



Aetna Better Health[®] of Florida

2024 Florida Healthy Kids Provider Manual

Provider Relations Department: **1-844-528-5815**



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

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Introduction to Aetna Better Health of Florida

Welcome

Welcome to Aetna Better Health of Florida. Our ability to provide excellent service to our members is dependent on the quality of our provider network. By joining our network, you are helping us serve those Floridians who need us the most. As a Florida Healthy Kids Professional, you play a very important role in the delivery of healthcare and support services to our members. The Provider Manual is intended to be used as an orientation tool and guideline for the provision of covered services to members. This manual contains policies, procedures, and general reference information including minimum standards of care which are required of Plan providers. As a Network provider, we hope this information will help you better understand Aetna Better Health of Florida.

Should you or anyone on your staff have any questions about any information contained in this manual or anything else about Aetna Better Health of Florida, please feel free to contact our Provider Relations department. We look forward to working with you and your staff to provide quality managed healthcare service to our members. Our vision is to benefit all stakeholders while considering consumer choice and outcomes, provider qualifications, and Aetna Better Health of Florida's requirements.

History

Coventry Health Care of Florida Inc., Coventry Health Plan of Florida Inc., Coventry Summit Health Plan and Coventry Health and Life Insurance Company are subsidiaries of Coventry Health Care, Inc. – acquired by Aetna Health Insurance May 2013 operating insurance companies, network rental and workers' compensation services companies. Aetna Better Health of Florida offers a full range of risk and fee-based managed care products and services including HMO, PPO and POS, Medicare Advantage, Medicaid, Florida Healthy Kids, Workers' Compensation and network lease products to a broad cross-section of employer and government-funded groups, government agencies, individuals and other insurance carriers and administrators in all 50 states, as well as, the District of Columbia and Puerto Rico.

Florida has offered Florida Healthy Kids services since 1990. Florida Healthy Kids provides access to health care coverage for eligible children. It is funded by both the state and federal governments. Florida Healthy Kids is one of the three programs grandfathered into the original Children's Health Insurance Program (CHIP) legislation in 1997. Those three programs and the newly created MediKids program were joined together to create the Florida KidCare program in 1998.

Experience and innovation

We have more than 30 years' experience in managing the care of the most medically vulnerable. We use innovative approaches to achieve both successful health care results and cost-effective outcomes.

We are dedicated to enhancing member and provider satisfaction, using tools such as predictive modeling, case management, and state-of-the-art technology to achieve cost savings and help members attain the best possible health, through a variety of service models.

Meeting the promise of Managed Care

We work closely and cooperatively with providers to achieve sustainable improvements in service delivery. We are committed to building on the significant improvements in preventive care by facing the challenges of health literacy and personal barriers to healthy living.

Our state partners chose us because of our expertise in effectively managing integrated health models for Florida Healthy Kids that provides quality service while saving costs. The members we serve know that everything we do begins with the people who use our services – we care about their health, their quality of life, and the social determinants of health that impact their health and wellness. Aetna Better Health of Florida has developed and implemented programs that integrate prevention, wellness, disease management and care coordination.

Aetna Better Health of Florida offers the Florida Healthy Kids Program statewide in the following regions and counties:

- Region 1:** Escambia, Okaloosa, Santa Rosa, Walton
- Region 2:** Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington
- Region 3:** Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union
- Region 4:** Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia
- Region 5:** Pasco, Pinellas
- Region 6:** Hardee, Highlands, Hillsborough, Manatee, Polk
- Region 7:** Brevard, Orange, Osceola, Seminole
- Region 8:** Charlotte, Collier, Desoto, Glades, Hendry, Lee, Sarasota
- Region 9:** Indian River, Martin, Okeechobee, Palm Beach, St. Lucie
- Region 10:** Broward
- Region 11:** Miami Dade, Monroe

Purpose of this Manual

The purpose of this Provider Manual ("Manual") is to provide your office with business guidelines and requirements necessary to conduct business transactions with Aetna Better Health of Florida.

The manual contains meaningful information that makes it easier for you to work with us more effectively and efficiently. Topics range from how to get claims paid faster to learning how to reduce administrative burdens. We designed the provider manual to give you more time to focus on what's most important to you — improving the health and well-being of your patients.

Periodically, it will become necessary to update this Manual. Updated versions of this Manual are available at [AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida). Updates may also be delivered via fax, mailing or other electronic means for significant changes and/or updates. Please retain updates for future reference and guidance. Additional reference material can be located at [AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida).

Protocols and guidelines

Provider acknowledges and agrees that (i) all decisions rendered by The Plan its administration of the Agreement, including, but not limited to, all decisions with respect to the determination of whether or not a service is a covered service, are made solely to determine if payment of benefits under applicable member contract is appropriate; and (ii) any and all decisions relating to the necessity of the provision or non-provision of medical services or supplies shall be made solely by the member and Provider in accordance with the usual Provider patient relationship and Provider as applicable, shall have sole responsibility for the medical care and treatment of members under their care. Providers should encourage members under their care to review their member contract concerning benefits, procedures and exclusions or limitations prior to receiving treatment.

Florida Healthy Kids Key Contact Information

Health Plan Main Office	Provider & Member Services Phone Number
Aetna Better Health of Florida Florida Healthy Kids Program 9675 NW 117 th Ave, Suite 202 Miami, FL 33178-1228	1-844-528-5815
Hours of Operation	Provider & Member Services Fax Numbers
Member Services Monday – Friday 7:30 AM – 7:30 PM Eastern Time Provider Services Monday – Friday 8:00 AM – 5:00 PM	Provider Services Fax: 1-844-235-1340 Member Services Fax 1-959-888-4124 Case Management Fax: 1-844-404-5455 Grievance & Appeals Fax: 1-860-607-7894
Claims/billing Address	Provider Appeal Address
Aetna Better Health of Florida P.O. Box 982960 El Paso, TX 79998-2960	Aetna Better Health of Florida PO Box 81040 5801 Postal Road Cleveland, OH 44181
Claims payer ID for EDI	Real time payer ID
128FL	ABHFL
Claim timely filing – initial & corrected claims	Claims inquiry / claims research (CICR)
180 days from date of service or date of discharge	1-844-528-5815 , prompt 2, then prompt 2 again
Aetna Better Health of Florida Website	Nurse Line
AetnaBetterHealth.com/Florida	1-888-607-8180
Provider Services Email Address	CVS Mail Order Phone Number
FLMedicaidProviderRelations@aetna.com	1-855-271-6603
Pharmacy Helpdesk Number	Web Portal
1-866-693-4445	AetnaBetterHealth-Florida.Aetna.com
Prior Authorization Phone Number Case Management	Prior Authorization Fax Numbers
1-844-528-5815	Medical (general services) 1-860-607-8056 Obstetrics 1-860-607-8726 Pharmacy 1-855-799-2554 Behavioral Health 1-833-365-2493

Florida Healthy Kids Corporation

Florida Healthy Kids Corporation
P.O. Box 980 Tallahassee, FL 32302

1-888-540-KIDS (5437)
 TTY **1-800-955-8771**
 7:30 AM – 7:30 PM (ET)
 Monday - Friday (except holidays)
www.healthykids.org/

DCF Fraud & Abuse Hotline

To report Fraud, Waste or Abuse: **1-855-415-1558**

Aetna Better Health of Florida Compliance
 Hotline

1-888-891-8910

Florida Medicaid Consumer Complaint Hotline
 Agency for Health Care Administration
 Medicaid Program Integrity
 2727 Mahan Drive
 MS #6
 Tallahassee, FL 32308

1-888-419-3456
www.ahca.myflorida.com

Aetna Better Health of Florida Special
 Investigations Unit (SIU)

1-855-415-1558

Florida Attorney General

1-844-528-5815
1-866-966-7226

Florida Department of Children and Families -
 ACCESS

1-866-762-2237
www.myflfamilies.com

Florida Department of Health (DOH)

1-850-245-4444
www.floridahealth.gov/

Florida QUITLINE

Deaf or Hearing-Impaired Florida Relay

1-877-U-CAN-NOW (1-877-822-6669)
www.quitnow.net/florida/

TTY 711

Other Information

Durable Medical Equipment- DME:
 Please see our online provider search tool to
 locate DME providers.

AetnaBetterHealth.com/Florida

Change Healthcare (Emdeon) Customer Service
 Email Support: hdsupport@webmd.com

1-800-845-6592

Administrative overview

Provider tools

The Plan offers easy access to a variety of functions, web-based tools, and resources at [AetnaBetterHealth-Florida.Aetna.com/florida/providers](https://www.aetna.com/florida/providers). All participating providers may use this resource to access business activity information such as:

- Claim inquiries
- Remittance advices
- Business forms
- Member benefit information
- Member health alerts
- Authorization requirements and information
- Member eligibility
- Provider Manual
- Other business information or documentation

Our secure web portal can be accessed at [AetnaBetterHealth-Florida.Aetna.com/florida/provider portal](https://www.aetna.com/florida/provider-portal). Provider Relations team is available to address questions regarding the web site and services. You may contact a representative at **1-844-528-5815**. Hours of operation are Monday - Friday 8:00 AM to 5:00 PM Eastern Time. Sign up is quick and easy at [AetnaBetterHealth-Florida.Aetna.com](https://www.aetna.com). Please have your Federal Tax Identification Number available.

Translation services

If a language barrier prevents you from communicating effectively with our members, we have translation services available to assist. Our language line provides interpreter services at no cost. Please contact our Member Service Center at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time. Inform the Member Service Representative of your need of an interpreter and the language. The connection will be made for you.

For individuals with hearing impairment, we offer a **711** relay. For members who are hearing impaired, the health plan will utilize the **711** Telecommunications Relay Service (TRS). Members should call **711** and a representative will contact Member Service on their behalf.

As a provider of services, you should be aware of members who do not speak English or who have hearing impairments. Under Title VI of the Civil Rights Act and the Federal Rehabilitation Act, interpreter services must be available to ensure effective communication regarding treatment, medical history or health education. The Plan will arrange and pay for trained professionals when technical, medical or treatment information needs to be discussed with members. Please contact our Member Service department at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time, if you need translation services.

Providers must offer the member access to interpreter services, even when the member brings a friend or family member to interpret.

In this event, the member must be offered interpreter services and be informed that the services are available at no charge; the friend or family member should not be used to interpret unless specifically

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requested by the member, after having been advised of the availability of free interpreter services.

IVR (Integrated Voice Response System)

Access to information such as eligibility, claim status and authorization are available by using our Integrated Voice Response system (IVR) by calling Member Services and following the appropriate prompts at **1-844-528-5815**.

Forms and reference documents

Required forms and reference documents can be downloaded and printed from **AetnaBetterHealth.com/Florida**.

Designated liaison

Each Provider's office shall designate an office manager or administrator to be the primary contact person for the Provider Relations department.

Member responsibility

Providers acknowledge and agree that the Plan shall have no financial or other liability with respect to a member's failure to pay Providers amounts due the Providers for co-payment, co-insurance, or deductible as required under the member's contract or for non-covered services. Providers may not refuse to provide services to an eligible member solely because the member fails to pay the applicable co-payment at the time services are rendered.

