



Aetna Better Health[®] of Florida

Florida Healthy Kids New Provider Orientation

Learning objectives

As part of your Aetna Better Health of Florida's new provider orientation, we will:

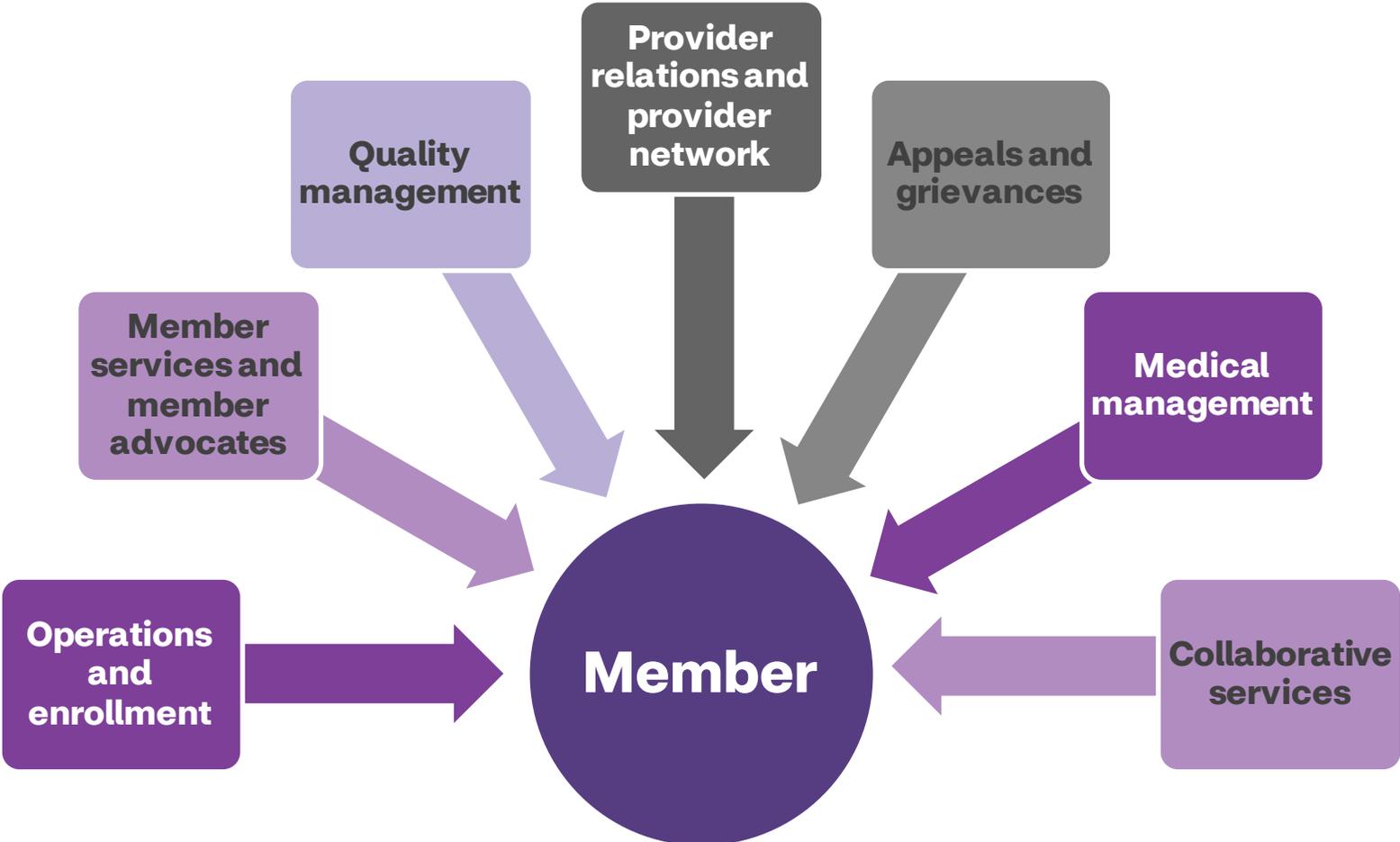
- Discuss the background of the Florida Healthy Kids program
- Review the Aetna Better Health of Florida website
- Explain how to register for our secure provider portal and access our suite of electronic tools and resources
- Explain how to verify patient eligibility and locate plan benefits

We'll also:

- Review how to submit referrals and prior authorizations
- Identify the requirements for submitting clean claims and how to locate claims-related policies
- Discuss Aetna Better Health of Florida's compliance and quality management programs
- Discuss the importance of cultural competence in the health care environment and the role of the provider as a mandated reporter

Introduction

Our members - the center of what we do



Aetna Better Health of Florida website

Providers can access the Aetna Better Health of Florida website at AetnaBetterHealth.com/Florida

There you'll find tools and resources to make doing business with Aetna quick and simple. We've listed a few of the tools and resources found on the For Providers tab below:

- Provider Directory
- Provider Manual
- Notifications and Newsletters
- Authorizations
- Document Library
- Pharmacy
- Practice Guidelines/Screening Tools
- Provider Education
- Secure Provider Portal
- HEDIS



Secure provider portal registration

To register for access to the secure provider portal on Availity, simply follow these four easy steps:

- 1 Select the For Providers tab on the navigation bar at the top of our website.
- 2 Select Provider Portal from the menu on the left side of your screen.
- 3 Scroll to the bottom of the page and select Click here to register and follow the on-screen prompts to complete your registration.
- 4 Once logged into the Availity homepage, go to Payer Spaces on the navigation bar. Select Aetna Better Health from your payer list to access all available transactions and features.

Home	Become A Member	For Members	For Providers	Health & Wellness	About Us
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For Providers
Join Our Network
Provider Manual
Notifications And Newsletters
Authorizations
Document Library
Pharmacy
Practice Guidelines/Screening Tools
Provider Education
Complaints, Grievances And Appeals
Provider Portal
Resources
HEDIS
Compare Health Plan Ratings

Provider Portal

Our enhanced, secure and user-friendly web portal is now available. This HIPAA-compliant portal is available 24 hours a day. And it supports the functions and access to information that you need to take care of your patients. Popular features include:

- *Single sign-on* – One login and password allows you to move smoothly through various systems.
- *Mobile interface* – Enjoy the additional convenience of access through your mobile device.
- *Personalized content and services* – After log-in, you will find a landing page customized for you.
- *Real-time data access* – View updates as soon as they are posted.
- *Better tracking* – Know immediately the status of each claim submission and medical PA request.
- *eReferrals* – Go paperless. Refer patients to registered specialists electronically and communicate securely with the provider.
- *Auto-Auths* – Depending on the auth type and service location, it is possible to receive an auto-approval on your request.
- *Detailed summaries* – Find easy access to details about denied PA requests or claims.
- *Enhanced information* – Analyze, track and improve services and processes.
- *Access to Member Care* – You can connect to your patients and their care teams. You can access:
 - A real-time listing of your patients
 - Information on your practice
 - Email capability with care managers

Visit our [Provider Portal page](#) - [Log in](#)

Effective 1/19/2021 Aetna Better Health will begin using the Availity Provider Portal.

- Provider Portal Benefits as of 1/19/2021 include
 - Payer Spaces
 - CHC Claim Submission Link
 - Contact Us & Messaging
 - Claim Status Inquiry
 - Grievance Submission
 - Appeals Submission
 - Grievance and Appeals Status
 - PDM
 - Ambient (Business Intelligence Reporting)
 - Clear Claim
 - ProPAT
 - Provider Intake
- If you are not registered, we recommend that you do so immediately.
 - [Click here](#) to learn more about Availity Portal Registration
 - [Click here](#) to register 
 - For registration assistance, please call Availity Client Services at 1-800-282-4548 between the hours of 8:00 am and 8:00 pm Eastern, Monday-Friday (excluding holidays)

Secure provider portal tools and resources

Availity Provider Portal Benefits include:

- Payer Spaces
- Claim Submission and Status transactions
- Contact Us & Messaging
- Grievance and Appeals transactions
- PDM
- Ambient (Business Intelligence Reporting)
- Clear Claim
- Prior Authorizations tools
- Provider Intake
- Dynamo (Case Management)

Additional transactions will be rolled out as follows:

- Eligibility and benefits inquiries – 4/29/21
- Enhanced Grievance & Appeals transactions – 7/1/21
- Panel roster – 7/1/21
- View EOB – 7/1/21
- Remittance viewer – 9/30/21

For access to the following features, please continue to use the Aetna Better Health of Florida provider portal until they transition to the secure provider portal on Availity (see roll-out dates displayed above).

