Aetna Better Health® of Florida

Behavioral Health Provider Training

aetna®

June 30, 2023

Agenda

- Behavioral Health Expanded Benefits
- Housing Pilot Program
- In Lieu of Services Resource Guide
- Behavioral Health Resources
- Electronic Funds Transfers (EFT) & Electronic Remittance advise (ERA)
- Provider Surveys
- Timely Filing Requirements
- Grievance & Appeals
- Prior Authorization
- Availity Provider Portal
- Provider Manual, Newsletters and Notifications

Behavioral Health Expanded Benefits

BH Expanded Benefits

Service	Description	Coverage/Limitations	Prior Authorization
Behavioral Health Assessment / Evaluation Services	Services used to detect or diagnose mental illnesses and behavioral health disorders	Covered as medically necessary. No limit for members 21 and older	Prior authorization required once Medicaid coverage/limitations are met
Behavioral Health Day Services / Day Treatment	Intensive therapeutic treatment used to stabilize symptoms of a behavioral health disorder	Covered as medically necessary. No limit for members 21 and older	Yes
Behavioral Health Medical Services	Medication management, drug screening, etc	Covered as medically necessary. No limit for members 21 and older	Prior authorization required once Medicaid coverage/limitations are met
Computerized Cognitive Behavioral Therapy	Standardized cognitive performance testing	Covered as medically necessary. No limit for members 21 and older	Prior authorization required once Medicaid coverage/limitations are met
Group Therapy (Behavioral Health)	Services for a group of people to have therapy sessions with a mental health professional	Covered as medically necessary. No limit for members 21 and older	Prior authorization required once Medicaid coverage/limitations are met
Individual / Family Therapy	Services for people to have one-to-one or family therapy sessions with a mental health professional	Covered as medically necessary. No limit for members 21 and older	Prior authorization required once Medicaid coverage/limitations are met

BH Expanded Benefits

Service	Description	Coverage/Limitations	Prior Authorization
Intensive Outpatient Services (mental health and substance use)	Delivers focused, specialized behavioral health treatment in an outpatient setting	Covered as medically necessary. No limit for members 21 and older	Yes
Medication Assisted Treatment (MAT)	Medications given to help with drug or alcohol withdrawal	Covered as medically necessary. No limit for members 21 and older	Prior authorization required once Medicaid coverage/limitations are met
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental Illnesses	Covered as medically necessary. 344 units per month for each member 21 and older	Yes
Psychosocial Rehabilitation	Therapy that helps restore function and well being	Covered as medically necessary. No limit for members 21 and older	Prior authorization required once Medicaid coverage/limitations are met
Substance Use Treatment or Detoxification Services	Outpatient services for substance use or detoxification	Covered as medically necessary. No limit for members 21 and older	Yes

Housing Pilot Program

Housing Pilot Program

Build multi-sector collaborations and implement evidence-based strategies promoting housing stability, assistance with transitions, crisis intervention services, tenancy support and education, and peer support by partnering with community providers who have current relationships with homeless coalitions in the areas served.

Provide services and support for members who are the most vulnerable while ensuring that they have a stable home and access to health care and community services.

Provide true service integration by connecting behavioral health case management services with physical health case management.

Leverage the capabilities and experience of our behavioral health providers in conjunction with our case management team to transform homeless services to crisis response systems that prevent homelessness and rapidly return people who experience homelessness to stable housing.

Housing Pilot Program

Areas served

- Region 7 to include Seminole, Orange, Osceola, and Brevard counties

Eligibility

- Aetna Medicaid and Long-Term Care members, aged 21 and older, with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD
- Homeless or at risk of homelessness

Referring a member

- To make a referral for the Housing Assistance Pilot, please call **1-800-441-5501** or send an email to: **abhfl-specialtycm@aetna.com**.
- If making a referral through email, please include “Housing Program Referral” on the subject line of the email.