Direct access and cost-sharing

Providers shall, as mandated by State or Federal law, the applicable member contract and this Manual; (i) allow members direct access to certain specialist physicians; (ii) not inhibit members' self-referral for certain services, including mammography screening and influenza vaccinations; and (iii) not impose cost-sharing on any member for influenza or pneumococcal vaccines. To the extent permitted by applicable law and benefit plan design (i.e. open access), members may self-refer without a primary care physician ("PCP") referral for (a) mental and behavioral health services.,

(b) gynecologists and obstetricians; (c) chiropractors; (d) podiatrists for routine care; (e) dermatologists for five (5) visits per year; and (f) optometrists, if such services are covered for the member, in addition to any other services for which applicable law allows direct access.

Marketing

Any Provider marketing activities or materials for Aetna Better Health of Florida must be approved by us in advance to ensure compliance with CMS and Florida Healthy Kids guidelines. This mandatory review will include letters announcing affiliation with Aetna Better Health of Florida, plan availability, events, health fairs, etc. Any gifts or promotional items must also follow guidelines promulgated by Florida Healthy Kids. Contact the Provider Relations representative for more information at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time.

Providers may not make available, accept or distribute Aetna Better Health of Florida enrollment applications or offer inducements to enroll in a specific plan. Providers shall not offer anything of value to induce a prospective Member to select them as their Provider.

Compliance and Ethics Program

The Plan is dedicated to conducting our business in accordance with the highest standards of ethical conduct. We are committed to conducting business activities with uncompromising integrity and in full compliance with the Federal, State and local laws governing the health benefits industry. This commitment applies to relationships with shareholders, customers (enrollees, Federal Providers, State and local governments), vendors, competitors, auditors and all public and government bodies. Most importantly, it applies to Directors, Officers, employees and representatives. Each employee is responsible for upholding the highest level of ethical standards that exemplify professionalism and promote confidence in the organization.

Provider subcontractor responsibilities

The Plan will be responsible for all work performed under this Contract, but may, with the prior written approval of Florida Healthy Kids enter into subcontracts for the performance of work required under this Contract. All subcontracts must comply with 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105 and 42 CFR 455.106.

Independent contractor relationship

In consideration of monthly premium payments made on behalf of Members, the Plan agrees to arrange for the delivery of health care services in accordance with and subject to the terms and conditions of the applicable member contract entered between the members, or on the member's behalf, and the Plan. Provider agrees the Plan, in so arranging for the delivery of health care services and supplies to members, provides such services or supplies through independently contracted providers.

In accordance with the agreement, provider and the Plan are independent contractors. The Plan shall not be liable for any negligent act or omission committed by a provider or any provider staff or hospital vendor who may from time to time, furnish services or supplies to members. Provider acknowledges and agrees that any decisions made by the Plan concerning appropriateness of setting or whether any service is covered are made solely for purposes of determining whether benefits are due under the applicable member contract, and not for purposes of recommending any medical treatment or non-treatment.

Florida Healthy Kids Program

Florida Healthy Kids is one of four programs under Florida KidCare children's health insurance program. Florida Healthy Kids provides access to health care for school age children 5-18 years of age that meet established eligibility guidelines such as citizenship, not residing in a public institution, and income.

Florida Healthy Kids is responsible for:

- Administering the Florida Healthy Kids program for children ages 5 through 18
- Determining eligibility for the non-Medicaid parts of the Florida KidCare program
- Collecting monthly premiums
- Managing the Florida KidCare customer service call center

Florida Healthy Kids holds the contract for the Plan which outlines policies, procedures, and programs to promote access to quality medical, behavioral, and therapeutic services for Florida Healthy Kids recipients. For additional information regarding the Florida Healthy Kids program visit, www.healthykids.org. The Plan will adhere to and otherwise fully comply with all terms and conditions of its contract with Florida Healthy Kids, notwithstanding any relationship(s) the Plan may have with any subcontractor.

Florida Healthy Kids Coverage and Limitations

Aetna Better Health of Florida and Providers shall comply with applicable Florida Healthy Kids coverage and limitations and shall not be more restrictive than the Florida Healthy Kids limitations and exclusions.

Other Agencies

If you need further help, you may contact:

Florida Department of Financial Services
200 East Gaines Street
Tallahassee, Florida 32399
Telephone **1-800-342-2762**

Florida Healthy Kids
P.O. Box 980
Tallahassee, Florida 32302
Telephone **1-888-540-5437**, Monday – Friday between 7:30 AM - 7:30 PM (ET)

Listing of Healthy Kids Covered Services See table below for the Covered Services:

Medical and Prescription 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

Summary of your benefits

VI. Other benefits	Copayment
<p>A. Outpatient physical, occupational, respiratory and speech therapy Limited to no more than 24 treatment sessions within 60 Calendar Days of illness or injury</p> <ul style="list-style-type: none"> • 60-day period begins with the first treatment • Some therapies require prior authorization from Aetna Better Health 	\$5
<p>B. Home health services</p> <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
<p>C. Hospice care</p>	\$5
<p>D. Refraction (Vision testing by Optometrist)</p>	\$5
<p>E. Corrective lenses and frames</p> <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
<p>F. Durable medical equipment and prosthetic devices</p>	\$0
<p>G. Nursing facility</p>	\$0
<p>H. Pharmacy</p> <ul style="list-style-type: none"> • Up to a 31 Calendar Day supply 	\$5

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

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	<p>The first gift card is available after ninety (90) days of sobriety as indicated by:</p> <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 • Participation in care management for a minimum of ninety (90) days • Negative urine toxicology screen at ninety (90) days <p>The second gift card is available after one hundred eighty (180) days of sobriety as indicated by:</p> <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 • 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	<p>The following additional benefits for members with an asthma diagnosis will be provided:</p> <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

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. Benefits are predetermined by Florida Healthy Kids and not Aetna Better Health of Florida. 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 after the enrollee receives approval from Florida Healthy Kids that their enrollment was accepted.

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

Open enrollment

Members have the option to change health plans during the first 90 days of enrollment. Thereafter, members can change Health Plans annually during open enrollment. The Florida Healthy Kids program will send members a notice of their option to change Health Plans and the associated deadline. Enrollment in a new Health Plan will be effective on the member's anniversary date.

Disenrollment

Member may disenroll from Aetna Better Health of Florida at any time during the first 90 days of enrollment. After the first ninety (90) days, the member is "locked in" as an Aetna Better Health of Florida member unless there is good cause to dis-enroll. Florida Healthy Kids will decide if the member has good cause.

Member identification card

All members receive an identification (ID) card shortly after enrollment. Members must present their ID card to their provider at the time services are rendered. The ID card will list the member's name, member number, primary care physician (PCP) (if applicable), group name and number, the benefit plan type, as well as copayments or coinsurance for office visits, prescriptions, outpatient and inpatient services.


Benefits vary among different products. Therefore, it is important to reference the member ID card for the correct copayment. The ID card will also contain important Member Services phone numbers for the Plan and the pharmacy vendor.

The member ID card contains the following information:

- Member Name

- Member ID Number
- Date of Birth of Member
- Member’s Gender
- Effective Date of Eligibility
- Claims address
- Health Plan Name - Aetna Better Health of Florida
- Aetna Better Health of Florida Logo
- Aetna Better Health of Florida’s Website

Sample ID Card:

Aetna Better Health® of Florida Florida Healthy Kids				Aetna Better Health of Florida 8200 NW 41st Street, Suite 125, Doral, FL 33166	
Name LastName, FirstName		Member ID # 0000000000		DOB 00/00/0000 Sex X	
PCP LastName, FirstName		PCP Phone 000-000-0000		Effective Date 00/00/0000	
Copays PCP: \$0 Spec: \$0 ER: \$0 UC: \$0		RxBIN: 610591 RxPCN: ADV RxGRP: RX8840		Important numbers for members Member Services 1-844-528-5815 (FL Relay 711) 24-Hour Nurse Line 1-844-528-5815	
Pharmacist Use Only: 1-866-693-4445		AetnaBetterHealth.com/Florida		Important numbers for providers Authorization/Eligibility 1-844-528-5815 Billing Information for Non-Contracted Provider 1-844-528-5815	
MEFLPHK1		MEFLPHK1		Submit Medical Claims to: Aetna Better Health of Florida PO Box 982960 El Paso, TX 79998-2960 Payer EDI: 129FL <small>THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. FLPHKI</small>	

Continuity of care in enrollment

Aetna Better Health of Florida shall be responsible for coordination of care for new Florida Healthy Kids enrollees transitioning into the Plan. In the event a new enrollee is receiving a prior authorized, ongoing course of treatment for a covered service with any provider, the Managed Care Plan shall be responsible for the costs of continuation of such course of treatment without regard to whether such services are being provided by participating or non-participating providers.

Aetna Better Health will honor documented authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment. We will also cover some services beyond the sixty (60) days. Enrollees can keep getting these services from their providers, even if he or she is not in our network under the following reasons:

- Maternity care: including prenatal and postpartum care through completion of postpartum care(6 weeks after birth);
- Transplant services: through the first post-transplant year;
- Radiation and chemotherapy: through the current round of treatment;
- Controlled substance prescriptions: if a new, printed paper prescription is required by Florida law, the new plan will help schedule an appointment with the original prescribing provider, or a new provider if needed, so the child can get a new prescription without a medication gap

Community Outreach and Marketing Activities

Provider may not:

1. 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.
2. Mail marketing materials on behalf of Aetna Better Health of Florida.
3. Offer anything of value to induce recipients/members to select them as their provider.
4. Offer inducements to persuade recipients to enroll in Aetna Better Health of Florida.
5. Conduct health screening as a marketing activity.
6. Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.
7. Distribute marketing materials within an exam room setting.
8. Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan. For a complete list of community outreach and marketing activities, refer to [AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida).

In accordance with the following regulatory requirements, providers are not authorized to send referrals to Comprehensive Assessment and Review for Long Term Care Services (CARES) offices.

- In accordance with 42 CFR 438.104(b) (1) (iv), the contractor and its subcontractors will not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
- In accordance with 42 CFR 438.104 (b) (1) (v), the contractor and its subcontractors will not, directly or indirectly, engage in door-to-door, telephone, or other cold-calling marketing activities.
- In accordance with 42 CFR 438.104 (b)(2)(i), the contractor and its subcontractors will not, directly make any assertion or statement (whether written or oral) that the beneficiary must enroll with the contractor in order to obtain (Medicaid State Plan benefits) or in order to not lose benefits (Medicaid State Plan benefits).
- In accordance with s. 409.912(21) (B), F.S., and 42 CFR 438.104 (b) (2) (ii), the contractor and its subcontractors will not make any inaccurate false or misleading claims that the contractor is recommended or endorsed by any federal, state or county government, the Agency, CMS, department, or any other organization which has not certified its endorsement in writing to the contractor.

Provider compliance

Aetna Better Health of Florida will verify, through provider education and outreach, that its health care providers are aware of and comply with the following requirements:

- Health care providers may display Aetna Better Health of Florida -specific materials in their own offices.
- Health care providers cannot 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.
- Health care providers may announce a new affiliation with Aetna Better Health of Florida and give their patients a list of managed care plans with which they contract.
- Health care providers may 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.

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- Health care providers will not furnish lists of their Florida Healthy Kids patients to Aetna Better Health of Florida, or any other entity, nor can providers furnish other Managed Care Plans' membership lists to Aetna Better Health of Florida, nor can providers assist with Managed Care Plan enrollment.
- For Aetna Better Health of Florida, health care providers may 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 to Florida Healthy Kids.