- Eligibility & Benefits
- Panel Roster
- Remit PDF
- Provider Portal Registration Form
- Provider Portal Instructions

Provider manual

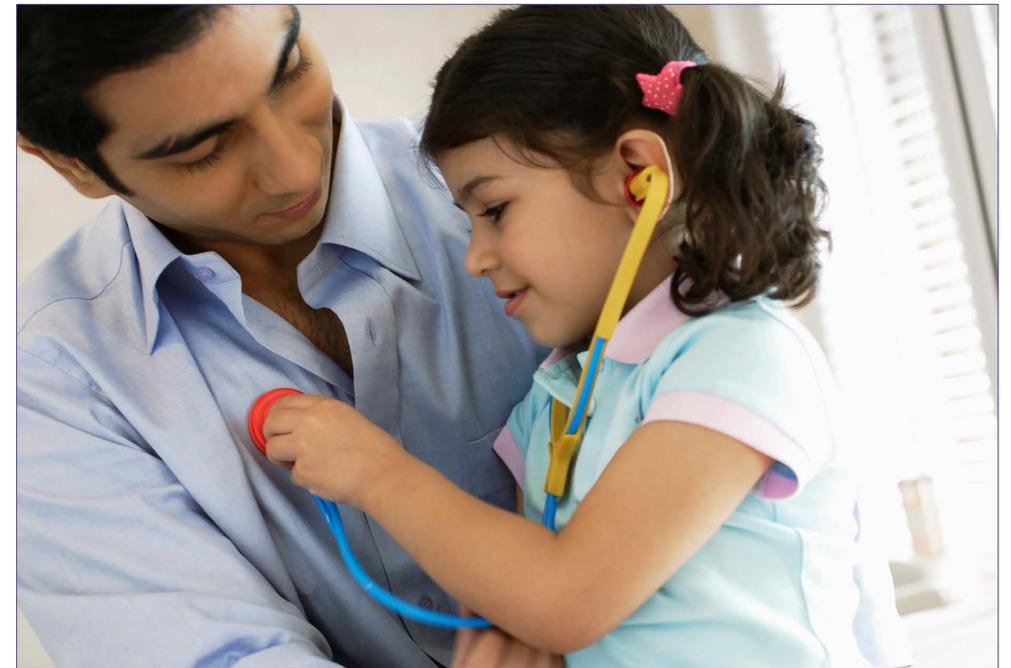
The provider manual contains plan policies, procedures and benefits. You'll also find general reference information such as the minimum standards of care required of Plan providers.

The most current version of the provider manual is available on [AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida).

To request a copy of the provider manual by email or mail, or for general questions, simply contact our Provider Relations Department:

Email: FLMedicaidProviderRelations@Aetna.com

Phone: **1-844-528-5815**



Aetna Better Health® of Florida

Florida Healthy Kids Provider Manual

Provider Relations Department:
1-844-528-5815



[AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida)

Member rights and responsibilities

Understanding members' rights and responsibilities is vital to helping your patients and their families make informed health care decisions. We've provided a few examples below. For the full lists, please refer to the Member Rights and Responsibilities section of the provider manual.

Rights

A member has the right to know who is providing medical services and who is responsible for his or her care.

A member has the right to refuse any treatment, except as otherwise provided by law.

A member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A member has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

Responsibilities

A member is responsible for following the treatment plan recommended by the health care provider.

A member is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A member is responsible for following health care facility rules and regulations affecting member care and conduct.

Translation services

Interpreter services, including sign language for the hearing impaired, are available at no cost to members.

For more information regarding these services, please contact our Member Services Department by calling **1-844-528-5815**.

For members who are hearing impaired, the health plan will utilize the **711** Telecommunications Relay Service (TRS).



Provider education

Aetna Better Health of Florida is committed to offering ongoing training and education to all network providers.

Providers can access all educational content as well as a schedule of upcoming webinars on our website under the Provider Education tab.

There you'll find information on topics such as:

Behavioral Health Trainings	+
Provider Orientations	+
Cultural Competency	+
Health Literacy	+
Project ECHO (Extension for Community Healthcare Outcomes)	+
Prematurity Symposium Presentations	+



Provider credentialing

To learn more about the credentialing process, please refer to the Join our Network tab on our website. There you'll also find a list of our network vendors for specialty services, areas and products. Please contact the designated vendor to inquire about joining the Aetna Better Health of Florida network for one of the listed specialties.

Existing contracted facilities that wish to initiate credentialing of a new provider, please contact our Provider Relations Department by using the Provider Nomination Form found on our website. A valid CAQH number will be required.

Please allow 60 days for your request to be processed. After 60 days, to inquire about the status of your request, please email the provider's name and NPI to **FLMedicaidCredentialing@Aetna.com**.



Florida outreach team

Good communication among our providers and our plan administrators is key to the delivery of quality health care services to our members. To show our commitment to our members and provider community, Aetna Better Health of Florida has assembled an outreach team that is dedicated to:

- Coordinating, facilitating, and participating in Health and Wellness initiatives
- Increasing our knowledge of community resources for members
- Facilitating enrollment events
- Increasing our community visibility and connectivity
- Building collaborative community relationships
- Demonstrating our investment in the communities we serve through volunteerism



Eligibility and benefits



Continuity of care

Aetna Better Health of Florida shall be responsible for coordination of care for new Florida Healthy Kids enrollees transitioning into the Plan.

Providers should continue to provide care during the transition period.

Aetna Better Health of Florida will honor documented authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment.

Providers should bill claims to the health plan to which the Florida Healthy Kids enrollee is assigned for the costs of continuation of such course of treatment by participating or non-participating providers.

Enrollees may continue to receive covered services from participating and non-participating providers beyond the sixty (60) day timeframe under certain circumstances. Please refer to the provider manual for more information regarding our continuity of care policies.

Eligibility and enrollment

Eligibility

To become a member with Aetna Better Health of Florida, a member must first be eligible for the Florida Healthy Kids program.

To be eligible for Florida Healthy Kids, a child must:

- Be between the age of 5 through the end of age 18
- Meet income eligibility requirements
- Be a resident of Florida
- Be a U.S. citizen or lawful U.S. resident

The Florida Healthy Kids program must approve an enrollee's enrollment with Aetna Better Health of Florida.

An enrollee's coverage with us starts on the first day of the month following approval.

Enrollment

For general information about our Florida Healthy Kids Plan, please contact our Member Services Department by calling **1-844-528-5815**.

If your patient already has a Florida Healthy Kids Plan, they can choose or change their Florida Healthy Kids Plan Health Plan by visiting the SMMC website at flmedicaidmanagedcare.com or contact a SMMC Choice Counselor at **1-877-711-3662 (TTY 1-866-467-4970)**.

Verifying eligibility

All participating and nonparticipating providers are encouraged to verify members' eligibility status before they deliver covered services.

The provider is responsible for verifying a member's current enrollment status before providing care.

Providers will not be reimbursed for services to members who are no longer eligible.

Presentation of an Aetna Better Health of Florida ID card is not a guarantee of eligibility.

Eligibility can be verified in the following ways:

- Contact Member Services by calling **1-844-528-5815**
- Access our secure provider portal - **AetnaBetterHealth.com/Florida/providers/provider-portal**

Effective 4/29/2021 all eligibility & benefits transactions will transition to Availity.



Member ID card

Aetna Better Health of Florida issues an identification card for each member.