Housing Pilot Program

Transitional housing services:

- Services that support an individual to prepare for and transition into housing, tenant screening and housing assessment, individualized housing support plan, assist with search for housing and application process, identify resources to pay for ongoing expenses like rent, ensure living environment is safe and ready to move-in, cover one-time incidentals such as assistance with deposits up to $500

Tenancy sustaining services:

- Early intervention for behaviors that might jeopardize housing,
- education/training in roles, rights & responsibilities between tenant and
- landlord, coaching on developing/maintaining relationships with property
- managers, assist with resolving disputes, reduce risk of eviction, advocacy
- and linkage with community resources, assistance with community
- recertification process, review, coordinate and modify housing support and
- crisis plans

Mobile Crisis Management:

- Delivery of immediate de-escalation services for emotional symptoms
- and/or behaviors at the location in which the crisis occurs, behavioral health
- crisis team available 24/7/365, prevent loss of housing or emergency
- inpatient behavioral health admission when possible

Self-Help/Peer Support:

- Person-centered services promoting skills for coping with and managing
- symptoms, utilizing natural resources and preservation or enhancing
- community living skills with the assistance of a peer support specialist

In Lieu of Services Resource

In Lieu of Services Resource Guide

For our Aetna Medicaid members there are behavioral health treatment options. They are considered in lieu of services that may be medically appropriate alternate treatments for our members.

Members have the choice to receive the Medicaid covered service or an in lieu of service. We ask that providers document in the enrollee record the members choice in the members' record.

For the services outlined below, medical necessity applies.

Description of Service	In lieu of:	Procedure Code	Modifier	PA Required?	Limitations
Crisis Stabilization Unit (CSU)	Inpatient Psychiatric Hospital Care	129		Notification is required within 24 hours of admission. Authorization is provided for the first 3 days of an emergency involuntary (Baker Act) admission. Prior authorization is required for continued stay.	No limits
Addiction Receiving Facilities	Inpatient Detoxification Hospital Care	169		Yes	No limits

In Lieu of Services Resource Guide

Description of Service	In lieu of:	Procedure Code	Modifier	PA Required?	Limitations
Intensive Outpatient (IOP)-Substance use disorder (SUD)	Inpatient Detoxification Hospital Care	906 H0015		Yes	No limits
Intensive Outpatient (IOP)-Mental Health (MH)	Inpatient Hospital	905 S9480		Yes	No limits
Partial Hospitalization Program (PHP)	Inpatient Psychiatric Hospital Care	Half Day 912 Full Day 913		Yes	No limits
Ambulatory Detox- Substance use disorder (SUD)	Inpatient Detoxification Hospital Care	944		Yes	No limits
Ambulatory Detox-Alcohol	Inpatient Detoxification Hospital Care	945		Yes	No limits
Ambulatory Detox	Inpatient Detoxification Hospital Care	S9475 H0014		Yes	No limits
Substance Abuse Short-Term Residential Treatment (SRT)	Inpatient Detoxification Hospital Care	H0018		Yes	No limits
Self-Help/Peer Support	Psychosocial Rehabilitation	H0038		No	Up to 4 hours (16 units) per day
Community-Based Wrap Around Services	Therapeutic Group Care services or Statewide Inpatient Psychiatric Program (SIPP) services	H2022		Yes	No limits
Drop-In Center	Clubhouse Services	S5102	HE	No	Up to 20 days per year
Mobile Crisis Assessment and Intervention	Emergency Behavioral Health Care	S9484 H2011		No	S9484: Up to 2 hours per day (32 units) H2011: No limits

In Lieu of Services Resource Guide

Description of Service	In lieu of:	Procedure Code	Modifier	PA Required?	Limitations
Infant Mental Health Pre & Post Testing Services	**Psychological Testing services**	**T1023**	**HA**	**Yes**	**No limits**
Family Training/Counseling for Child Development	Therapeutic Behavioral On-Site Services	T1027		No	Up to 9 hours (36 units) per month
Behavioral Health Services-Child Welfare	Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services	T2023	HA	Yes	No limits
Nursing Facility Services	Inpatient Hospital Services	0101 0190 0191 0192 0193 0194 0199 0655 0658		Yes	No limits

BH Service Resources

BH Service Resources

Opioid Resources:

- https://www.aetnabetterhealth.com/florida/providers/opioid-use-disorder.html

Clinical Practice Guidelines:

- https://www.aetnabetterhealth.com/florida/providers/clinical-guidelines-policy-bulletins.html

AHCA Resource Guide:

- https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/florida/provider/pdf/abhfl_provider_resource_guide.pdf
  - ➢ Updated quarterly
  - ➢ Housed both on the ABHFL website and on AHCA website

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

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

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

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

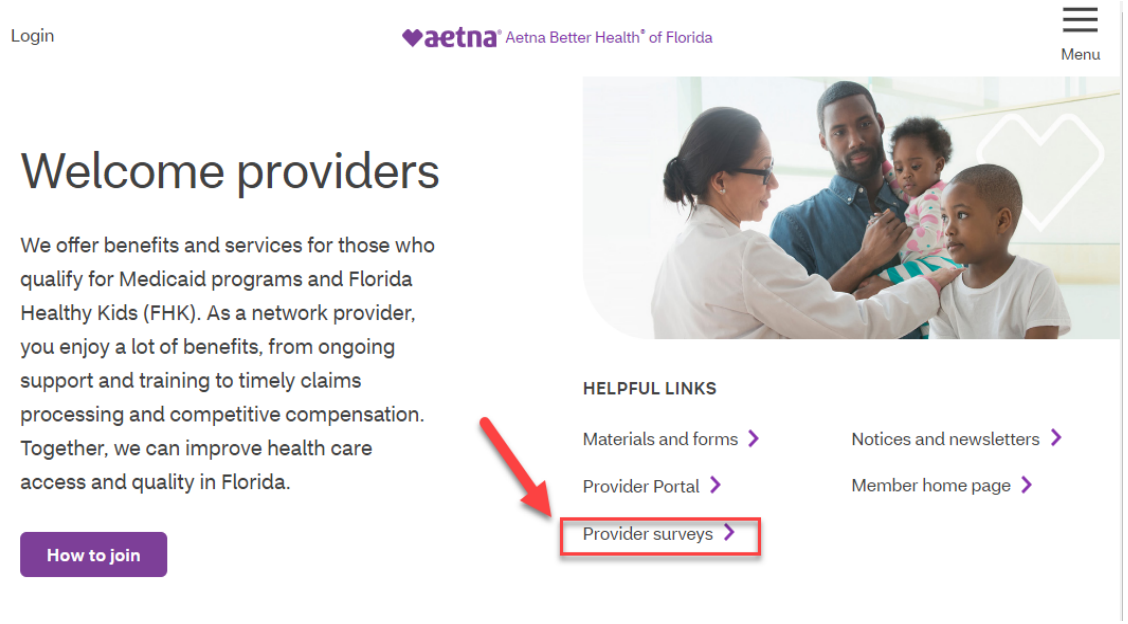
- Create your enrollment by filling out the Provider Information, Contact Information, Bank Information (only if adding EFT enrollment(s)), and Enrollment Information.
- Submit your enrollment(s) and you will receive an email notification confirming submission to Change Healthcare.
- Log in to the Provider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

Provider Surveys

Provider Surveys

Ongoing surveys are posted on our ABHFL website as we are continuously working in obtaining the most updated information to improve services to our members and provider directory.

We added a new helpful link



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

Provider surveys

- ABH FL Provider Data Validation
- ABH FL Provider Data Change Form
- ABHFL Provider OB/GYN Survey (PDF)
- Aetna Better Health of Florida Behavioral Health and Primary Care Provider Collaboration
- Aetna Better Health of Florida Primary Care and Behavioral Health Provider Collaboration
- ABH FL Provider Office Hours & Telemedicine Services Survey

Provider Surveys

ABH FL Provider Data Validation

- Direct Link: https://www.surveymonkey.com/r/AETPDV
- In support of NCQA, federal, and CMS regulations and standards, Aetna Better Health of Florida requires participating providers to visit our Provider Online Directory at https://www.aetnabetterhealth.com/florida/find-provider each calendar quarter to validate the accuracy of your practice information.

ABH FL Provider Data Change Form

- Direct Link: https://www.surveymonkey.com/r/AETPDCF
- Keeping your practice data up to date through Aetna Better Health of Florida's online Provider Data Change Form is essential to ensuring member satisfaction, appropriate referrals, appointment availability, and accurate and timely claims processing.