Emergency service responsibilities

Aetna Better Health of Florida has an emergency management plan that specifies what actions Aetna Better Health will take to ensure the ongoing provision of covered services in a disaster or man-made emergency including, but not limited to, localized acts of nature, accidents, and technological and attack-related emergencies. Aetna Better Health of Florida offers an after-regular business hours provider services line that is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for a member with an emergency or urgent medical condition. This will not be construed to mean that the provider must obtain verification before providing emergency services and care.

The Plan will provide pre-hospital and hospital-based trauma services and emergency services and care to members. See ss. 395.1041, 395.4045 and 401.45, F.S.

- When a member presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician. See ss. 409.9128, 409.901, F.S. and 641.513, F.S.
- The physician, or the appropriate personnel, will indicate on the member's chart the results of all screenings, examinations and evaluations.
- The Plan will cover all screenings, evaluations and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the member's condition is an emergency medical condition.
- If the provider determines that an emergency medical condition does not exist, the Plan is not required to cover services rendered subsequent to the provider's determination unless authorized by the Plan.
- If the provider determines that an emergency medical condition exists, and the member notifies the hospital, or the hospital emergency personnel otherwise have knowledge that the patient is a member of the Plan, the hospital must make a reasonable attempt to notify:
 - The member's PCP, if known, or
 - The Plan, if the Plan has previously requested in writing that it be notified directly of the existence of the emergency medical condition.
- If the hospital, or any of its affiliated providers, do not know the member's PCP, or have been unable to contact the PCP, the hospital must:
 - Notify the Plan as soon as possible before discharging the member from the emergency care area; or
 - Notify the Plan within twenty-four (24) hours or on the next business day after the member's inpatient admission.

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- If the hospital is unable to notify the Plan, the hospital must document its attempts to notify the Plan, or the circumstances that precluded the hospital's attempts to notify the Plan. The Plan will not deny coverage for emergency services and care based on a hospital's failure to comply with the notification requirements of this section.
- If the member's PCP responds to the hospital's notification, and the hospital physician and the PCP discuss the appropriate care and treatment of the member, the Plan may have a member of the hospital staff with whom it has a participating provider contract participate in the treatment of the member within the scope of the physician's hospital staff privileges.
- The Plan shall advise all members of the provisions governing emergency services and care. The Plan shall not deny claims for emergency services and care received at a hospital due to lack of parental consent. In addition, the Plan will not deny payment for treatment obtained when a representative of the Plan instructs the member to seek emergency services and care in accordance with s. 743.064, F.S.

Provider Responsibilities and Programs

This section outlines general provider responsibilities; however, additional responsibilities are included throughout the manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the Florida Healthy Kids Program, your Provider Agreement, and requirements outlined in this manual. Aetna Better Health of Florida may or may not specifically communicate such terms in forms other than your Provider Agreement and this Manual. Providers must cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, the Florida Healthy Kids , Department of Health (DOH), the Medicaid Fraud Control Unit (MFCU), Health and Human Services – Office of Inspector General (HHS-OIG), Federal Bureau of Investigation (FBI), Drug Enforcement Administration (DEA), Food and Drug Administration (FDA), and the U.S. Attorney’s Office.

Providers must act lawfully in the scope of practice of treatment, management, and discussion of the medically necessary care and advising or advocating appropriate medical care with or on behalf of a member, including providing information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered including all relevant risk, benefits and consequences of non-treatment. Providers must use of the most current diagnosis and treatment protocols and standards established by Florida Healthy Kids and the medical community. Advice given to potential or enrolled members should always be given in the best interest of the member. Providers may not refuse treatment to qualified individuals with disabilities, including but not limited to individuals with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS).

A provider must complete an application, Provider Agreement and be fully credentialed to be approved for participation and treat any members. Upon execution of the agreement a copy will be returned to the provider for his/her records along with a welcome letter advising of product participation and effective dates.

Provider agreements may be executed pending the outcome of the provider’s enrollment process. The Plan will terminate network providers immediately upon notification from the Agency that the provider cannot be enrolled, or upon expiration of the one hundred twenty (120) day period without enrollment of the provider.

For Public Health Providers, providers are required to contact the Plan before providing health care services to members and are required to provide the Plan with results of the office visit, including test results.

Provider Selection Criteria

Our network is open for application by a particular Provider/Provider specialty type if at least one of the following criteria is met:

1. Access and availability standards are not being met in that area
2. There appears to be a need in the marketplace for a particular specialty due to referral patterns
3. Member, group or provider self-nomination (*Depending upon product and geography any provider requesting a direct contract, provider information will be shared with the specialty network for review and consideration.*)

The Plan shall not discriminate with respect to participation, reimbursement, or indemnification as to any

Provider, who is acting within the scope of Provider's license, or certification under applicable state law solely on the basis of such license or certification in accordance with s. 1932(b) (7) of the Social Security Act (as enacted by s. 4704[a] of the Balanced Budget Act of 1997). The Plan shall not discriminate against any Provider serving high-risk populations or those that specialize in conditions requiring costly treatments.

Minority recruitment and retention plan

Aetna Better Health makes every effort to recruit and retain providers of all ethnicities to support the cultural preferences of its members. Our provider networks are not closed to new provider participation barring provider willingness to accept contractual requirements, contractual rates and satisfy all credentialing and regulatory requirements. The Plan reviews and accommodates all provider nomination requests, when appropriate, from both members and providers to ensure all providers are equally represented in Aetna Better Health's provider network.

As part of this process, Aetna Better Health collects and publishes spoken languages and ethnicity in our provider directories. Please be sure to accurately indicate all languages spoken in your office(s) on your Aetna Better Health re-credentialing application and/or CAQH application or contact your Provider Relations representative to have updates completed.

Native Americans

Aetna Better Health does not impose enrollment fees, premiums or similar charges on Native Americans served by a Native American Healthcare provider; Native American Health Service, a Native American Tribe, Tribal Organization or Urban Indian Organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.

Requirements regarding background screening

Aetna Better Health of Florida has established and verified provider credentialing and re-credentialing criteria that includes a determination of whether the provider, employee or volunteer of the provider, meets the definition of "Direct Service Provider" and completion of a Level 2 criminal history background screening on each Direct Service Provider to determine whether any have disqualifying offenses as provided for in s. 430.0402, F.S., and s. 435.04, F.S. Any Provider, employee, or volunteer of the provider meeting the definition of "Direct Service Provider" who has a disqualifying offense is prohibited from providing services to members.

No additional Level 2 screening is required if the individual is qualified for licensure or employment by AHCA pursuant to its background screening standards under s. 408.809, F.S., and the individual is providing a service that is within the scope of his or her licensed practice or employment. (See s. 430.0402(3), F.S.)

- Aetna Better Health of Florida must maintain a signed affidavit from each provider attesting to its compliance with this requirement, or with the requirements of its licensing agency if the licensing agency requires Level 2 screening of Direct Service Providers.
- Aetna Better Health of Florida must include compliance with this requirement in its provider contracts and subcontracts and verify compliance as part of its subcontractor and provider monitoring activity.

Aetna Better Health of Florida shall not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any

of the offenses listed in s.435.04, F.S. Individuals already screened as Medicaid providers or screened within the past twelve (12) months by another Florida agency or department using the same criteria as the Agency are not required to submit fingerprints electronically but shall document the results of the previous screening.

Individuals listed in s. 409.907(8)(a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency's background screening website.

Changes to Provider Information or Status

Please notify The Plan in writing within sixty (60) days or in accordance with your agreement of any additions, deletions or changes to the topics listed below. Failure to notify The Plan timely could negatively impact claims processing.

- Tax identification number (submission of W-9 required). Changing a tax identification number will require a new agreement with the new tax identification number
- Office or billing address
- Telephone or fax number
- Specialty (may require additional credentialing)
- New physician additions to the practice (please allow time for credentialing)
- Licensure (DEA, state licensure or malpractice insurance)
- Group affiliation
- Hospital privileges

If you have any changes, written notification is required as far in advance as possible to the Plan's Network Operations department at:

Aetna Better Health of Florida
9675 NW 117th Ave, Suite 202
Miami, FL 33178-1228

Our phone number is **1-844-528-5815** and hours of operation are, Monday – Friday 8:00 AM to 5:00 PM Eastern Time. You can fax us at **1-844-235-1340**. By providing the information prior to the change, the following is ensured:

- The practice address is properly listed in the Provider Directory
- All claim payments are properly reported to the Internal Revenue Service (IRS)
- There is no disruption in claims payments and claims are processed accordingly
- Members are notified in a timely manner if a change to their PCP becomes necessary or if they desire as a result of a Provider address change or inability to continue participation

Staff/administration changes and training

Providers are responsible to notify our Provider Relations Department on any changes in professional staff at their locations. This includes any physicians/medical director, physician assistants, or clinician

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practitioners. Aetna Better Health understands that changes in office staff may result in the need for additional training. Contact our Provider Relations Department to schedule staff training.

Continuity of care (COC)

Providers terminating their contracts without cause are required to provide a 60-day notice before terminating with Aetna Better Health of Florida. Provider must also continue to treat our members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services.

Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. Aetna Better Health of Florida is not responsible for payment of services rendered to members who are not eligible. You may also contact our Member Services department at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time.

Unique identifier/national provider identifier (NPI)

Providers who provide services to Aetna Better Health of Florida members must obtain identifiers. Each provider is required to have a unique identifier, and qualified providers must have a National Provider Identifier (NPI) on or after the compliance date established by the Secretary of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996. You may apply for an NPI number by visiting the National Plan & Provider Enumeration Systems (NPPES) website:

<https://nppes.cms.hhs.gov>.

Providers are required to submit their NPI on every claim.

If you provide direct health care services to members, you need to add your national provider identifier (NPI) number to claims. Claims may be rejected or denied when submitted without an NPI or with an invalid NPI, depending on the method of submission. Be sure to:

- Use the NPI you registered with Florida Medicaid
- Bill for services as you are registered on the Florida PML

You can verify this information:

- Online: **mymedicaid-florida.com**
- Phone: Florida Medicaid Provider Enrollment Call Center at **1-800-289-7799**, Option 4.

Verifying member eligibility

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. Providers are NOT reimbursed for services rendered to members who have lost eligibility. Presentation of an Aetna Better Health of Florida ID card is not a guarantee of eligibility. The provider is responsible for verifying a member's current enrollment status before providing care.

Member eligibility can be verified through one of the following:

Telephone Verification: Call our Member Services department at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time . To protect member confidentiality, providers are asked for at least

three pieces of identifying information such as the members identification number, date of birth and address before any eligibility information can be released. Additional member eligibility requirements are noted in Section 08 of this manual.

Secure Web Portal: The Secure Web Portal is a web-based platform that allows us to communicate member health care information directly with providers. Providers can perform many functions within this web-based platform.