The member ID card contains the following information:

- Member's name
- Member's ID number
- Member's date of birth
- Member's gender
- Member's effective date
- Claims address

Aetna Better Health® of Florida			
Florida Healthy Kids			
Name	Last Name, First Name	DOB	00/00/0000 Sex X
Member ID #	0000000000		
PCP	Last Name, First Name	Effective Date	00/00/0000
PCP Phone	000-000-0000		
.....			
Copays	PCP: \$X	Spec: \$X	ER: \$X UC: \$X
RxBIN: 610591	RxPCN: ADV	RxGRP: RX8840	
Pharmacist Use Only: 1-866-693-4445			
aetnabetterhealth.com/florida			
THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MERLPHK1			

Summary of benefits

Summary of your benefits	
I. Professional and Outpatient Services	Copayment
A. Office visit(s) to PCP for minor illness or accident care	\$5
B. Well-child care and school-related physicals; visits to PCP or for preventive care, including all immunizations recommended by American Academy of Pediatrics	\$0
C. Routine vision screening (performed by PCP)	\$0
D. Routine hearing screening (performed by PCP)	\$0
E. Specialist office visit(s) (with referral)	\$5
F. Chiropractic services (24 visits per contract year)	\$5
G. Diagnostic testing (lab, x-rays, etc.)	\$0
H. Second medical opinion from a network provider (or outside the network if a doctor cannot be found in the network)	\$0
I. Outpatient behavioral health services and alcohol or substance use disorder treatment services	\$5
II. Inpatient Services	Copayment
Hospital admissions, including surgeries, behavioral health services and alcohol or substance use disorder treatment services. <ul style="list-style-type: none"> Admissions for rehabilitation or rehabilitation or physical therapy are limited to 15 Calendar Days per year 	\$0
III. Maternity	Copayment
Prenatal, delivery, postnatal and newborn care <ul style="list-style-type: none"> Infants are covered up to three (3) Calendar Days following birth 	\$0
V. Emergency Services	Copayment
A. Emergency room visits in a hospital – copayment is waived if admitted or authorized by doctor	\$10
B. Transportation for emergencies	\$10
C. Urgent Care Centers	\$5
VI. Other benefits	Copayment
A. Outpatient physical, occupational, respiratory and speech therapy <ul style="list-style-type: none"> Limited to no more than 24 treatment sessions within 60 Calendar Days of 	\$5

Summary of your benefits	
illness or injury <ul style="list-style-type: none"> 60-day period begins with the first treatment Some therapies require prior authorization from Aetna Better Health 	
B. Home health services <ul style="list-style-type: none"> Home health visits by RN or LPN to provide skilled nursing services on a part time basis only Limited to skilled nursing services only Meals, housekeeping and personal comfort items are excluded Private duty nursing is limited to medically necessary conditions Services must be authorized by Aetna Better Health 	\$5
C. Hospice care	\$5
D. Refraction (Vision testing by Optometrist)	\$5
E. Corrective lenses and frames <ul style="list-style-type: none"> Examination to determine the need for and prescribe eyeglasses Corrective lenses (eyeglasses) and frames are limited to one (1) pair every two (2) years unless your child's head size or prescription changes Coverage is limited to the Aetna Better Health standard frames with plastic or SYL non-tinted lenses 	\$10
F. Durable medical equipment and prosthetic devices	\$0
G. Nursing facility	\$0
H. Pharmacy <ul style="list-style-type: none"> Up to a 31 Calendar Day supply 	\$5

Summary of benefits

Value Added Services

Service	Description	Coverage
Transportation to Specialist	Transportation for a member and a family relative or guardian to a specialist or dentist located between forty (40) and seventy (70) miles away from the member's home when no comparable specialist or dentist is located closer.	Four (4) round trips per year per Member
CVS ExtraCare Card	One (1) CVS ExtraCare Health Card to each member's household by mail upon enrollment. The CVS ExtraCare Health Card provides a twenty percent (20%) discount on CVS brand over-the-counter health-related items available in CVS retail stores or online.	One (1) CVS ExtraCare Health Card per household
After School Engagement	Reimbursement for member's membership fees, up to thirty-five dollars (\$35) per year, for the YMCA, 4-H, Boys & Girls Clubs of America, Boy Scouts of America, Girl Scouts of the United States of America, and other established community organizations, afterschool programs or organized team sport programs.	\$35 per year
Swim Lesson Benefit Program	Insurer shall cover the cost of swimming lessons with drowning prevention practices, up to \$50 per Enrollee lifetime. Reimbursement will be made directly to the Enrollee's YMCA or other certified swimming school or organization.	\$50 per enrollee lifetime
Weight Management Program	Weight management program for children. Program will include the following for qualified participants: <ul style="list-style-type: none"> • A wearable Bluetooth® fitness tracker; • Up to three (3) nutritional counseling visits per year; • Program participation incentives including \$20 gift cards at three (3) months and six (6) months of program participation 	Members will be enrolled in the weight management program through case management
Tobacco/Vaping Cessation Program	Tobacco/vaping cessation program which shall include the up to two (2) \$20 gift cards as incentives. The first \$20 gift card shall be available after three (3) months of case management support and medication. The second \$20 gift card shall be available after an additional three (3) months of continued case management engagement and possible therapy from a behavioral health network Provider and the attending physician who will determine the need for continued medication.	Limited to a six (6) month period

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 Provider Relations 1-844-528-5815 (TTY: 711) • [AetnaBetterHealth.com/Florida](https://www.aetna.com/Florida)

Service	Description	Coverage
Prenatal and Post-partum Incentive Program	One (1) home diaper delivery for members who have completed a minimum of seven (7) prenatal visits (or the number of visits recommended by the American College of Obstetricians and Gynecologists from the date of enrollment) and a post-partum visit between 21 and 56 days after delivery.	One (1) home diaper delivery, limited to two (2) boxes per pregnancy and a maximum value of \$5
Substance Use Program	The first gift card is available after ninety (90) days of sobriety as indicated by: <ul style="list-style-type: none"> • Verification of a minimum of three (3) visits to an intensive outpatient program or group meetings • Case manager verified attendance at psychosocial rehabilitation provided through Beacon Health • Participation in care management for a minimum of ninety (90) days • Negative urine toxicology screen at ninety (90) days The second gift card is available after one hundred eighty (180) days of sobriety as indicated by: <ul style="list-style-type: none"> • Verification of continuous participation in an intensive outpatient program or group meetings with a minimum of one (1) per month • Case manager verified attendance at psychosocial rehabilitation provided through Beacon Health • Participation in care management for a minimum of one hundred eighty (180) days • Negative urine toxicology screen at one hundred eighty (180) days 	Limited to a six (6) month period; limited to a \$40 total value
Expanded Asthma Program	The following additional benefits for members with an asthma diagnosis will be provided: <ul style="list-style-type: none"> • \$60 lifetime benefit to purchase hypoallergenic bedding • An additional peak flow meter and spacer 	One-time benefit
Health Risk Assessment Incentive	A fifteen-dollar (\$15) gift card will be provided to members that complete an HRA and a well-child visit within the first ninety (90) Calendar Days of enrollment. If a member does not require a well-child visit within the first ninety (90) Calendar Days of enrollment because of a recent well-child visit, the previous visit satisfies the well-child visit requirement.	One-time benefit

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 Provider Relations 1-844-528-5815 (TTY: 711) • [AetnaBetterHealth.com/Florida](https://www.aetna.com/Florida)

Immunizations

PCPs must provide all covered immunizations to members.

PCPs need to be enrolled in SHOTS, Florida's State Health Online Tracking System, and keep the member's immunization records updated.

Immunizations may be administered at locations other than a PCP's office as long as the treating provider submits the information to SHOTS or notifies the member's PCP of the immunization administration.

Providers should follow the CDC's immunization schedules found on **[cdc.gov](https://www.cdc.gov)**.

Aetna Better Health of Florida will reimburse providers for all vaccines not covered by Vaccines for Children at 100% of the vaccine's wholesale acquisition cost (WAC).



Pharmacy coverage

For the Florida Healthy Kids list of covered drugs, please access our searchable formulary in the Pharmacy section under the For Providers tab of our website.

Medically necessary drugs on this list are generally covered under the plan.

Members can fill their prescriptions at any in-network pharmacy.

Aetna Better Health of Florida's PBM is CVS/Caremark.

