail, explanation of benefits and remittance advice
- View provider lists and panel roster
- Contact the health plan via secure messaging

Providers can access the new provider portal through a link on the public website from www.aetnabetterhealth.com/florida



Provider Secure Portal Demonstration

Electronic Tools – Electronic Remittance Advice

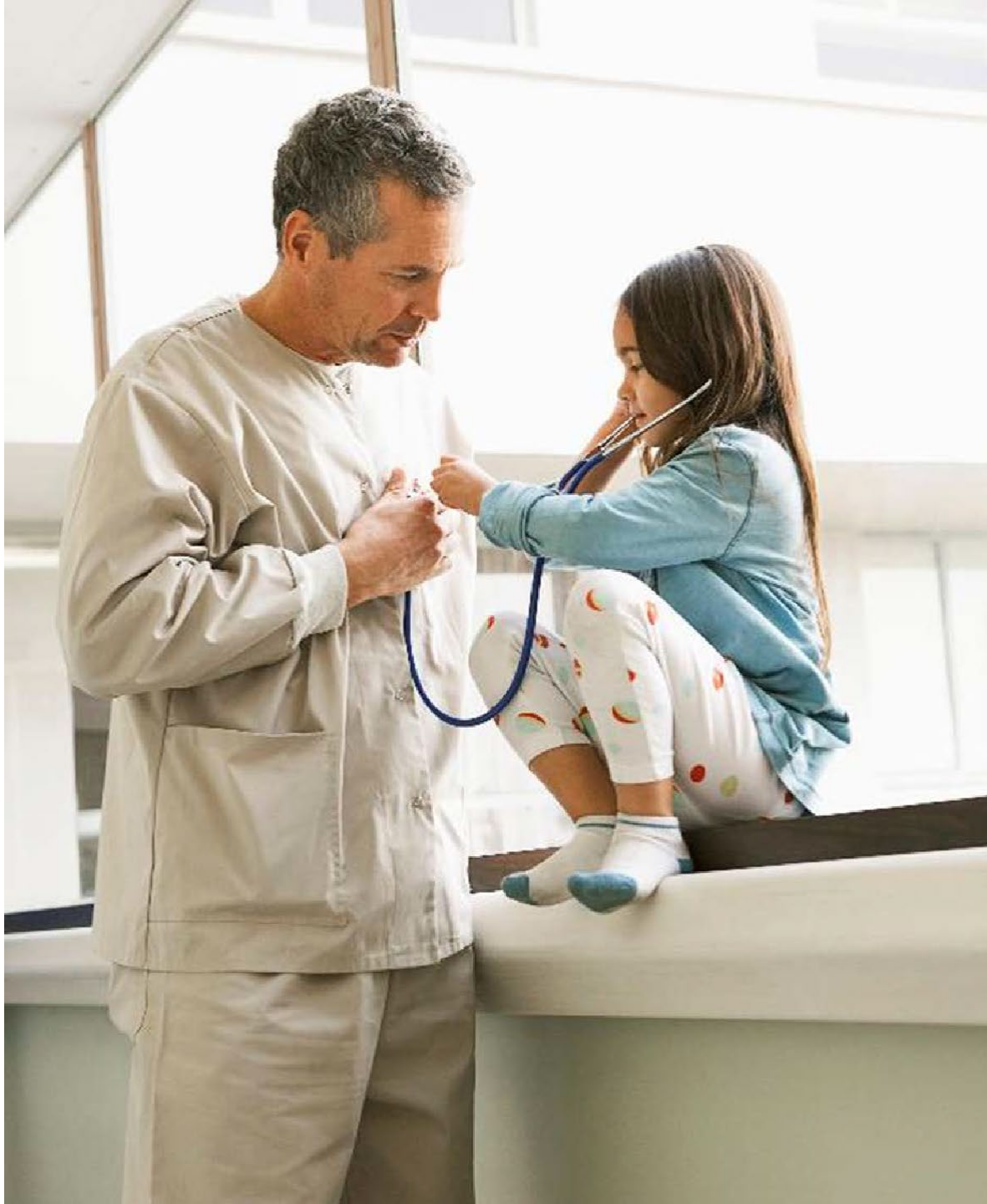
- **Electronic Remittance Advice (ERA)**
  - Electronic remittance advice is an electronic file that contains claim payment and remittance information sent to your office. This is sometimes referred to by its HIPAA transaction number, 835.
- **Benefits of ERA**
  - Reduces manual posting of claims payment information, which saves you time and money, allowing you to more efficiently manage your resources
  - Eliminates the need for paper explanation of benefits (EOBs)
- **How to enroll on ERA:**
  - Fill out the ERA enrollment form and submit them via our secure fax at 1-844-235-1340 or via email to FLFinanceEFTEnrollment@AETNA.com.
  - Allow 10-15 business days for processing once enrollment form is received. We'll send a confirmation letter to your office indicating the process has been completed.