The following information can be obtained from the Secure Web Portal:

- Member Eligibility Search – Verify current eligibility of one or more members.
- Provider List – Search for a specific provider by name, specialty, or location.
- Claims Status Search – Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user’s account provider ID will be displayed.
- Electronic Remittance Advice (ERA) Search – Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user’s account provider ID will be displayed.
- Provider Prior Authorization Look up Tool – Search for provider authorizations by member, Provider, authorization data, or submission/service dates. Only authorizations associated with the user’s account provider ID will be displayed. The tool will also allow providers to:
 - Search Prior Authorization requirements by individual or multiple Current Procedural Terminology/Healthcare Common Procedures Coding System (CPT/HCPCS) codes simultaneously
 - Review Prior Authorization requirement by specific procedures or service groups
 - Receive immediate details as to whether the codes (s) are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information
 - Export CPT/HCPCS code results and information to Excel
 - Verify staff is working with the most up-to-date information on current prior authorization requirements
 - Submit Authorizations – Submit an authorization request on-line.
- Healthcare Effectiveness Data and Information Set (HEDIS) – Check the status of the member’s compliance with any of the HEDIS measures. A “Yes” means the member has measures that they are not compliant; a “No” means that the member has met the requirements.
- Provider manual
- Provider newsletters
- Pharmacy information
- Electronic Fund Transfer (EFT) – Direct deposit information to improve payment consistency
- Network Vendor List
- Provider notifications including all fax blast and provider bulletins

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website.

Educating members on their own health care

Aetna Better Health of Florida does not prohibit providers from acting within the lawful scope of their practice and encourages them to advocate on behalf of a member and to advise them on:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
- Any information the member needs to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions

Acceptance of members

Provider shall accept as patients all Members that select or are assigned to a Provider unless otherwise agreed upon in writing with our Provider Relations Department. Written approval is required for a Provider's panel to be frozen preventing or refusing new Members. Upon approval, Provider's panel may remain open only to existing patients who are Members at the time the Provider's panel is frozen ("Existing Members"). In such case, if a Member desires to select a Provider with a panel open only to existing Members, the Plan will contact the Provider to verify that the Member meets the criteria for an existing Member. If the Provider confirms that this is an existing Member, we will open the panel to allow that Member to select the Provider. Upon a Provider's acceptance of a Member, Provider may terminate the Member from its panel or as its patient only upon satisfaction of applicable provisions of this Manual and applicable laws and regulations.

If a member is non-compliant or does not comply with the member rights and responsibilities as set forth herein, the Provider may notify the member of the situation in writing. However, the Provider may not terminate the member from their panel or services. Provider must request, in writing, that a member be removed from their panel; provided, however, that no such request can be based on the member's medical condition, which request shall be determined by the Plan's sole discretion. Such request must be sent to our Provider Relations Department.

The Plan shall make reasonable efforts to confirm or deny eligibility using the most current information available; provided however, that Providers' compliance with such verification procedures and/or confirmation of a member's eligibility does not constitute a guarantee of such member's eligibility or the Plan's coverage of any services provided by Providers in reliance on such confirmation. Providers may verify eligibility by contacting a Provider Relations Representative or [AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida).

Managing the member's health care

Under certain member Contracts, a referral or prior authorization must be obtained prior to the provision of certain covered services, as set forth in this manual and as required by the applicable coverage plan and the agreement. All prior authorizations and referrals can be done electronically via [AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida). If you are submitting a prior authorization request with clinical attachments, complete a Prior Authorization form and fax to the Authorization Department at **1-860-607-8056**. Paper versions of the prior authorization and referral forms can be downloaded and printed from the Authorizations section on the Plan's Provider secure website portal at [AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida).

No PCP referral is required for any care listed under the Direct Access provision of this manual. Except in

the case of emergency services, urgently needed services, as otherwise permitted under this manual or applicable state or federal law, upon the prior written approval of a medical director or his/her designee, or as otherwise permitted under the applicable member contract, all referrals shall be made and prior authorizations obtained by providers in accordance with this manual, the agreement and the applicable member contract. Any laboratory services provided to members in providers' offices shall not be reimbursable covered services, unless otherwise expressly provided in the agreement.

PCP shall use his/her best efforts to provide members with any necessary referrals or obtain any required prior authorization while the member is in PCP's office.

Providers are required to participate in the Plan's Peer Review, Grievance and Appeals, QI and UM activities, as directed by the Plan.

Authorizing treatment for members

Authorization is not a guarantee of payment. All Providers must contact the Plan via **[AetnaBetterHealth Florida.Aetna.com](https://www.aetna.com/Florida)** or the Authorization Department at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time, or by fax at **1-860-607-8056** to obtain a prior authorization before scheduling a member for any medical service subject to prior authorization. The Plan may require the submission of clinical information to support a prior authorization request. Hospitals shall notify the Plan of an admission occurring subsequent to the provision of emergency services.

Emergency services do not require prior authorization.

IMPORTANT: The following services may not be covered under all member contracts even though such services are listed below. Members should refer to their schedule of benefits or evidence/certificate of coverage for information regarding their covered services. This applies to all member contracts.

- Drug Order for Home Use
- Chemotherapy Drug Replacement
- Physician Office Medications

Providers must contact the Plan via **[AetnaBetterHealth-Florida.Aetna.com](https://www.aetna.com/Florida)** or the Authorization Department at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time, or by fax at **1-860-607-8056** to obtain a prior authorization for medically necessary services for members when the service is not listed in the Coverage Policy. This is applicable for medically necessary services typically not covered by the Plan or for services typically limited in amount, frequency or duration.

Timeliness of authorizations

Providers are encouraged to submit their requests for authorization of services utilizing the Provider portal at **[AetnaBetterHealth-Florida.Aetna.com](https://www.aetna.com/Florida)**. Best efforts shall be utilized to provide requested prior authorizations promptly; provided, however, that providers agree to take a pending or tracking number in the event further information is required to make the coverage decision or if the request is subject to clinical review. For Florida Healthy Kids members, routine prior authorization requests will be completed within 14 calendar days of receipt of the request. All medical denial determinations will be made by a Florida licensed Medical Director. Denial letters will be sent to the member by U.S mail and provider by fax or U.S. mail.

It is critical to allow enough time to process standard requests in a timely manner and only submit

expedited requests when truly necessary. Expedited authorization is appropriate when a provider indicates, or the Plan determines, that following the standard timeline could seriously jeopardize the members life or health or ability to attain, maintain or regain maximum function.

Urgent prior authorization requests will be processed within 72 hours of the Plan's receipt of the request, unless additional information is required. The determination, approval or denial, will be verbally communicated or faxed to the requesting provider and/or the member at the time the decision is rendered followed by written notice of a denial determination to the provider and the member. Authorization status can be obtained by using [AetnaBetterHealth-Florida.Aetna.com](https://www.aetna.com).

Weather and emergency-related closings

At times, emergencies such as severe weather, fires, or power failures can disrupt operations. In such instances, it is important for Aetna Better Health of Florida to be kept informed of your status. This is of real significance if you have an active authorization for a member. If you have a member and need assistance, please contact our Provider Relations department at **1-844-528-5815**, Monday – Friday 8:00 AM to 5:00 PM Eastern Time.

Membership assigned to PCPs

Members may choose a PCP from the Provider Directory. Every month, PCPs receive a membership listing of the members that have chosen them as their PCP. PCPs shall contact any new Florida Healthy Kids members within 30 days of being assigned to their panel to ask if they need any assistance or to schedule an office visit for continued medical care.

Each PCP office shall designate an encounter/referral coordinator to ensure that encounters and referrals are completed and submitted to the Plan and/or the member. Encounters may be submitted electronically or on a CMS1500 form.

Individuals with disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Regular provider office visits will be conducted by our Provider Relations staff to verify that network providers are compliant.

Hospitalist program

Under the Plan's Hospitalist Program (the "Program"), PCP acknowledges and agrees that hospitalist physicians provide primary care services which PCP is otherwise obligated to provide under the

agreement on behalf of members assigned to PCP (“PCP Members”) who present as observation or as inpatients to a hospital, including, but not limited to (i) evaluation of PCP members presenting to the hospital’s emergency room; (ii) conducting daily hospital rounds of PCP members; (iii) coordinating care of PCP members and ensuring timely provision of covered diagnostic tests and procedures; (iv) communicating regularly with PCP, PCP members and the PCP members’ families, as appropriate; and (v) overseeing and coordinating discharge planning of PCP members with the PCP, The Plan and the hospital. PCPs who elect to participate in the program shall assign responsibility of PCP members to hospitalist physicians when PCP members present to the emergency department or are inpatients of a hospital.

In cases where a PCP elects not to participate in the program, the PCP shall continue to perform all other primary care services with respect to PCP members, including, but not limited to (i) resuming responsibility for all care, including follow-up care, of a PCP member immediately upon the PCP member’s discharge from the hospital; (ii) communicating all medical information/history to the hospitalist physician or other physician attending to a PCP member which is necessary to the PCP member’s care and treatment in the hospital; and (iii) performing any and all other requirements as requested by the Plan in connection with the PCP’s participation in the program.

Hospitals acknowledge and agree that if a PCP member presents to the emergency department, the hospital shall notify PCP member’s PCP and/or hospitalist physician participating in the Plan’s hospitalist program. There is no provision that prohibits the PCP from providing inpatient services in a participating hospital to a member if such services are determined to be medically necessary and covered services under the Florida Healthy Kids contract.

Specialist physicians

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

Referrals for specialist services

Except for (i) emergency services; (ii) urgently needed services; (iii) as otherwise permitted under this Manual, the applicable member contract or applicable state or federal laws; or (iv) upon the prior written approval of the Plan’s medical director or his/her designee, specialist shall not provide specialist services to members who’s member contract has a referral requirement unless the member furnishes specialist with a completed referral from the member’s PCP.

Follow-up care

Specialist shall coordinate the provision of specialist services with the member’s PCP in a prompt and efficient manner and, except in the case of an emergency medical condition, shall not provide any follow- up or additional specialist services to members other than the covered services indicated on the applicable referral form provided to specialist by the Plan or the PCP. Within ten business days of providing specialist services to a member, specialist shall furnish the member’s PCP with a written report regarding the member’s medical condition in such form and detail reasonably acceptable to the member’s PCP and the Plan. Specialist shall at all times promptly and openly communicate with the member’s PCP regarding the member’s medical condition, including, without limitation obtaining the appropriate pre-authorization should a member require additional or follow-up covered services.

Except in the case of emergency services, **urgently needed services**, as otherwise permitted under the

applicable member contract, applicable law or upon the prior written approval of the Plan's medical director or his/her designee, specialist shall refer members back to the member's PCP in the event specialist determines the member requires the services of another specialist physician.

Urgently Needed Services/Urgent care

Covered Services for conditions that (i) though not life- threatening, could result in serious injury or disability to the member unless medical attention is received or (ii) substantially restrict a member's activity; and (iii) which are provided (a) when a member is temporarily absent from the service area or; (b) under unusual and extraordinary circumstances, when the member is in the service area but all participating providers are temporarily unavailable or inaccessible when such covered services are medically necessary and immediately required (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable given the circumstances to obtain the covered services through a participating provider. Examples include, without limitation, high fever, animal bites, fractures, severe pain, infectious illness, flu and respiratory ailments.

Obstetricians

The obstetrical notification form should be completed during a members' first prenatal visit. The form is located in the Document Library under the Preauthorization Lists section of the Plan's website at AetnaBetterHealth.com/Florida. The obstetrical notification form should be faxed to Aetna Better Health at **1-860-607-8726**.

Prescriptions from OB/GYN

A gynecologist or obstetrician may issue prescriptions for (i) covered services which do not otherwise require prior authorization in accordance with this Manual; and (ii) covered services provided by gynecological oncologists, maternal and fetal medicine specialists, reproductive endocrinologists and uro-gynecologists. The gynecological oncologist, maternal and fetal medicine specialist, reproductive endocrinologist or uro-gynecologist must contact Aetna Better Health directly at **1-844-528-5815**, Monday– Friday 7:30 AM to 7:30 PM Eastern Time, for prior authorization prior to providing services to members.