For questions regarding prescription coverage or our formulary, please contact Member Services at **1-844-528-5815** or **TTY 711**.



Child health checkup

A child health checkup is a regularly scheduled comprehensive, preventive health screening service for children from age 5 through the end of age 18.

The screening generally includes the following:

- Comprehensive health and developmental history, including assessment of past medical history, developmental history and health status
- Nutritional assessment
- Developmental assessment
- Comprehensive physical examination
- Dental screening, including a dental referral, when required
- Vision screening, including objective testing, when required
- Hearing screening, including objective testing, when required
- Laboratory test, including blood lead testing, when required
- Appropriate immunizations
- Health education and anticipatory guidance
- Diagnosis and treatment
- Referral and follow-up, as appropriate



PCP assignments and changes

Members may choose any primary care physician (PCP) that is participating in the Aetna Better Health of Florida's network. If a member does not choose a PCP, one will be assigned by the Plan.

For PCP change requests, please contact Member Services by calling **1-844-528-5815** Monday through Friday from 7:30 AM to 7:30 PM ET.

PCP change requests received on or before the 15th of the month will be effective immediately. Requests received after the 15th of the month will be effective on the first day of the following month.

PCPs should not cancel appointments or deny care if the member is assigned to an incorrect PCP. If the member has an existing appointment or has presented for care, the PCP is encouraged to contact Member Services to request an immediate provider change.



Timely access standards

Appointment Type	Accessibility Standard
Emergency services	Immediate
Follow-Up Care	As medically appropriate
Routine Care	Within seven (7) calendar days of the enrollee's request for services
Urgent care	Within 24 hours
Well Child Visits (as recommended by the American Academy of Pediatrics)	Within 4 weeks

Prior authorizations and referrals

Hospital authorizations and peer to peer reviews

Hospital authorizations

All hospital admissions and observation stays require authorization.

When a member is admitted, hospitals are required to call Aetna's Healthy Kids authorization number at **1-800-441-5501** within 24 hours of the admission for both scheduled and emergency admissions.

Clinical information should be faxed to **1-844-878-3583**.

Peer to peer requests with the Medical Director

The request for a peer-to-peer review between the treating physician and the Medical Director must be received within two business days of the issuance of the verbal denial independent of the discharge date.

If a concurrent peer-to-peer review request is received more than two business days after the issuance of the verbal denial, the treating physician will be advised to follow the appeal process.

Prior authorizations

Providers can submit electronic prior authorizations for medically necessary services for members age 5 through the end of age of 18 by logging into our secure provider portal on Availity

Please remember that *emergencies do not require prior authorization.*

When submitting authorization requests via Availity, Elective and Urgent are the only applicable options for the Admission Type (level of service) field for Aetna Better Health of Florida. **Providers can attach clinical documentation to electronic authorization requests.**

Turn around times for processing requests are as follows:
Standard – 14 calendar days
Urgent – 72 hours

To check the status of a prior authorization, please login to Availity or contact our Utilization Management Department by calling **1-844-528-5815** (TTY 711) Monday through Friday from 8:00 AM to 7:00 PM ET.

To determine which services require prior authorization, please review our ProPat Auth Lookup Tool on our secure provider portal

Prior authorizations cont.

If you are unable to submit your requests electronically, you can submit your request in the following ways:

- Authorization Department- **1-844-528-5815**
- Fax- **1-860-607-8056**

Providers only need to submit one form for all lines of business. The Prior Authorization Form can be found on **AetnaBetterHealth.com/Florida**.

If you are attaching clinicals or scripts, please fax your request to:

Medical Prior Authorization: **1-860-607-8056**
 Obstetrics Prior Authorization: **1-860-607-8726**
 Pharmacy Prior Authorization: **1-855-799-2554**

Urgent/expedited requests should be clearly labeled on the Prior Authorization Form.

Aetna Better Health® of Florida
 261 N University Drive
 Plantation, FL 33324



Prior Authorization Form

MMA/FHK/Comprehensive/LTC

Prior Auth MMA/FHK Fax: 1-860-607-8056; Obstetrical (OB) Fax: 1-860-607-8726 Prior Auth Telephone: 1-800-441-5501
 Comprehensive/Long Term Care Requests Fax: 1-844-404-5455 Comprehensive/Long Term Care Telephone: 1-844-645-7371

A determination will be communicated to the requesting provider

- Visit Propat Search Tool to research whether a service requires prior authorization: <http://www.aetnamedicaidportal.com/propat/Default.aspx>
- An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services rendered must be a covered health plan benefit and medically necessary with prior authorization as per plan policy and procedures.
- All Inpatient and Observation Hospital admissions for MMA/FHK/Comprehensive members must be called in to the MMA/FHK Prior Authorization Department: Phone number 1-800-441-5501

TYPE OF REQUEST

***URGENT/EXPEDITED** (to be used when non-urgent/standard prior authorization could seriously jeopardize the life or health of a member, the member's ability to attain, maintain, or regain maximum function, or a delay in treatment would subject the member to severe pain that could not be adequately managed without the service requested—response within 2 calendar days for Medicaid and Comprehensive/LTC members; 3 calendar days for Florida Healthy Kids)
 OUTPATIENT
 ***NON-URGENT/STANDARD** (for routine services – response within 7 calendar days for Medicaid and Comprehensive/LTC members; 14 calendar days for Florida Healthy Kids)
 HOME HEALTH CARE
 DME/Supplies

PATIENT INFORMATION

Asterisk (*) Indicates **REQUIRED** fields. Incomplete requests will delay the authorization process.
 Please include pertinent clinical notes to expedite this request.

* Membership Type: MMA FHK Comprehensive LTC

*Patient Name: Last	First	MI	*Member ID/Medicaid ID:	*Date of Birth:
*PCP Name:	*Phone:	*Fax:	*PCP Contact Name:	

REQUESTING PROVIDER INFORMATION

*Requesting Provider Name:	*Requesting NPI:	*Requesting TIN:
*Requesting Contact Name:	*Phone:	*Fax:

SERVICING PROVIDER INFORMATION

Servicing Provider same as Requesting Provider (Please select if the Provider's information above is the same)

*Servicing Provider Name:	*FL Medicaid Provider#:	*Servicing NPI:	*Servicing TIN:
*Servicing Provider Contact Name:	*Phone:	*Fax:	
*Servicing Facility Name:	*FL Medicaid Provider#:	*Facility NPI:	*Facility TIN:
*Servicing Facility Contact Name:	*Phone:	*Fax:	

AUTHORIZATION REQUEST

*Start Date:	*End Date:	*Total Units/Visits (Total units should be based on CPT/HCPCS description of units):
*Have services already been rendered? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Procedure Codes:	*ICD- 10 Codes:	
Comments:		

CLINICAL INDICATIONS/RATIONALE FOR REQUEST: *DME, Home Health, Therapies and infusions must have Rx attached.
 To expedite a determination on your request for services, please attach clinical documentation/medical records to support your request. Please include the following: Conservative treatment tried and failed, applicable diagnostic testing with results and lab values and a medication list.
 ATTESTATION: I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

*Provider Signature: *Date:

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Referrals

The PCP is responsible for coordinating the provision of specialty services. The specialist and PCP work together to coordinate medical care for the member.

A PCP referral is not required for the following Direct Access services: Chiropractic, Dermatology (5 visits/year), routine Podiatric care, Optometry, Behavioral Health and OB/GYN.

A PCP referral is required for all other specialty services.

Referrals can be submitted electronically via our secure portal. If manual submission is preferred, providers can download a copy of the referral form on our website under the Authorizations tab.

Specialists are asked to provide the referring PCP with a written report within 10 business days of rendering specialty services.

Specialists are required to refer the member back to their PCP if they determine the member needs to be seen by another specialist.



Claims

EFT/ERA

Change Healthcare is the preferred EFT/ERA vendor for Aetna Better Health of Florida.

EFT (electronic funds transfer)

EFT improves the consistency of your payments by providing fast, accurate and secure payments directly into your bank account.