ABH FL Behavioral Health & Primary Care Provider Collaboration

- Direct Link: https://www.surveymonkey.com/r/AETBHPCP
- Aetna Better Heath would like to understand how well primary care and behavioral health providers communicate and coordinate care. By completing this survey and sharing your feedback ABHFL will measure how well we are meeting the expectations and needs of our network providers and practitioners.

ABH FL After Hours & Telemedicine

- Direct Link: https://www.surveymonkey.com/r/ABHHRTEL
- In order to keep the provider directory up to date, Aetna Better Health of Florida would like to obtain more information regarding the practice's after-hours availability and Telemedicine services provided.

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.

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

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**

You can also call us with your complaint or appeal:

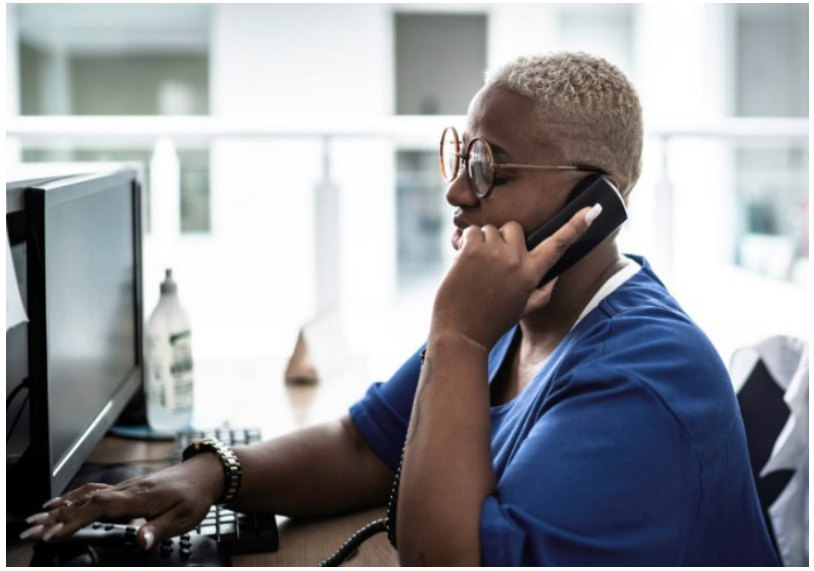
- Medicaid Managed Medical Assistance: 1-800-441-5501 (TTY: 711)
- Long-Term Care: 1-844-645-7371 (TTY: 711)
- Florida Healthy Kids: 1-844-528-5815 (TTY: 711)

If you prefer to mail hard copy requests for an appeal, complaint or grievance, they must be sent to:

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



Prior Authorization

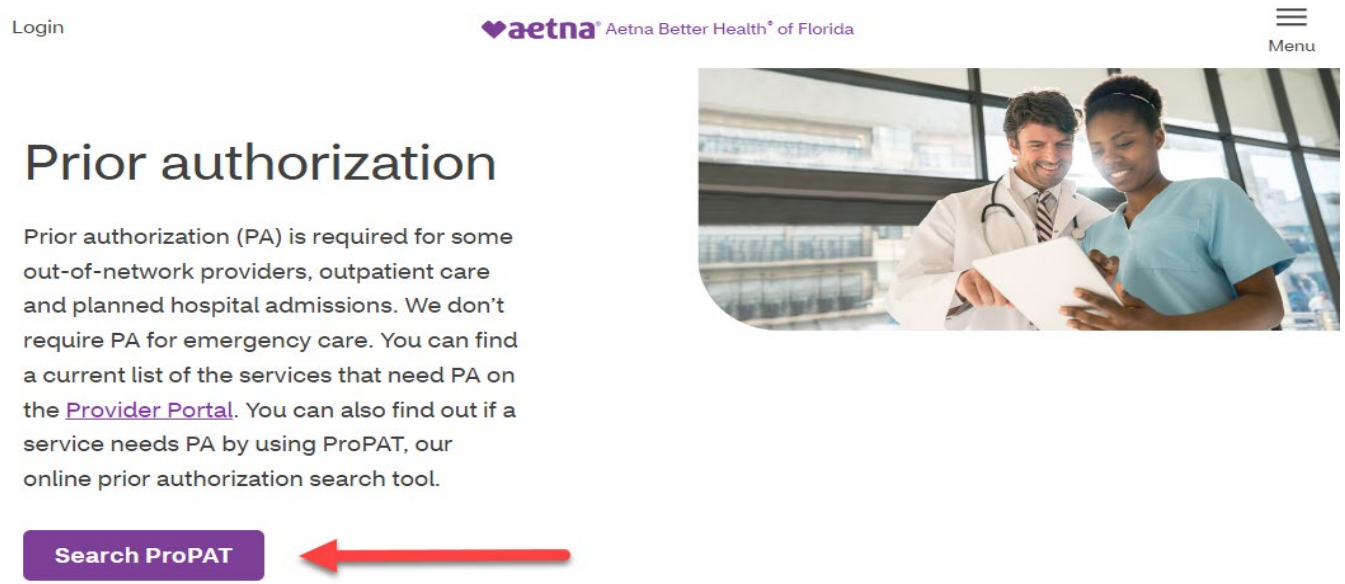
Prior Authorization

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.

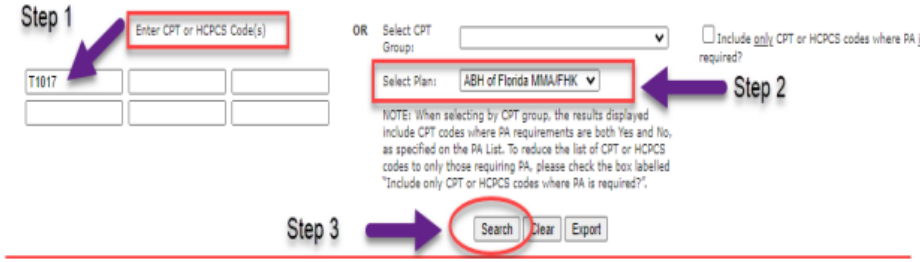
You can also find out if a service needs PA by using ProPAT, our online prior authorization search tool.

Propat Link: **Search ProPAT**



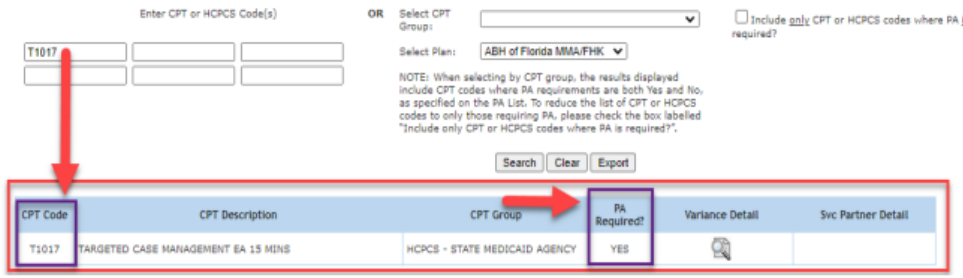
How to Search a CPT or HCPCS Code(s) in Propat & determine if PA Authorization is required?

- **Step 1** – Enter CPT or HCPCS Code (s). You can enter up to six Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes or a CPT group to search and determine if a PA is required for rendering services.
- **Step 2** – Select Plan option (Required). The tool is the same for all lines of business, however, it's important to note that you must indicate the line of business you are searching for in the tool to make sure accurate information is pulled for that line of business.
- **Step 3** – Click on "Search" to obtain the results



Results – PA Required YES/NO

Once step 3 (Search) is completed, the below results will appear and confirm if a PA is required for the CPT or HCPS code entered.



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.