Hospital services

For Hospital Services, members have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand. Members have the right to participate in decisions regarding their health care, including the right to refuse treatment.

Hospital Emergency Services

In the case of an emergency medical condition, hospitals are not required to obtain prior authorization from the Plan prior to providing emergency services to members; provided, however, that upon admitting a member into hospital, hospital shall immediately notify the hospitalist physician participating in The Plan's hospitalist program or other designated Provider of such admission and obtain the required prior authorization by going to Provider Portal at AetnaBetterHealth.com/Florida or contacting the Utilization Department at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time, in

accordance with this manual.

Except for emergency services, coverage of all services rendered to members by hospital is subject to The Plan's sole determination of whether such service is a covered service under the applicable member contract. In the event it is determined that an emergency medical condition does not exist with respect to a member who presented to the hospital, hospital must comply with all prior authorization requirements as set forth in this manual prior to providing any non-emergency services to a member. Hospital's failure to obtain all required prior authorizations for non-emergency services may, in The Plan's sole discretion, result in the Plan's denial of payment for such services as set forth in the agreement.

Hospital shall comply with this manual and the agreement in providing non-emergency services to members. Hospital acknowledges and agrees that the Plan has the right to review the admission of any member for an emergency medical condition for appropriateness of continued stay in accordance with the Manual.

Follow-Up Care

Hospital shall coordinate the provision of hospital services with the member's PCP in a prompt and efficient manner and, except in the case of an emergency medical condition, as otherwise permitted under the manual or applicable state or federal law or upon the prior written approval of the Plan's medical director or his/her designees', shall not provide any follow-up or additional hospital services to members other than the covered services in accordance with the prior authorization for such services. Hospital shall at all times promptly and openly communicate with the member's PCP regarding the member's medical condition, including, without limitation obtaining the appropriate prior authorization should a member require additional or follow-up covered services.

Child Health checkup

A child health checkup is a regularly scheduled comprehensive, preventive health screening service for children from birth through age 20. Child health checkups are performed according to a periodic schedule to help children have routine health screenings to identify and correct medical conditions before the conditions become more serious and potentially disabling. Child Health Checkup (CHCUP) is Florida's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

A child health checkup is composed of the following:

- Comprehensive health and developmental history, including assessment of past medical history, developmental history and health status
- Nutritional assessment
- Developmental assessment
- Comprehensive unclothed physical examination
- Dental screening, including 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, anticipatory guidance
- Diagnosis and treatment
- Referral and follow-up, as appropriate

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Well child visits are performed based on age and developmental needs. There is no limit to the number of visits.

Early and periodic screening, diagnosis, and treatment

As required by federal law, Florida Healthy Kids provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information on how to obtain an authorization, please refer to Authorizing Treatment for Members.

Family planning services

Members younger than 18 are required to receive family planning services provided the member is married, a parent, pregnant, has written consent from a parent or legal guardian or, in the opinion of a physician, the member may suffer health hazards if the services are not provided.

Hysterectomies, sterilizations and abortions

Participating providers must maintain a log of all hysterectomy, sterilization and abortion procedures performed on members. The log must include, at a minimum, the member's name and identifying information, date of procedure and type of procedure. The participating provider should provide abortions only in the following situations:

- If the pregnancy is a result of an act of rape or incest; or
- The physician certifies that the woman is in danger of death unless an abortion is performed.

Value Based Services (VBS)

Aetna Better Health currently offers a very targeted approach to our value-based continuum. Participants are selected based on the provider practice size and specialties, membership panel, location and population as well as on the level of clinical and technological capabilities. Our Value-Based Program (VBP) arrangements are based on collaboration between provider and plan. The collaboration supports clinical success and aims at achieving key objectives:

- Increase access to care for our members in the regions we serve
- Improve quality of care and outcomes

This collaboration supports providers in their transition from pay-for volume (fee for service) to pay-for-value by improving access and quality in the healthcare system. We offer performance-based reimbursement as well as performance reporting and analytics. The performance-based reimbursement may be tied to clinical outcomes.

Cultural Competency

Introduction

Aetna Better Health of Florida and its Florida affiliates recognize that a person's cultural norms, values and beliefs shape how they approach and utilize health care services. Numerous cultural variables including, but not limited to, ethnicity, race, gender, age, socio-economic status, primary language, English proficiency, spirituality, religion and literacy level influence the way in which a person seeks and utilizes health services and the manner in which a person approaches and manages recovery.

The Cultural Competency Plan (CCP) has been developed to outline the methods used by Aetna Better Health of Florida (the Plan) to ensure that members receive care that is delivered in a culturally and linguistically sensitive manner. The CCP is comprehensive and incorporates all members, employees and providers. The Health Plan recognizes that respecting the diversity of our members has a significant and positive effect on outcomes of care and have adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards, as developed by the Department of Health and Human Services, Office of Minority Health, as guidelines for providing culturally and linguistically competent services. These 15 standards are organized by themes:

- Principle Standard (Standard 1)
- Governance, Leadership, and Workforce (Standards 2-4)
- Communication and Language Assistance (Standards 5-8)
- Engagement, Continuous Improvement and Accountability (Standards 9-15)

The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that may experience unequal access to health services.

Cultural Competence definition

Cultural and linguistic competence is a set of coinciding behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups. "Competence" implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and their communities (Rural Assistance Center, 2008).

Stated more simply, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

Also, cultural competence can be defined as services that are sensitive and responsive to cultural differences whereby caregivers are aware of the impact of culture and possess the skills to help provide services that respond appropriately to a person's unique cultural differences, including race and ethnicity, national origin, religion, age, gender, sexual orientation or physical disability.

Goals of the Cultural Competency Plan

The purpose of the Plans' Cultural Competency Plan is to implement enterprise-wide methodologies and processes that measure and improve clinical care and services that are mindful of the language and cultural needs of the Plans' members.

The Plan has implemented procedures to help our staff and Providers develop awareness and appreciation of cultural customs, values and beliefs, and provide educational information and references to facilitate their incorporation into the assessment of, treatment of, and interaction with our members. We encourage our staff to share and utilize their own cultural diversity to enhance the services provided to our members.

We're committed to providing competent health care that is culturally and linguistically sensitive to members. We will achieve this by:

Program Activities

Cultural Competency Workgroups

Cultural Competency Workgroups are formed on an ad hoc basis to support the Plan in implementing portions of the CLAS project plan. An annual Cultural Competency Work plan/Project Plan (CCP) is developed to guide the activities of the Plan and the Company's affected functional areas. The CCP Annual Evaluation is used to assess the progress of initiatives and make recommendations to the Quality Improvement Committee and executive leadership, when barriers are identified.

Member Outreach

The Plan requests voluntary information on race and language from members and utilize this information to improve linguistic and cultural services.

The Plan supports activities promoting health literacy and ensures member communications are in plain language.

Member Satisfaction Assessment

Member satisfaction survey data is reviewed annually, paying special attention to those who identify themselves with limited English proficiency, in order to determine any identifiable clinical care and service gaps.

Member and Provider Education

Cultural Competency information and links are posted on the Provider, Member and Employee web portals or via the Plan's approved communication venues. Provider and Employee Surveys are conducted in order to determine how best to assist Providers and Employees in meeting the cultural needs of the population we serve. The Plan monitors complaints on an ongoing basis from Providers and subcontractors to ensure complaints regarding cultural and linguistically services are identified and resolved in a timely manner.

Program Evaluation and Assessment

Annually, the Plan conducts an evaluation of the Cultural Competency Plan to assess overall effectiveness and to determine future directions. The evaluation serves as the foundation for planning the upcoming year's plan and activities relating to elevating cultural awareness. If you have any questions or would like to request a free copy of the Health Plan's Cultural Competency Plan, please

contact a Member Service representative at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time.

Providers and subcontractors are required to comply with the plan’s Cultural Competency Plan.

Fraud, Waste and Abuse

Aetna Better Health of Florida has an aggressive, proactive fraud, waste, and abuse program that comply with state and federal regulations. Our program targets areas of healthcare related fraud and abuse including internal fraud, electronic data processing fraud and external fraud. A Special Investigations Unit (SIU) is a key element of the program. This SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste, or abuse to appropriate State and federal agencies as mandated by Florida Administrative Code. During the investigation process, the confidentiality of the patient and people referring the potential fraud and abuse case is maintained.

Aetna Better Health of Florida uses a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including Claims, Provider Relations, Member Services, Medical Management, as well as providers and members, shares the responsibility to detect and report fraud. Review mechanisms include audits, review of provider service patterns, hotline reporting, claim review, data validation, and data analysis.

Fraud, waste and abuse defined

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: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Florida Healthy Kids plan, 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 plan.

Examples of fraud, waste, and abuse include:

- Charging in excess for services or supplies
- Providing medically unnecessary services
- Billing for items or services that should not be paid for by Florida Healthy Kids
- Billing for services that were never rendered
- Billing for services at a higher rate than is actually justified
- Misrepresenting services resulting in unnecessary cost to Aetna Better Health of Florida due to improper payments to providers, or overpayments
- Physical or sexual abuse of members

Fraud, waste, and abuse can incur risk to providers:

- Participating in illegal remuneration schemes, such as selling prescriptions.

- Switching a member’s prescription based on illegal inducements rather than based on clinical needs.
- Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider.
- Theft of a prescriber’s Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing login information.
- Falsifying information in order to justify coverage.
- Failing to provide medically necessary services.
- Offering members, a cash payment as an inducement to enroll in a specific Plan.
- Selecting or denying members based on their illness profile or other discriminating factors.
- Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness.
- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services (for example, by not referring a member to an appropriate provider).
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment).
- Billing for services not rendered or supplies not provided would include billing for appointments the members fail to keep. Another example is a “multi patient” in which a provider visits a nursing home billing for 20 nursing home visits without furnishing any specific service to the members.
- Double billing such as billing both Aetna Better Health of Florida and the member, or billing Aetna Better Health of Florida and another member.
- Misrepresenting the date services were rendered or the identity of the member who received the services.
- Misrepresenting who rendered the service, or billing for a covered service rather than the non-covered service that was rendered.

Fraud, waste, and abuse can incur risk to members as well:

- Unnecessary procedures may cause injury or death.
- Falsely billed procedures create an erroneous record of the member’s medical history.
- Diluted or substituted drugs may render treatment ineffective or expose the member to harmful side effects or drug interactions.
- Prescription narcotics on the black market contribute to drug abuse and addiction.

In addition, member fraud is also reportable, and examples include:

- Falsifying identity, eligibility, or medical condition to illegally receive the drug benefit.
- Attempting to use a member ID card to obtain prescriptions when the member is no longer covered under the drug benefit.
- Looping (i.e., arranging for a continuation of services under another members ID).
- Forging and altering prescriptions.
- Doctor shopping (i.e., when a member consults a number of doctors for obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.

Reporting suspected fraud, waste and abuse

Fraud, Waste and Abuse training is provided by the health plan annually to all subcontractors, providers and vendors. Participating providers are required to report to Aetna Better Health of Florida all cases of suspected fraud, waste, and abuse, inappropriate practices, and inconsistencies of which they become aware within the Florida Healthy Kids plan.