To enroll in EFT, fill out the enrollment form located on our website and submit it via our secure fax to **1-844-209-2060** or by email to **FLFinanceEFTErollment@aetna.com**.

ERA (electronic remittance advice)

An electronic file (also known as an 835 file) that contains claims payment and remittance information. The transmission of these files reduces manual posting of claims payment by allowing the user to upload financial data directly into your office's system. This process eliminates the need for paper explanation of benefits (EOBs).

To enroll in ERA, fill out the enrollment form located on the ABHFL website and submit it via our secure fax to **1-844-235-1340** or by email to **FLMedicaidProviderRelations@aetna.com**.

Please allow 10-15 business days for processing once your enrollment form is received. We'll send a confirmation letter to your office indicating the process has been completed.

Claims submissions

Please refer to the Claims and Encounter Submission Protocols and Standards section of the provider manual for information on filing clean claims to ensure prompt payment.

We also encourage you to review the Claims Information section under the Resource tab of our website. There you'll also find provider communication and bulletins with updated policies and other important claims-related information.

Clean claims can be sent to:

Aetna Better Health of Florida
 P.O. Box 63578
 Phoenix, AZ 85082-1925
 Claims payer ID for EDI – 128FL
 Real time payer ID - ABHFL

Need help? We're here for you. Simply reach out to our Claims Inquiry/Claims Research team (CICR) by calling **1-844-528-5815** for assistance with:

- Claims related questions, inquiries and reconsiderations
- Reviewing claims or remittance advices
- Assistance with claims-related prior authorization questions
- Viewing recent updates
- Locating forms

Claims and Encounter Submission Protocols and Standards

Claims and encounter submission protocols and standards are available in this section. Additional claims and encounter submission protocols and standards are available through provider communications and bulletins. These communications and bulletins may be found on the Aetna Better Health of Florida website [AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida). Providers shall submit claims in accordance with applicable state and federal laws. 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.

Timely Filing and Prompt Pay Guidelines Grid

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))

Claims resubmissions and reconsiderations

Resubmitted claims may be sent electronically or by mail.

When filing a resubmission, please write “Resubmission” at the top of the claim.

Submit all claim lines, not just the line being corrected.

When submitting a corrected or voided paper claim:

- UB04 claims must include the appropriate bill type (xx7)
- CMS1500 claims must include the appropriate bill frequency code – 7 for corrected and 8 for voided - and the original claim number.

Send paper claims for reconsideration with attached documentation to:

Aetna Better Health of Florida
P.O. Box 63578
Phoenix, AZ 85082-1985

Send electronic claims for reconsideration through your EDI vendor.



Balance billing

For covered services, Providers shall not balance bill Members any amount in excess of the contracted amount in their provider agreement.

Providers shall accept payment from Aetna Better Health of Florida for covered services provided to Aetna Better Health of Florida Members in accordance with the reimbursement terms outlined in the provider agreement.

For more information on balance billing, please refer to Florida Statutes 641.3154 and 641.3155 (5)a.(8).

Providers shall not charge members for missed appointments.



Overpayment recovery

Providers are required to return identified overpayments to the Plan within 60 calendar days after the overpayment is identified.

Payment must be returned to the address below along with written notice explaining the reason for returning the payment:

Aetna Better Health of Florida
Provider Finance Department
4500 E Cotton Center Blvd
Phoenix, AZ 85040

If the plan identifies that a claim is overpaid, the provider will receive a letter via U.S. mail from the plan requesting the return of monies paid in error in accordance with Florida statute.

Providers can access and view their overpayment recovery detail under the Tasks section of our secure provider portal.

For all overpayment questions or concerns, please email us at **FLMedicaidProviderRelations@Aetna.com** or by mail via the address above.

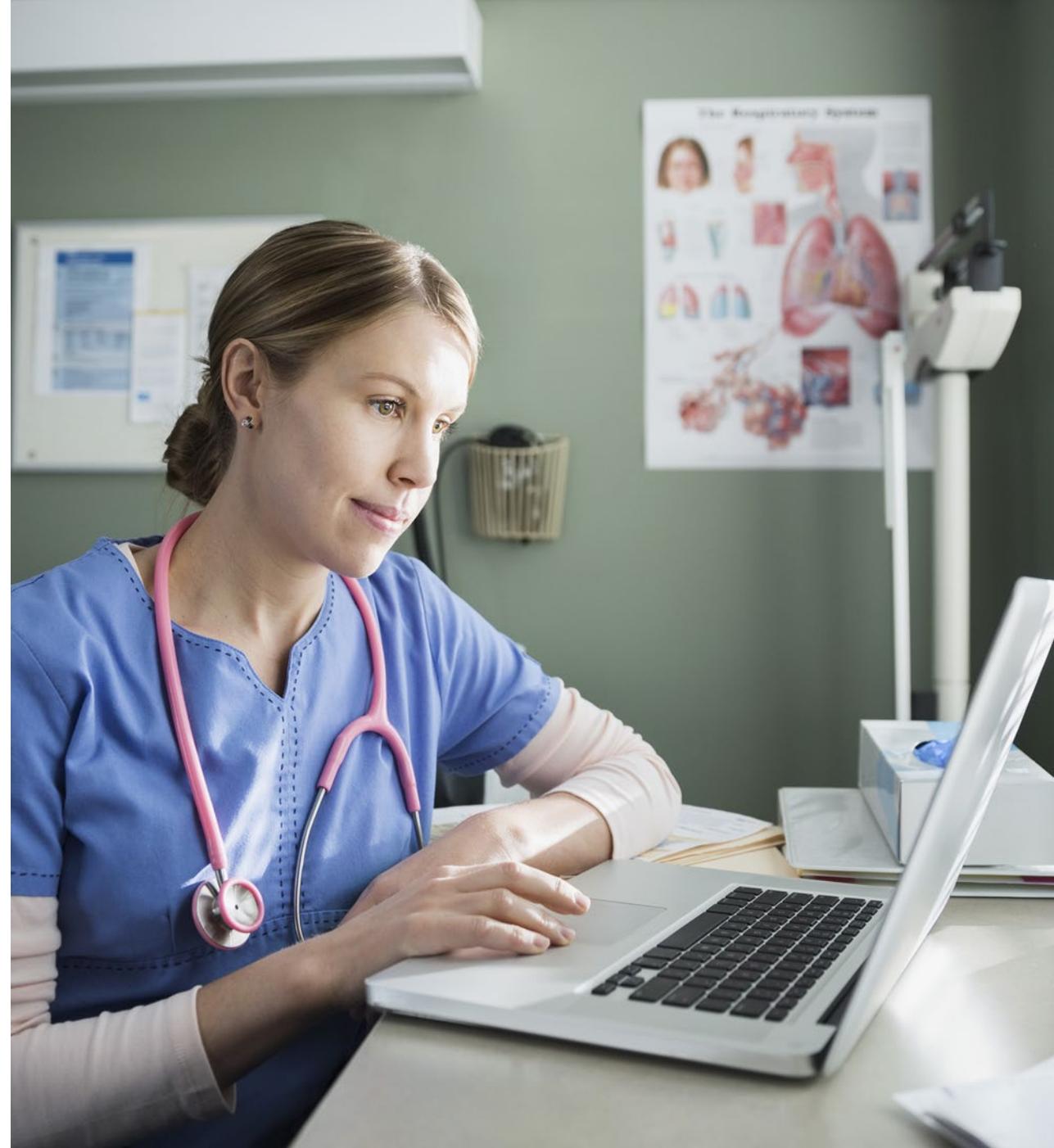


Provider Appeals - Medical necessity reconsideration

If a Provider does not agree with a denial for lack of medical necessity, he/she may request a reconsideration of the decision by providing additional information in one of two ways:

- Request a Peer-to-Peer Review with the Medical Director who made the decision by calling the Peer-to-Peer coordinator at **1-954-858-3219**
- By providing additional information by phone at **1-800-447-3725**, by fax to **1-860-607-8056** or by mail to:

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



Provider Appeals - Medical necessity reconsideration cont.