Electronic Tools – Electronic Fund Transfer

- **Electronic Fund Transfer (EFT)**
  - Electronic fund transfer offers electronic payments deposited directly into providers' bank accounts.
- **Benefits EFT**
  - An EFT can improve the consistency of your payments and provide fast, accurate and secure payments directly into your bank account.
- **How to enroll on EFT:**
  - Fill out the EFT enrollment form and submit them via our secure fax at 1-844-235-1340 or via email to FLFinanceEFTEnrollment@AETNA.com.
  - Allow 10-15 business days for processing once enrollment form is received. We'll send a confirmation letter to your office indicating the process has been completed.

Provider Credentialing

- The Aetna Better Health of Florida credentialing process is monitored by the Provider Relations Department
- Contact your EIS contact person to initiate credentialing.
- To check the credentialing status of a provider after 60 business days you may e-mail the Name/Provider NPI# to: FLMedicaidCredentialing@aetna.com



Claims Resources

Clearinghouse and Clean Claims

- Aetna Better Health accepts both paper and electronic claims
- Change Healthcare, formally known as Emdeon, is our preferred clearinghouse for electronic claims
  - EDI claims received directly from Change Healthcare are processed through pre-import edits to:
    - Evaluate data validity
    - Ensure HIPAA compliance
    - Validate member enrollment
    - Facilitate daily upload to Aetna Better Health system

Claim Submission

- All claims should be submitted using the most current claim forms.
- Claims must be legible and suitable for imaging and microfilming for permanent record retention.
- Complete ALL required fields and include additional documentation when necessary.
- The claim form may be returned unprocessed (unaccepted) if illegible or poor quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.

Claims/billing Address
Aetna Better Health of Florida P.O. Box 982960 El Paso, TX 79998-2960
Claims payer ID for EDI
128FL
Real time payer ID
ABHFL

Claims Timely Filing

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)
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)
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)

Claims Resubmissions and Reconsiderations

- Resubmitted claims may be sent electronically or by paper.
  - These should be labeled as "Corrected Claim" on the claim form
  - Submit all claim lines, not just the line being corrected
    - CMS1500: Use the appropriate Resubmission Code 7 and Original Ref. No(claim number being corrected) for corrected claims
- Send paper claims for reconsideration with attached documentation to:

Aetna Better Health of Florida
P.O. Box 982960
El Paso, TX 79998-2960

Claims Inquiry/ Claims Research Team

You must contact our Claims Inquiry/Claims Research (CICR) at **1-888-441-5501** to follow up on the following:

- Assist with claims questions, inquiries and reconsiderations
- Review claims or remittance advices
- Assist with claim related prior authorization questions
- View recent updates
- Locate forms

Provider Complaint System

Provider Complaint System

- The Provider complaint system allows providers to dispute any aspect of Aetna Better Health of Florida's policies, procedures, administrative functions, including proposed actions, claims, billing disputes and prior authorizations.
- Both network and out-of-network Providers may file a formal complaint verbally or in writing directly with Aetna Better Health of Florida in regard to our staff behavior, vendor behavior, policies, procedures or any aspect of our administrative functions including dissatisfaction with the resolution of a dispute that is not requesting review of an action.
- To file a provider complaint please submit it via e-mail FLAppealsandGrievances@AETNA.com or write to:
  Aetna Better Health of Florida
  Attention: Medicaid Appeals and Grievance
  PO Box 81040
  5801 Postal Road
  Cleveland, OH 44181

Non-Claims Related Provider Complaints

- Provider complaints must be filed within 45 calendar days from the date the Provider became aware of the issue (not related to claims) or within 45 calendar days from the dispute resolution.
- To file a provider complaint please submit it via e-mail FLAppealsandGrievances@AETNA.com or write to:

  Aetna Better Health of Florida
  Attention: Medicaid Appeals and Grievance
  PO Box 81040
  5801 Postal Road
  Cleveland, OH 44181

- An acknowledgement letter will be sent within three (3) business days summarizing the complaint.
- Aetna will provide a status update on the complaint every 15 calendar days.
- Provider complaints will be resolved within 90 calendar days of receipt of the complaint and will notify the provider of the resolution within 3 business days of the decision.

Claims Related Provider Complaints

- Providers have 90 days to submit their complaint from the determination (Explanation of Benefit).
- Once the complaint is received, Aetna will do the following:
  - Acknowledge the complaint within 3 business days (verbally or in writing)
  - Provide written notice every 15 days which includes a status update
  - Resolve complaints within 60 days and provide a written notification within 3 days
- There is no second level consideration for cases denied for untimely filing.
- To file a dispute in writing, Providers should write to:

Aetna Better Health of Florida
Attention: Medicaid Appeals and Grievance
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Provider Claim Dispute Timely Filing Guidelines Grid

Claim Type	Guideline
Underpayment/ Overpayment	Providers have 365 calendar days after receipt of the notification (EOB/EOP/ Remit) to submit an underpayment claims dispute or submit additional information or documentation. (F.S. 641.3155)
Claim Denial	Providers have 90 calendar days from the time of a claim denial to file a provider claims dispute or submit additional information or documentation. (SMMC Contract) (Section VIII) (D)(5)(d)(1)
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)

Questions

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