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 SIU: **FL-FraudandAbuse@Aetna.com**
- Fax the SIU: **1-860-975-9719**
- FL Attorney General's Office: **1-866-966-7226**
- By visiting our website: **AetnaBetterHealth.com/Florida/fraud-abuse**

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

Prevention of fraud, waste and abuse

A provider's best practice for preventing fraud, waste, and abuse (also applies to laboratories as mandated by 42 C.F.R. 493) is to:

- Develop a compliance program
- Monitor claims for accuracy - verify coding reflects services provided
- Monitor medical records – verify documentation supports services rendered
- Perform regular internal audits
- Establish effective lines of communication with colleagues and members
- Ask about potential compliance issues in exit interviews
- Take action if you identify a problem
- Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim

Special investigations unit (SIU)

Our Special Investigations Unit (SIU) conducts proactive monitoring to detect potential fraud, waste, and abuse, and is responsible to investigate cases of alleged fraud, waste, and abuse. With a total staff of approximately 100 individuals, the SIU is comprised of experienced, full-time investigators; field fraud (claims) analysts; a full-time, a dedicated information technology organization; and supporting management and administrative staff.

The SIU has a national toll-free fraud hotline for providers who may have questions, seek information, or want to report potential fraud, waste, or abuse. The number is **1-855-415-1558**. The hotline has proven to be an effective tool, and Aetna Better Health of Florida encourages providers and contractors to use it.

To achieve its program integrity objectives, the SIU has state-of-the-art technology and systems capable of monitoring Aetna Better Health's huge volume of claims data across health product lines. To help

prevent fraud, it uses advanced business intelligence software to identify providers whose billing, treatment, or member demographic profiles differ significantly from those of their peers. If it identifies a case of suspected fraud, the SIU's Information Technology and investigative professionals collaborate closely both internally with the compliance department and externally with law enforcement as appropriate, to conduct in-depth analyses of case-related data.

Elements of a compliance plan

An effective Compliance Plan includes seven (7) core elements:

- **Written Standards of Conduct:** Development and distribution of written policies and procedures that promote Aetna Better Health of Florida's commitment to compliance and that address specific areas of potential fraud, waste, and abuse.
- **Designation of a Compliance Officer:** Designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program.
- **Effective Compliance Training:** Development and implementation of regular, effective education, and training.
- **Internal Monitoring and Auditing:** Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem area.
- **Disciplinary Mechanisms:** Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded from participating in the Florida Healthy plan.
- **Effective Lines of Communication:** Between the Compliance Officer and the organization's employees, managers, and directors and members of the Compliance Committee, as well as related entities.
- Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance, while maintaining confidentiality.
- Related entities must report compliance concerns and suspected or actual misconduct involving Aetna Better Health of Florida.
- **Procedures for responding to Detected Offenses and Corrective Action:** Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry.

Relevant laws

There are several relevant laws that apply to Fraud, Waste, and Abuse:

- The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional \$5,500 to \$11,000 per false claim. The False Claims Act prohibits, among other things:
 - Knowingly presenting a false or fraudulent claim for payment or approval
 - Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
 - Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

"Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; 3) acts in reckless disregard of the truth or falsity of the information.

Providers contracted with Aetna Better Health of Florida must agree to be bound by and comply with all applicable State and federal laws and regulations.

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- Anti-Kickback Statute
 - The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
- Self-Referral Prohibition Statute (Stark Law)
 - Prohibits providers from referring members to an entity with which the provider or provider’s immediate family member has a financial relationship, unless an exception applies.
- Red Flag Rule (Identity Theft Protection)
 - Requires “creditors” to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.
 - Health Insurance Portability and Accountability Act (HIPAA) requires:
 - Transaction standards
 - Minimum security requirements
 - Minimum privacy protections for protected health information
 - National Provider Identification (NPIs) numbers

The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are \$5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

- Under the Federal Anti-Kickback statute (AKA), codified at 42 U.S.C. § 1320a-7b, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal health care program, including programs for children and families accessing Aetna Better Health of Florida services.
- Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Aetna Better Health of Florida providers will follow federal and State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs, including programs for children and families accessing Aetna Better Health of Florida services through the Florida Healthy Kids plan.
- The Florida False Claims Act (FFCA) s. 68.081 F.S. authorizes civil actions by individuals and the state against persons who file false claims for payment or approval by a state agency. Under the FFCA any person who knowingly presents or causes to be presented a false or fraudulent claim or payment or approval; knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim; conspires to commit a violation of act; has possession, custody, or control of property or money used or to be used by the state and knowingly delivers or causes to be delivered less than all of the money or property is knowingly makes, uses or causes to be made or used a false record or statement material to an obligation to pay or transmit money or property to the state, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state is liable to the state for a civil penalty not less than \$5,500 and not more than \$100,000 and for the

treble the amount of damages the state sustains because of the act of that person.

- Under the Florida Anti-Tampering Act s. 501.001 F.S., refers to any drug which means any agent or product recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement thereof; any agent or product intended for use in the diagnosis, cure, mitigation, treatment, therapy, or prevention of disease. It also refers to any device which means any apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is:
 - To affect the structure or any function of the body of humans
 - In addition, which does not achieve any of its principal intended purposes through chemical action within or on the body of humans and is not dependent upon being metabolized for the achievement of any of its principal intended purposes.

Whoever, with reckless disregard for the risk that another person will be placed in danger of death or bodily injury, tampers with, or conspires or attempts to tamper with, any consumer product or the labeling of, or container for, any such product is guilty of a felony of the first degree, punishable as provided in s. [775.082](#) or s. [775.083](#). or whoever, with intent to cause serious injury to the business of any person, tampers with any consumer product or renders materially false or misleading the labeling of, or container for, a consumer product is guilty of a felony of the second degree, punishable as provided in s. [775.082](#) or s. [775.083](#). or whoever knowingly communicates false information that a consumer product has been tampered with, if such tampering, had it occurred, would create a risk of death or bodily injury to another person, is guilty of a felony of the second degree, punishable as provided in s. [775.082](#) or s. [775.083](#). or “Communicates false information” means to communicate information that is false, and that the communicator knows is false, under circumstances in which the information may reasonably be expected to be believed. Alternatively, whoever knowingly threatens, under circumstances in which the threat may reasonably be expected to be believed, that he or she will commit or cause to be committed an act which would violate paragraph (a) is guilty of a felony of the third degree, punishable as provided in s. [775.082](#) or s. [775.083](#).

- Under the Medicaid Provider Fraud Act s. 409.920 F.S., refers to any particular item, device, medical supply, or service claimed to have been provided to a recipient and listed in an itemized claim or payment; or in the case of a claim based on costs, any entry in the cost report, books of amount, or other documents supporting such claim.

A person may not:

- Knowingly make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the agency or its fiscal agent or a managed care plan for payment.
- Knowingly make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.
- Knowingly charge, solicit, accept, or receive anything of value from a Medicaid recipient, from any source in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Medicaid program or knowingly fail to credit the agency or its fiscal agent for any payment received from a third-party source.
- Knowingly make or in any way cause to be made any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and

expense that is or may be used by the agency to determine a general or specific rate of payment for an item or service provided by a provider.

- Knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program.
- Knowingly submit false or misleading information or statements to the Medicaid program for being accepted as a Medicaid provider.
- Knowingly use or endeavor to use a Medicaid Provider's identification number or a Medicaid recipient's identification number to make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

Office of the Inspector General (OIG) and General Services Administration (GSA) Exclusion Program Prohibits identified entities and Providers excluded by the OIG or GSA from conducting business or receiving payment from any Federal health care program.

Administrative sanctions

Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare or Medicaid provider number application (if applicable)
- Suspension of provider payments
- Being added to the OIG List of Excluded Individuals/Entities (LEIE) database
- License suspension or revocation

Remediation

Remediation may include any or all of the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
- Automatic disbarment
- Prison time

Abuse, Neglect and Exploitation

The Plan must ensure that all staff and providers are required to report adverse incidents to the Florida Abuse Hotline at **1-800-962-2873** or the Plan Member Service Department at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time, immediately but not more than twenty-four (24) hours of the incident. Reporting will include the member’s identity, description of the incident and outcomes including current status of the member. If the event involves a health and safety issue, the Plan and case manager will arrange for the member to move from his/her current location or change providers to accommodate a safe environment and provider of the member’s choice.

Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, separate from the enrollee’s case file, that is designated as confidential.

Identifying Victims of 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 (child abuse and maltreatment, interpersonal violence and sexual assault, community and gang violence) and individuals disconnected from stable support networks (runaway and homeless youth, unaccompanied minors, persons displaced during natural disasters).

Definition of Trafficking in Persons

- 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:

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Provider Relations **1-844-528-5815 (TTY: 711) • AetnaBetterHealth.com/Florida**

- 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.

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: **www.acf.hhs.gov/trafficking**.

Call: 1-888-373-7888

Text: HELP to BEFREE (233733)

Email: help@humantraffickinghotline.org

Visit: www.humantraffickinghotline.org

Enrollee quality of care issues must be reported to and a resolution coordinated with the Plan's Quality Management Department.

Access to Care and Service Standards

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history. Our Provider Relations Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standard. Providers are contractually required to meet standards for timely access to care and services, taking into account the urgency of and the need for the services. Providers shall offer appointments and access to members within the following guidelines.

Primary Care Physicians

Aetna Better Health of Florida established standards for member access to primary care services are included in the participation criteria that are a part of each participating physician contract. Each primary care practitioner is required to have appointment availability within the following time frames:

- Routine care: within 7 days
- Routine physical exam: within 4 weeks
- Follow-up care: as medically appropriate
- Urgent complaint: Same day or within 24 hours

In addition, all participating primary care physicians must have a reliable 24-hour-a-day, 7-day-a-week answering service or paging system. A recorded message or answering service that refers members to the emergency room is not acceptable.

Specialist physicians

For access standards specific to your state and specialty, refer to your contract.

Primary care physicians (PCP) are responsible for coordinating and managing the health care of their assigned members in accordance with the applicable member contract, this manual, and the agreement. The primary care physician provides primary care services to all their patients and coordinate all other covered services, including specialist services defined as those covered services generally provided by specialist physicians in their respective fields of training and experience.

Access and appointment availability standards guidelines

Timely access-standards for hours of operation for PCP's:

General appointment accessibility - 20 hours per week per practice location

Practitioner type	Appointment type	Accessibility standard
Primary Care Practitioner (PCP)	Preventive care & routine (non-urgent)	Within 28 calendar days
	Urgent care	Within 24 hours
	Non-urgent	Within 72 hours
	Emergency services – non-life threatening	Immediately or referred to ER facility
Practitioner type	Appointment type	Accessibility standard
Specialty Referral	Preventive care & routine (non-urgent)	Within 4 weeks
	Urgent care	Within 24 hours of referral
	Non-urgent	Within 72 hours
	Emergency services – non-life threatening	Within 24 hours
Practitioner type	Appointment type	Accessibility standard
Behavioral Health/Substance Abuse	Preventive care & routine (non-urgent)	Within 10 business days
	Routine/follow-up (non-urgent, symptomatic conditions)	Accessibility within 7 days/30 days/60 days is assessed
	Urgent care	Within 24 hours
	Emergency Services – non-life threatening	Within 6 hours
Practitioner type	Appointment type	Accessibility standard
Lab and Radiology Services	Preventive care & routine (non-urgent)	Within 3 weeks
	Urgent care	Within 48 hours

Non-symptomatic office visits will include, but will not be limited to, well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits.