Reconsiderations of prior authorization decisions must be:

- Received within five (5) business days of the date the denial of coverage determination was issued
- Received prior to services being rendered
- Received prior to the receipt of a claim or request for an appeal

Hospital concurrent review reconsideration requests for peer-to-peer review must be received within two (2) business days of the verbal denial being issued.



Quality management and compliance

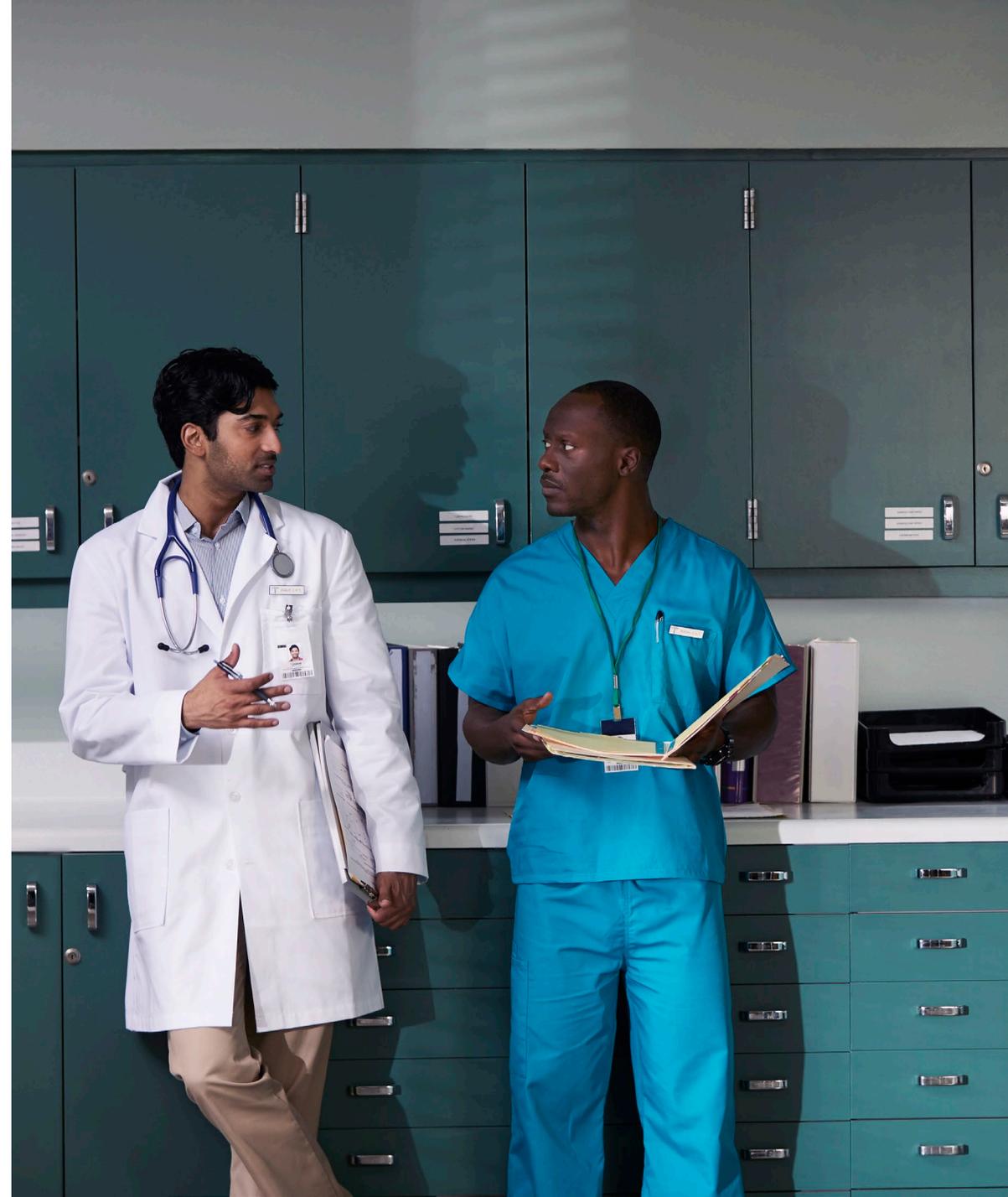
Utilization management

Our Utilization Management program helps our members access medically necessary health care services in the most cost-effective setting under their benefit package.

Our UM decision-making process is based on consistent application of appropriate 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.

For more information on our Utilization Management program, please refer to the Authorizations section under the For Providers tab of our website.



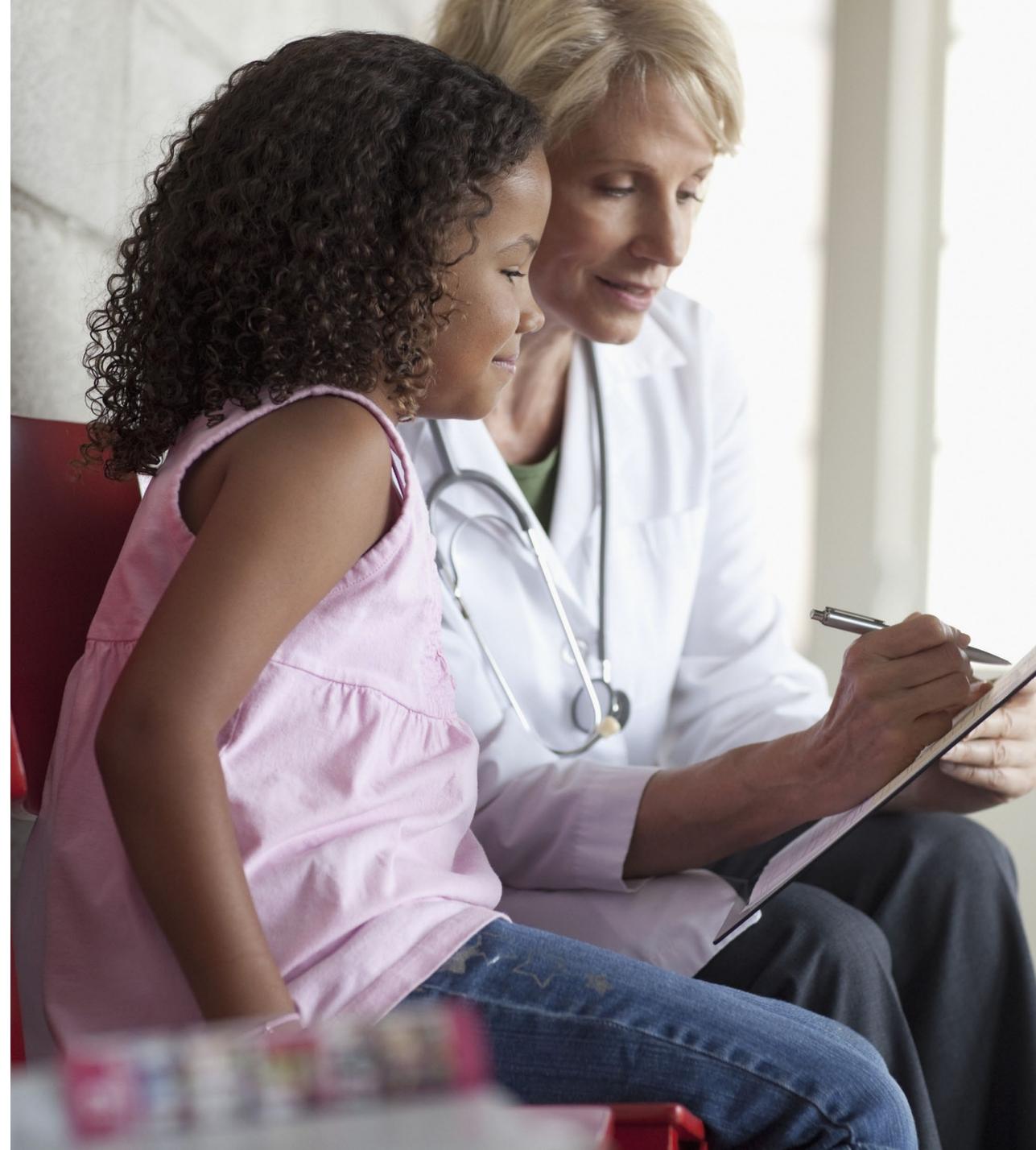
Care and disease management

Our Integrated Care Management (ICM) program help members and their families manage chronic diseases or high-risk factors such as:

- Asthma
- Cancer
- Diabetes
- Palliative care

Case managers work with members and their families by providing resources as well as one-on-one health coaching and special care to help them understand their health care needs. The case managers will also help to coordinate care with the member's doctors.