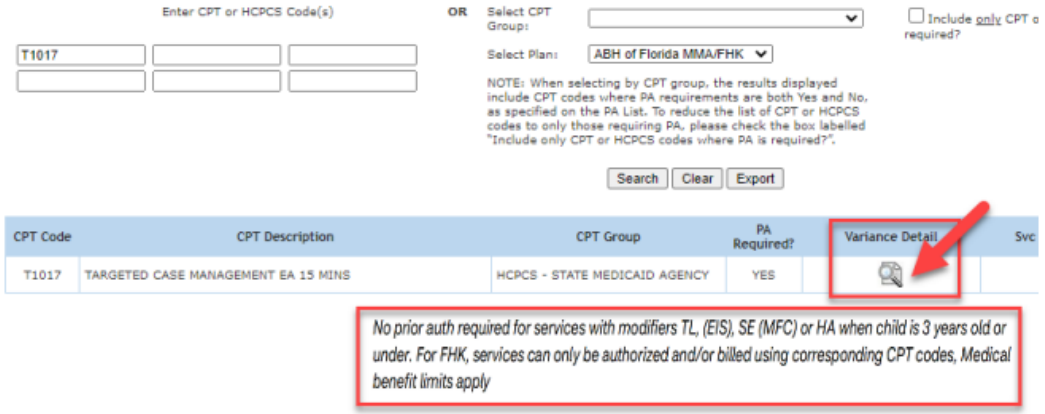
Variance Detail

The "Variance Detail" is a very important and informational feature. You can simply hover over the icon, and it will provide detailed information about the requirements of the PA.

Example

When you hover over the "Variance Detail" for code T1017, it will provide you with the following message:

"No prior auth required for services with modifiers TL, (EIS), SE (MFC) or HA when child is 3 years old or under. For FHK, services can only be authorized and/or billed using corresponding CPT codes, Medical benefit limits apply".



To request a prior authorization, be sure to:

- Always verify member eligibility prior to providing services.
- Complete the appropriate authorization form (medical or pharmacy).
- Attach supporting documentation when submitting. This could include:
  - Recent progress notes documenting the need for the service
  - Lab results
  - Imaging results (x-rays, etc.)
  - Procedure/Surgery reports
  - Notes showing previous treatment tried and failed
  - Specialty notes

Important to Note: When checking whether a service requires an authorization under Aetna Better Health of Florida, please keep in mind that a listed service does not guarantee that the service is covered under the plan's benefits. Always check plan benefits first to determine whether the service is covered or not.

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

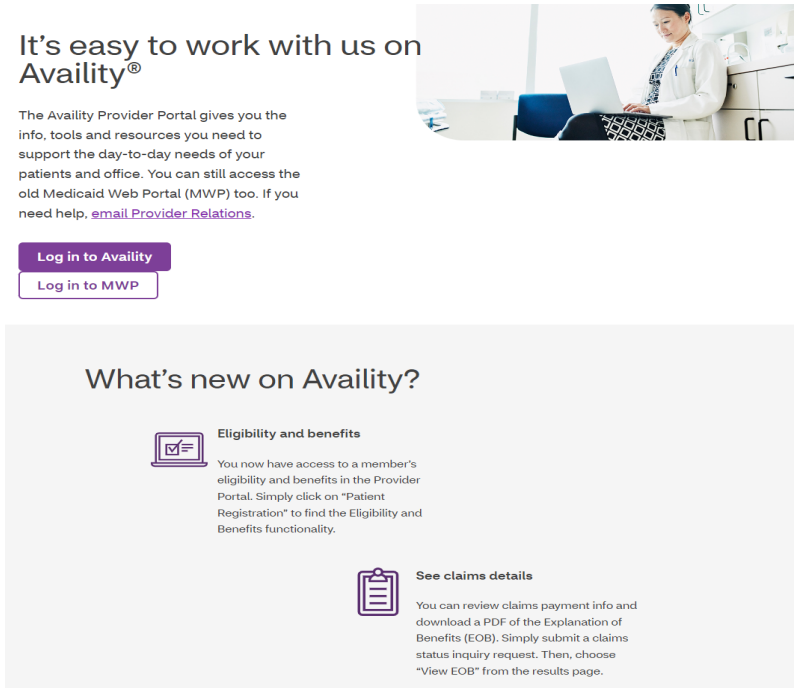
Availity Provider Portal

Availity Provider Portal

Current Functionalities

- **Claim Status Inquiry**
- **Eligibility and Benefits**
- **Payer Space**
  - **Claim Submission Link (Through Connect Center)**
  - **Contact Us Messaging for**
    - Changing Provider Demographics
    - Claim Issues
    - Prior Auth/Auth Issues
    - Member Eligibility Issues
    - HEDIS Record Submissions
    - Credentialing Inquiries
  - **Appeals and Grievances**
    - Grievance Submission
    - Appeal Submission
    - Grievance and Appeal Status Check
  - **Panel Roster- Panel Look Up**
  - **Reports**
    - PDM/ProReports (Provider Deliverables Manager)
    - Ambient (Business Intelligence Reporting)
  - **EFT/ERA Registration/Change Forms**
  - **Prior Authorization Requirements Look Up**
- **Prior Authorization**
  - Submission
  - Status

Note- For Registration/Login/or Technical Issues, please contact Availity Client Services at 1-800-282-4548
M-F 8am to 8pm eastern (except holidays).