Physicals:	
Baseline Physicals for New Adult Members	Within one hundred-eighty (180) calendar days of initial enrollment.
Baseline Physicals for New Children Members and Adult Clients of DDD (degenerative disk disease)	Within ninety (90) days of initial enrollment, or in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines.
Routine Physicals	Within four (4) weeks for routine physicals needed for school, camp, work, or similar.
Prenatal Care: Members will be seen within the following timeframes:	
Three (3) weeks of a positive pregnancy test (home or laboratory)	
Three (3) days of identification of high-risk	
Seven (7) days of request in first and second trimester	
Three (3) days of first request in third trimester	

Office waiting time

Aetna Better Health of Florida’s waiting time standards require that members, on average, should not wait at a PCP’s office for more than 45 minutes for an appointment for routine care. On rare occasions, if a PCP encounters an unanticipated urgent visit or is treating a member with a difficult medical need, the waiting time may be expanded to one hour. The above access and appointment standards are provider contractual requirements. Aetna Better Health of Florida monitors compliance with appointment and waiting time standards and works with providers to assist them in meeting these standards.

Telephone accessibility standards

Providers have the responsibility to make arrangements for after-hours coverage in accordance with applicable state and federal regulations, either by being available or having on call arrangements in place with other qualified participating Aetna Better Health of Florida providers for the purpose of rendering medical advice, determining the need for emergency and other after-hours services including authorizing care and verifying member enrollment.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on call coverage. On call coverage response for routine, urgent, and/or emergent health care issues are held to the same accessibility standards regardless if after hours coverage is managed by the PCP, current service provider or the on-call provider.

All providers must have a published after-hours telephone number and maintain a system that will

provide access to primary care 24 hours a day, 7 days a week. In addition, we will encourage our providers to offer open access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via e-mail) between members, their PCPs, and practice staff. We will routinely measure the PCP's compliance with these standards as follows:

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if a member may need care management intervention.
- Our compliance and provider management teams will evaluate member, caregiver, and provider grievances regarding after hour access to care to determine if a PCP is failing to comply on a monthly basis.

Providers must comply with telephone protocols for all of the following situations:

- Answering the member telephone inquiries on a timely basis.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by a member.
- Identifying and rescheduling broken and no-show appointments.
- Identifying special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs).
- Triage for medical conditions and special behavioral needs for non-compliant individuals who are mentally deficient.
- Response time for telephone callback waiting times:
 - 30 to 45 minutes for after-hours telephone care for non-emergent, symptomatic issues
 - Same day for non-symptomatic concerns
 - 15 minutes for crisis situations
- Scheduling continuous availability and accessibility of professional, allied, and supportive medical/ personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.

A telephone response should be considered acceptable/unacceptable based on the following criteria:

Acceptable	Unacceptable
<p>An active provider response, such as:</p> <ul style="list-style-type: none"> • Telephone is answered by provider, office staff, answering service, or voicemail. • The answering service either: <ul style="list-style-type: none"> – Connects the caller directly to the provider; – Contacts the provider on behalf of the caller and the provider returns the call; – Provides a telephone number where the provider/covering provider can be reached; or – The provider’s answering machine message provides a telephone number to contact the provider/covering provider. 	<ul style="list-style-type: none"> • The answering service: <ul style="list-style-type: none"> – Leaves a message for the provider on the PCP/covering provider’s answering machine; or – Responds in an unprofessional manner. • The provider’s answering machine message: <ul style="list-style-type: none"> – Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations; or – Instructs the caller to leave a message for the provider. • No answer. • Listed number no longer in service. • Provider no longer participating in the contractor’s network. • On hold for longer than 5 minutes. • Answering service refuses to provide information for survey. • Telephone lines persistently busy despite multiple attempts to contact the provider.

Provider must make certain that their hours of operation are convenient to, and do not discriminate against, members. These include offering hours of operation that are no less than those for non-members, commercially insured or public fee-for-service individuals.

In the event that a PCP fails to meet telephone accessibility standards, a Provider Relations Representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards, and work to correct the barrier to care.

Member Rights and Responsibilities

In accordance with 42 CFR 438.100, Aetna Better Health of Florida is committed to treating members with respect and dignity at all times. Member rights and responsibilities are shared with staff, providers, and members each year.

Treating a member with respect and dignity is good business for the provider's office and often can improve health outcomes. Your contract with Aetna Better Health of Florida requires compliance with member rights and responsibilities, especially treating members with respect and dignity. Understanding member' rights and responsibilities is important because you can help members to better understand their role in and improve their adherence with treatment plans.

It is Aetna Better Health of Florida's policy not to discriminate against members based on race, color, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law.

Please review the list of member rights and responsibilities below. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.

In the event that Aetna Better Health of Florida is made aware of an issue with a member not receiving the rights as identified above, Aetna Better Health of Florida will initiate an investigation into the matter and report the findings to the Quality Management Oversight Committee and further action may be necessary.

In the event Aetna Better Health of Florida is made aware of an issue when the member is not demonstrating the responsibilities as outlined above, Aetna Better Health of Florida will make good faith efforts to address the issue with the member; and educate the member on their responsibilities.

Member rights

As a member you:

- You have the right to be treated with courtesy and respect
- You have the right to have your privacy protected
- You have the right to a response to questions and requests
- You have the right to know who is providing services to you
- You have the right to know the services that are available, including an interpreter if you don't speak English
- You have the right to know the rules and regulations about your conduct
- You have the right to be given information about your health
- You have the right to refuse any treatment, except as otherwise provided by law
- You have the right to get service from out-of-network providers
- You have the right to get family planning services without prior authorization
- You have the right to be given information and counseling on the financial resources for your care
- You have the right to know if the provider or facility accepts the assignment rate
- You have the right to receive an estimate of charges for your care
- You have the right to receive a bill and to have the charges explained
- You have the right to be treated regardless of race, national origin, religion, handicap, or source of payment
- You have the right to be treated in an emergency

- You have the right to participate in experimental research
- You have the right to file a grievance if you think your rights have been violated
- You have the right to information about our doctors
- You have the right to be treated with respect and with due consideration for your dignity and privacy
- You have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand
- You have the right to participate in decisions regarding your health care, including the right to refuse treatment
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- You have the right to request and receive a copy of your medical records and request that they be amended or corrected
- You have the right to be furnished health care services in accordance with federal and state regulations
- You are free to exercise your rights, and the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat you
- You have the right to receive information on member rights and responsibilities
- You have the right to voice a complaint about care the organization provides
- You have the right to make recommendations regarding the organization's member rights and responsibilities policy

Member responsibilities

Aetna Better Health of Florida members, their families, or guardians are responsible for:

- You should provide accurate and complete information about your health
- You should report unexpected changes in your condition
- You should report that you understand your care and what is expected of you
- You should follow the treatment plan recommended
- You should keep appointments
- You should follow your doctor's instructions
- You should make sure your health care bills are paid
- You should follow health care facility rules and regulations
- You should listen to your provider, ask questions and follow instructions for care you have agreed to with your practitioner

Member rights under Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to organizations that receive financial assistance from any federal department or agency, including hospitals, nursing homes, mental health centers, and human service programs.

Section 504 prohibits organizations from excluding or denying individuals with disabilities an equal opportunity to receive benefits and services. Qualified individuals with disabilities have the right to participate in, and have access to, program benefits and services.

Under this law, individuals with disabilities are defined as persons with a physical or mental impairment that substantially limits one or more major life activities. People who have a history of physical or mental impairment, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. Some examples of impairments that may substantially limit major life activities, even with the help of medication or aids/devices, are Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness.

In addition to meeting the above definition, for purposes of receiving services, qualified individuals with disabilities are persons who meet normal and essential eligibility requirements.

Providers treating members may not, on the basis of disability:

- Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits
- Deny access to programs, services, benefits or opportunities to participate as a result of physical barriers

Medical Records Guidelines

Medical records standards

The Plan shall ensure maintenance of medical/case records for each enrollee in accordance with this section and with 42 CFR 431 and 42 CFR 456. Medical/case records shall include the quality, quantity, appropriateness and timeliness of services performed under the contract.

Providers shall prepare and maintain complete medical records for members under their care in a manner that complies with the following:

- Applicable federal and state laws
- Licensing, accreditation, and reimbursement rules and regulations applicable to Aetna Better Health, and
- Accepted medical practice

In accordance with federal and state law and the agreement, each Provider must protect the confidentiality of members' patient records. To fulfill this obligation, Providers must designate a person to be in charge of the Provider's medical records, and such person's responsibilities include, but are not limited to, the following duties in accordance with federal and state law and the agreement:

- Maintaining the confidentiality, security, and physical safety of patient records
- Retrieving Member records in a timely manner upon the request of an authorized party, and
- Supervising the collection, processing, maintenance, storage, retrieval, and distribution of records

Patient medical/case records shall comply with the following medical records standards:

- Include the enrollee's identifying information, including name, enrollee identification number, date of birth, sex and legal guardianship (if any)
- Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications
- Include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases
- Document referral services in enrollees' medical/case records
- Each record shall be legible and maintained in detail
- All records shall contain an immunization history
- All records shall contain information relating to the enrollee's use of tobacco, alcohol, and drugs/substances
- All records shall contain summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow-up
- All records shall reflect the primary language spoken by the enrollee and any translation needs of the enrollee
- All records shall identify enrollees needing communication assistance in the delivery of health care services
- All entries shall be dated and signed by the appropriate party
- All entries shall indicate the chief complaint of purpose of the visit, the objective, diagnoses, medical findings or impression of the provider
- All entries shall indicate studies ordered (e.g., laboratory, x-ray, EKG) and referral reports the signature or initials of the provider
- All entries shall include the disposition, recommendations, instructions to the enrollee, evidence of whether there was follow-up and outcome of services
- Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of thirteen (13)
- All records shall contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the enrollee has executed an advance directive. Providers shall not require the enrollee to execute or waive an advance directive as a condition of treatment.

In accordance with the agreement and this manual, the medical records must be available for utilization review, risk management and peer review studies, member service inquiries, grievance and appeals, and quality improvement initiatives.

All records should be kept confidential and maintained for ten (10) years. All Member information should be available to be transferred upon request by the member, or authorized representative, to any organization with which the member may subsequently enroll, or to a Provider to ensure continuity of care.

Providers must keep our members' information confidential and stored securely. Providers must also ensure all staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

We use practitioner/provider performance data to improve the quality of service and clinical care our members receive. Accrediting agencies require that providers let us use your performance data for this purpose.

Medical records requests

Providers must respond and submit requested medical records to the Plan's Grievance and Appeals and/or Quality Management departments promptly to enable the Plan to comply with Federal and Florida laws governing grievances and appeals and complaint investigation. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record. The submission should include test results, office notes, referrals, telephone logs and consultation reports.

Advance Directives

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

Medical record alteration or falsification

Alteration or falsification of medical records is unethical conduct for any medical professional. Any incident relating to unethical behavior regarding medical record documentation is subject to the following process:

- All incidents of possible medical record falsification are reported to the Plan's Peer Review Committee and the Special Investigation Unit (SIU).
- The Peer Review Committee reviews the records in question and allows the Provider to explain the circumstances.
- The Peer Review Committee makes the final decision regarding the allegations of unethical conduct and takes appropriate actions.
- Health professionals not subject to the peer review process (nurse, lab personnel, etc.) may be reported to the appropriate agency and/or governing body.