For more information about the Care Management services, please contact Member Services by calling **1-844-528-5815** (Relay **711**) Monday through Friday 7:30 a.m. to 7:30 p.m. ET.



Fraud, waste and abuse

Fraud

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Waste

Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Florida Healthy Kids program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Florida Healthy Kids program.

For more information or examples of fraud, waste and abuse, please refer to the Fraud, Waste and Abuse section of the provider manual.

Reporting fraud, waste and abuse

Providers can report suspected fraud, waste, or abuse in the following ways:

- Aetna Alert Line: **1-888-891-8910**
- Special Investigation Unit (SIU) Hotline: **1-855-415-1558**
- Email the Special Investigations Unit (SIU): **FL-FraudandAbuse@Aetna.com**
- Fax the SIU: **1-860-975-9719**
- FL Attorney General's Office: **1-866-966-7226**
- Visit our website: **AetnaBetterHealth.com/Florida/fraud-abuse**



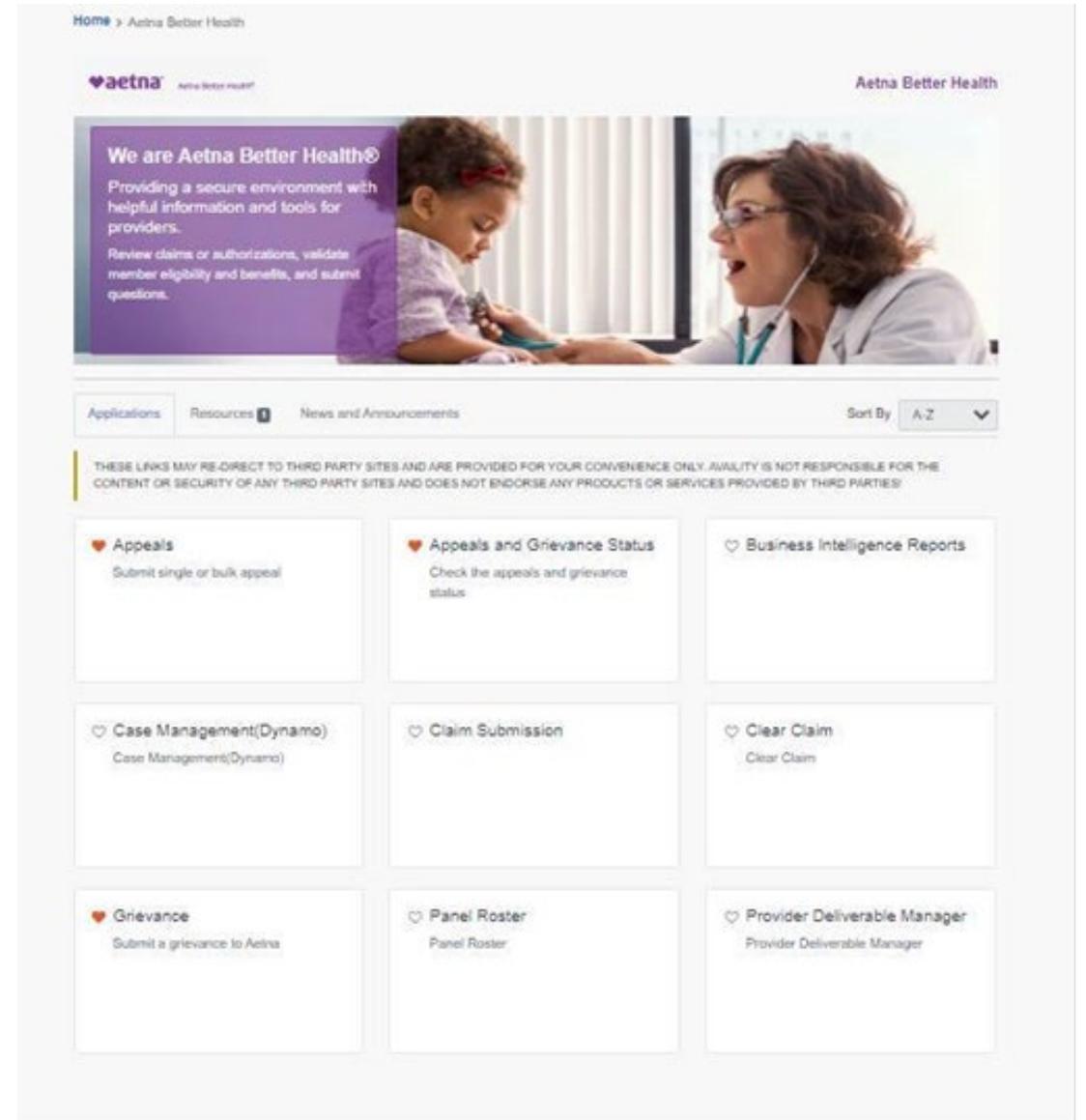
Provider complaint system

The provider complaint system allows providers to dispute any aspect of Aetna Better Health of Florida's policies and procedures, including claims, billing disputes and prior authorizations.

To file a grievance or an appeal:

- 1 Login to the secure provider portal on Availity.
- 2 Click on Payer Spaces and select Aetna Better Health of Florida.
- 3 Go to the Resource tab and select Grievance or Appeals from the menu options.

For more information about filing a grievance or an appeal, please visit our website and select the Complaints, Grievances and Appeals section under the For Providers tab.



Provider complaint types

Type of Complaint	Timing of Appeal	Response Time
Non-Claims Related	Must be submitted within forty-five (45) calendar days from the date the issue occurred.	<ul style="list-style-type: none"> • Providers will be notified within three (3) business days of receipt verbally or in writing that the complaint has been received and the expected date of resolution. • Providers will receive written notice every 15 days with a status update. • Complaints will be resolved within ninety (90) days of receipt. • Written notice will be sent out to provider within three (3) business days with resolution of complaint
Claims Related	Must be submitted within ninety (90) calendar days of the date of determination (Explanation of Benefits)	<ul style="list-style-type: none"> • Providers will be notified within three (3) business days of receipt verbally or in writing. • Providers will receive written notice every 15 days with a status update. • Complaints will be resolved within sixty (60) days of receipt of a claim complaint. • Written notice will be sent out to provider within three (3) business days with resolution of complaint

Note - There is no second level consideration for cases denied for untimely filing.

Provider complaint timely filing guidelines

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 ninety (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))

Quality Improvement (QI) Program

Performance indicators such as HEDIS and state-defined measures.

Monitor the coordination and continuity of care across health care network settings and transitions in those settings.

Results of annual provider and member satisfaction surveys.

Utilization of services provided by hospitals, emergency rooms, physician services, mental health facilities, home health agencies, DME companies and pharmacies.

For a detailed description of our QI Program, please refer to the Quality Improvement section of the provider manual.

HEDIS

HEDIS is a performance measurement requirement administered by NCQA and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of managed care organizations.

The graphic to the right illustrates how data is collected and ways that you can help ensure all annual standards are met. For a detailed description of the HEDIS program and all NCQA and CMS requirements, please refer to the Measuring Quality Performance section of the provider manual.

To receive HEDIS information specific to your practice or to obtain an electronic version of our Provider HEDIS Resource Guide, please email **FLMedicaidQualityDept@Aetna.com** or contact your Provider Relations representative.

All managed care organizations that are NCQA accredited perform HEDIS reviews at the same time each year.

We rely heavily on providers and their staff to document and maintain accurate medical records.

HEDIS data is collected through two primary methods:

- submitted claims and encounters
- chart collection/review

Providers can help us meet reporting deadlines by allowing us prompt access to medical records upon request.

HEDIS consists of over 80 measures across domains of care that address important health issues and preventive care.