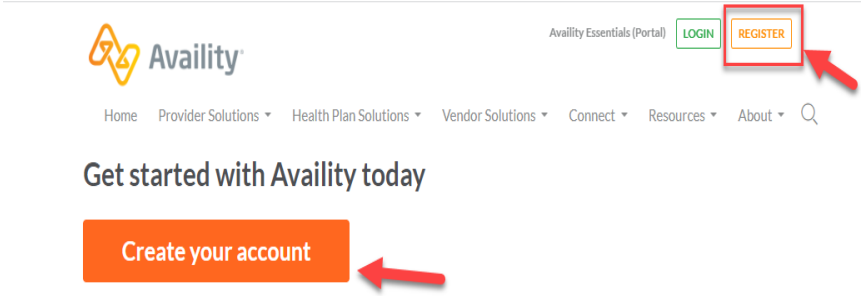
Availity Provider Portal

To register, select your organization type below

Select this option if you are a healthcare provider.

If you are a healthcare provider – i.e., physician practice, mental health provider, specialist, medical transportation service, or non-physician provider – click below to register. Questions about registering? Join us for a live webinar or explore other registration resources on our training microsite.

Register



Availity & Helpful Links:

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

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.

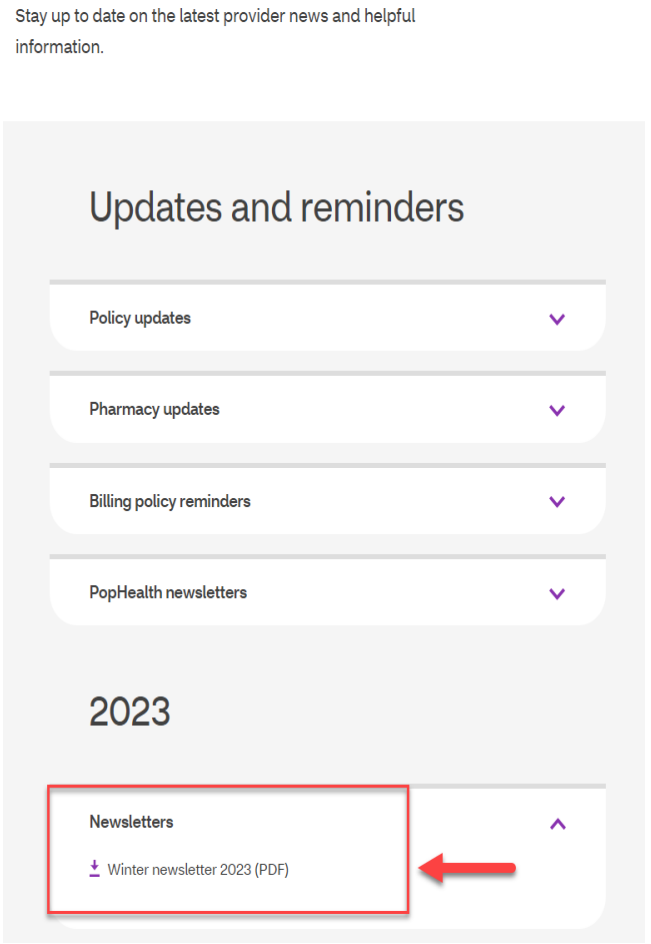
To stay informed with the most updated information please visit our ABHFL under the provider tab: ABHFL Provider Page

Provider Manual (s)

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

Newsletters

- Provider newsletter - Winter 2023
- Provider newsletter – Summer 2023 (PENDING)



Note: Provider Newsletters are issued 2 times a year. (Summer & Winter).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Questions?
We have answers!

Provider Services Department

- Phone: 1-844-528-5815
- Email: FLMedicaidProviderRelations@aetna.com

Behavioral Health Network Relations Specialist

- Name: Yolaine Joseph-Doralus
- Email: Joseph-DoralusY@AETNA.com

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