Provider marketing

Provider may

Display Aetna Better Health of Florida-specific materials in their own offices.

Announce a new affiliation with Aetna Better Health of Florida and give their patients a list of managed care plans with which they contract.

Co-sponsor events, such as health fairs and advertise with Aetna Better Health of Florida in indirect ways; such as television, radio, posters, fliers, and print advertisement.

Distribute information about non-Managed Care Plan-specific health care services and the provision of health, welfare and social services by the State of Florida or local communities, as long as any inquiries from prospective members are referred to the member services section of Aetna Better Health of Florida or the Agency's enrollment broker.

Providers may not

Offer marketing/appointment forms, make phone calls or direct, urge or attempt to persuade recipients to enroll in Aetna Better Health of Florida based on financial or any other interests of the provider.

Orally or in writing compare benefits or provider networks among Aetna Better Health of Florida other than to confirm whether they participate in Aetna Better Health of Florida's network.

Furnish lists of their Florida Healthy Kids patients or any other entity to Aetna Better Health of Florida.

Assist with Managed Care Plan enrollment.

Mail marketing materials on behalf of Aetna Better Health of Florida.

Offer anything of value to induce recipients/members to select them as their provider or enroll in Aetna Better Health of Florida.

Conduct health screening as a marketing activity.

Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.

Distribute marketing materials within an exam room setting.

Cultural competence and mandated reporting

“Cultural competence is the ability of practitioners and systems to respect and respond to diverse member values, beliefs, behaviors and needs (e.g. social, cultural, linguistic) when providing health care services.”

— NCQA

To learn more about our Cultural Competency tools and resources for providers, please visit our website and select the Provider Education section under the For Providers tab.



How you can demonstrate cultural competence

When treating a person with a disability, remember to:

- Talk to the patient, not someone who accompanies them
- Avoid making assumptions
- Ask, “How can I help you?” and respect their response
- Ensure that educational materials are easily accessible
- Allow time for history taking and exam

When treating a person who is deaf or hard of hearing:

- Ask how to best communicate
- Provide written educational material
- Look at the person while speaking
- Avoid shouting
- Minimize background noise
- Provide an interpreter, if necessary, for effective communication
- Patients cannot be charged for interpretation
- Family members should NOT serve as interpreters

When treating a person who is blind or visually impaired, provide written material:

- In an auditory format
- On computer disc
- In Braille
- In large print

When treating a person who is a wheelchair user:

- Provide access to exam areas
- Provide assistance, if necessary, for a full and complete exam, even if it requires more time or assistance
- Respect personal space, including wheelchairs and assistive devices
- Avoid propelling wheelchair unless asked
- Obtain adjustable exam tables for your facility, if possible

Emergency room criteria

Children

As mandated by Florida Administrative Code, emergency room providers are required to examine children for suspected physical abuse and/or neglect when placed in foster homes after normal agency business hours.

Vulnerable adults

Providers must report suspected or known physical abuse (domestic violence), neglect, maltreatment, and/or financial exploitation of a vulnerable adult immediately to one of the following agencies:

The National Domestic Violence Hotline -
1-800-799-SAFE (7233)

The Florida Department of Health and Human
Services- **1-304-558-0684**



Abuse, neglect and exploitation

Aetna Better Health of Florida network providers are considered mandated reporters. As a mandated reporter, you are obligated to report suspected abuse, neglect and/or exploitation to the Florida Abuse Hotline at **1-800-962-2873** or the Plan's Member Service Department at **1-844-528 5815**.

Potential symptoms/Signs of abuse:

- Bruises (old and new)
- Burns or bites
- Pressure ulcers (Bed sores)
- Missing teeth
- Broken Bones / Sprains
- Spotty balding from pulled hair
- Marks from restraints
- Domestic violence

Behaviors of abusers (Caregiver and/or family member):

- Refusal to follow directions
- Speaks for the patient
- Unwelcoming or uncooperative attitude
- Working under the influence
- Aggressive behavior

Types of neglect:

- The intentional withholding of necessities and care
- Not providing necessities and care because of lack of experience, information, or ability

Signs of neglect:

- Malnutrition or dehydration
- Un-kept appearance; dirty or inadequate
- Untreated medical condition
- Unattended for long periods or having physical movements unduly restricted

Examples of neglect:

- Inadequate provision of food, clothing, or shelter
- Failure to attend health and personal care responsibilities, such as washing, dressing, and bodily functions

For more information about your role in reporting suspected cases of abuse, neglect and exploitation, please refer to the Abuse, Neglect and Exploitation section of the provider manual.

Human trafficking

Human trafficking is a public health issue that impacts individuals, families, and communities. Traffickers disproportionately target at-risk populations including individuals who have experienced or been exposed to other forms of violence.

The Trafficking Victims Protection Act of 2000 (TVPA), as amended (22 U.S.C. § 7102), defines “severe forms of trafficking in persons” as:

- Sex trafficking: the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; (and)
- Labor trafficking: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery

Human trafficking may occur in the following situations:

- Prostitution and escort services;
- Pornography, stripping, or exotic dancing;
- Massage parlors;
- Sexual services publicized on the Internet or in newspapers;
- Agricultural or ranch work;
- Factory work or sweatshops;
- Businesses like hotels, nail salons or home-cleaning services;
- Domestic labor (cleaning, childcare, eldercare, etc. within a home);
- Restaurants, bars, or cantinas; or
- Begging, street peddling, or door-to-door sales.

Victims of human trafficking may exhibit any of the following:

- Evidence of being controlled either physically or psychologically;
- Inability to leave home or place of work;
- Inability to speak for oneself or share one’s own information;
- Information is provided by someone accompanying the individual;
- Loss of control of one’s own identification documents (ID or passport);
- Have few or no personal possessions;
- Owe a large debt that the individual is unable to pay off; or
- Loss of sense of time or space, not knowing where they are or what city or state, they are in.

Help for human trafficking victims

The National Human Trafficking Hotline provides assistance to victims in crisis through safety planning, emotional support, and connections to local resources. For more information on human trafficking visit [acf.hhs.gov/trafficking](https://www.acf.hhs.gov/trafficking).

If you know someone who is a victim of human trafficking or you suspect someone is a victim of human trafficking, you can contact the National Human Trafficking Hotline for assistance in the following ways:

Call: **1-888-373-7888**

Text: **HELP to BEFREE (233733)**

Email: help@humantraffickinghotline.org



Attestation requirement



ATTESTATION OF NEW PROVIDER ORIENTATION - FHK

I have received and completed Aetna Better Health of Florida's (ABHFL Self-Guided New Provider Orientation which covers the topics listed below:

- ✓ Language Assistance and Interpreter Services
- ✓ Care for Diverse Populations or Diverse Populations
- ✓ Policies and Procedures
- ✓ Communicating with Members
- ✓ Locating and referring to other ABHFL providers
- ✓ Navigating ABHFL Website
- ✓ Florida Healthy Kids covered services
- ✓ Claims Payment Policies
- ✓ Referrals and Authorizations
- ✓ Case Management

I have been educated about these essential components of ABHFL's Florida Healthy Kids (FHK) product and my responsibilities as a participating provider, including providing this orientation to new practitioners that join our practice.

Date	
Completed by / Title	
Group Name (Print)	
Group NPI	
Tax identification number (TIN)	
Telephone number	
Email address	
Signature	

Important:
ABHFL requires completion of this Attestation, in addition to a signed contract and credentialing, to complete the ABHFL provider enrollment process.

Note:
Failure to complete this Attestation may result in a delay of active status with ABHFL.

Return Signed Attestation via fax or Email
Fax: 844-886-8349
Email: FLMedicaidProviderRelations@aetna.com

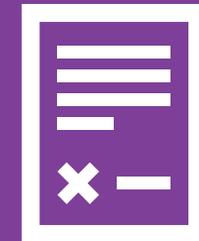
Internal Use Only

Received by _____ Date _____

Active Status Date _____

FL-20-08-001
Proprietary

Signature required



Questions? We've got answers.

**Just contact our Provider Services Department by calling
1-844-528-5815 or emailing us at
FLMedicaidProviderRelations@Aetna.com**

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