Transfer of medical records upon termination of the agreement

Upon the effective date of termination of the agreement (and the expiration of any period of any continuing care obligation), or such earlier date as a member may select or be assigned to another Provider regardless of whether the agreement then remains in effect, pursuant to a member's or the Plan's request, Provider shall copy all such member's medical records in Provider's possession and

forward such records, at no cost to the Plan or to the member, to (i) such other Provider as designated by the Plan; (ii) the member; and (iii) the Plan, as requested by the Plan or the member.

Medical records: member consent

Where required by law, Providers shall obtain specific written authorization from a member prior to releasing such member's medical records. Providers acknowledge and agree that the consent by a member in the applicable member contract enrollment form and/or Providers' standard consent form is hereby deemed satisfactory member consent for the release of members' records, to the extent required by applicable law.

Member's rights to access medical records

Providers shall ensure timely access by members to review, amend and obtain a copy of their medical records upon request, to the extent required by applicable law.

Utilization Management Program

Our utilization management policy

The Plan will provide oversight and monitor services rendered to members as described below:

Our utilization management program helps our members get medically necessary health care services in the most cost-effective setting under their benefit package. We work with members and physicians to evaluate services for medical appropriateness, timeliness and cost.

- Our decisions are based entirely on appropriateness of care and service and the existence of coverage, using nationally recognized guidelines and resources.
- We do not pay or reward practitioners, employees or other individuals for denying coverage of care.
- Financial incentives do not encourage our staff to make denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.
- We do not encourage utilization decisions that result in under-utilization.

Medically necessary or medical necessity

“Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided (FS 409.9131 (2) (b)).

Providers may obtain service-specific coverage requirements and medical necessity criteria by calling Provider Relations at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time. Services provided in accordance with 42 C.F.R. 438.210 (a)(4) and as defined in Section 59G-1.010(166), F.A.C., to include those medical or allied care, goods, or services furnished or ordered must:

1. Meet the following conditions:
 - a. Be necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain;
 - b. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member’s needs;
 - c. Be consistent with the generally accepted professional medical standards as determined by the Healthy Kids program, and not experimental or investigational;
 - d. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;

- e. Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or Provider;
 - f. For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type
"Medically Necessary" or "Medical Necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
2. The fact that Provider prescribed, recommended, or approved medical or allied goods, or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a Covered Service.

Out of network

Any services rendered by non-participating providers or facilities must be prior authorized by Aetna Better Health of Florida and must meet the member's medical need for specialized or unique services which Aetna Better Health of Florida considers unavailable within the existing network. Aetna Better Health will prior authorize as in-network, certain services rendered by non-participating providers or facilities only when the member's medical needs require specialized or unique services which Aetna Better Health of Florida considers unavailable within the existing network. If Aetna Better Health of Florida approves the member to go out of network, the cost to the member is not greater than it would be if the service was provided in-network.

Behavioral Health

Coordination of care between the Primary Care Physician (PCP) and the Behavioral Health Practitioners (BHP) is critical to the well-being of the patient. The Plan uses a variety of mechanisms to monitor continuity and coordination of care between behavioral health and medical care. Some of the indicators that the Plan may review on an annual basis are the exchange of information between behavioral healthcare and primary care physicians; the appropriate diagnosis, treatment and referral of behavioral health care disorders commonly seen in primary care; the appropriate use of psychopharmacological medications; management of treatment access and follow-up of members with co-existing medical and behavioral disorders; and primary or secondary preventive behavioral health care program implementation.

Skilled Nursing admissions

Skilled nursing facility admissions require prior authorization. The concurrent review nurse, as part of the discharge planning process, will coordinate the prior authorization of SNF admissions. Following the admission, the concurrent review nurse will review the stay via the telephone with the facility case manager or designated facility review staff. A provider may also obtain the required prior authorization by going to [AetnaBetterHealth.com/Florida](https://www.aetna.com/better-health/florida) or contacting the Utilization Department at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time.

Rehabilitation admissions

Admissions to rehabilitation facilities require prior authorization, which is often coordinated by the concurrent review nurse as a part of discharge planning. Concurrent review of acute rehabilitation admissions may be performed telephonically or onsite. A provider may also obtain the required prior authorization by going to [AetnaBetterHealth.com/Florida](https://www.aetna.com/better-health/florida) or contacting the Utilization Department at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time.

Discharge planning

The concurrent review nurse will begin the discharge planning process at the time of an inpatient, skilled nursing, or rehabilitative facility admission. The concurrent review nurse will collaborate with the hospital discharge planner and the member's physician to ensure that the member receives all medically necessary covered services available within the member's contract at the time of discharge.

Second opinions

Florida Statute 641.51 requires that The Plan provide members with access to a second medical opinion in any instance in which the member disputes The Plan's or the Provider's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious illness or injury. If requested, the member may select a Provider or a non-participating Provider in the geographical service area of the Plan.

If the member selects a participating Provider, PCPs may issue a referral for the second opinion. If the member selects a non-participating Provider, the PCP must request a prior authorization from the Plan.

New Medical Technologies

The Plan evaluates benefit coverage for new medical technologies or new applications of existing technologies on an ongoing basis. These technologies may include medical procedures, drugs and devices. The following factors are considered when evaluating the proposed technology:

- Input from appropriate regulatory bodies.
- Scientific evidence that supports the technology's positive effect on health outcomes.
- The technology's effect on net health outcomes as it compares to current technology.

The evaluation process includes a review of the most current information obtained from a variety of authoritative sources including medical and scientific journals, medical databases and publications from specialty medical societies and the government.

Care Management

Care Management Services are provided to members who have suffered a traumatic injury or illness or have a significant medical condition necessitating ongoing follow-up and treatment. Proper medical management of a catastrophic Care is intended to assure the continuity of high-quality care in a cost-effective manner. Care Managers follow patient care cases where extensive services are needed for chronic conditions.

Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and a family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes. Care Management is a collaborative process that promotes quality care and cost-effective outcomes that enhance physical, psychosocial, and vocational health of individuals. It includes assessing, planning, implementation, coordinating, and evaluating health-related service options.

Each Care manager works in conjunction with the member's primary or specialist physician as appropriate and coordinates their work activities with the Medical Director as deemed appropriate. Referrals to Care management may be received from a variety of sources, such as the Primary Care Physician, Specialist Physician, Utilization Management team members, Medical Director, member/family, internal departments, employer groups, etc. We welcome referrals from treating physicians to our Care management program. You can submit a referral through the toll-free phone number on the member ID card. Once we decide that a member is right for Care management and the member or caregiver agrees to it, we make an individualized plan. We work with the member, the member's family, physician(s), and other health care professional(s).

Care management programs

Aetna Better Health of Florida has an integrated care management program that includes biopsychosocial assessment, planning, facilitation, care coordination, evaluation and advocacy for service and support options to meet a member's and/or their family/representative's comprehensive care needs to promote quality and cost-effective outcomes. The integrated care management program is stratified by the complexity of the member's needs. All levels of care management include assistance to members with chronic conditions. We provide them with education and encouragement to learn self-management skills. We also coordinate access to appropriate services and support.

Members may self-refer, and Providers may refer members to The Plan's case management program. Providers may request assistance in the development of plans of treatment for members with complex or serious medical conditions. To refer a member to one of these programs, call Member Services at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time, and ask to speak to someone on our Case Management team to enroll a patient. Members can choose to join or leave the program at any time.

A Clinical Care Manager will work with the Provider, the member and the member's family in an effort to help decrease the risk of complications, support coordination of care and provide education. The Care Manager will work with Providers to assess, plan and monitor options and services for members with chronic illness or injury. Case management services are also offered to members upon discharge from the hospital, to help facilitate the receipt of post-discharge services administered by their Provider.

Obstetrical (OB) care management program

An obstetrical nurse works with Obstetricians and Perinatologists to help coordinate services during pregnancy for members with high-risk conditions. The care manager also monitors the mother and newborn progress through the sixth week postpartum follow-up visit. To make a referral for the OB Care Management program, call Member Services at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time, and ask to speak to someone on our Care Management team to enroll a patient. Members can choose to join or leave the program at any time.

Pediatric care management program

Pediatric members with catastrophic or chronic diseases are supported by a pediatric nurse who works with the member's Providers and family, while the child is in the hospital or at home. The nurse works to identify participating Providers, and resources in the area to meet the child's needs as defined by the Providers. To refer a member for the Pediatric Care Management Program, call Member Services at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time, and ask to speak to someone on our Care Management team to enroll a patient. Members can choose to join or leave the program at any time.

Transplant care management program

Transplant candidate members should be referred to the transplant coordinator. To refer a member to the Transplant Coordinator, fax the referral form to **1-844-847-5979**.

Disease management programs

Our disease management programs are designed to help your patients work with their doctors to effectively manage ongoing health conditions and improve outcomes. Disease management programs are available for asthma, cancer, dementia/ Alzheimer's, diabetes, COPD, hypertension, mental and substance use issues. Our aim is to proactively reach out to members and engage them in managing their health, by emphasizing prevention through education, supporting the physician-patient relationship and reinforcing compliance with their physicians' care plan. Members are identified by various methods including, but not limited to, claims, pharmacy, health risk assessments, physician referral, caregiver referral, or self-referral. Providers may refer a member to a disease management program by calling the Disease Management call center at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time.

The Clinical Practice Guidelines that support each of our disease management programs are found on our website at [AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida).

Clinical Practice Guidelines

The Plan's employees make clinical decisions regarding members' health based on the most appropriate care and service available. The Plan makes these decisions based on appropriate clinical criteria. The criteria used in the decision-making process will be provided upon request by contacting the Member Services Representative number listed on the back of the member's ID card. Criteria may be viewed on aetnabetterhealth-florida.aetna.com or a hard copy may be requested.

Aetna Better Health adopts evidence based clinical practice guidelines (CPG) from national recognized sources. These guidelines have been adopted to promote consistent application of evidence-based treatment methodologies and made available to practitioners to facilitate improvement of health care and reduce unnecessary variations in care.

Aetna Better Health reviews the CPGs every two years or more frequently if national guidelines change within the two-year period. CPGs that have been formally adopted can be found on the Aetna Better Health website at AetnaBetterHealth.com/Florida.

The CPGs are provided for informational purposes only and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider's clinical judgment regarding the appropriate treatment of a patient in any given case.

Diabetes Clinical Practice Guidelines Purpose

As part of our goal of providing quality care and improved health outcomes, as well as improving Provider awareness, The Plan supports the use of evidence-based medicine to reduce unnecessary variations in care. For diabetes management, The Plan has adopted the current recommendations from the American Diabetes Association, a recognized, national, expert source on diabetes management. A summary of the standards may be accessed at:

http://care.diabetesjournals.org/content/33/Supplement_1/S4.full.pdf¹

This is intended solely as a guide and information source. The Plan recognizes that any management plan should be individualized and developed in coordination with the physician, health care team, patient and family, as deemed necessary.

Diabetes is a chronic illness that requires continuing medical care and patient self-management education to prevent acute complications and to reduce the risk of long-term complications. Diabetes care is complex and requires that many issues, beyond glycemic control, be addressed. A large body of evidence exists that supports a range of interventions to improve diabetes outcomes.

¹ "Please note that not all health insurance and group health plans cover all recommended services. Please check the member's benefit documents to determine whether their health insurance or group health plan covers these services"

Guidelines Components to be Monitored

- Hemoglobin A1C testing
- Percentage of members with Hemoglobin A1c greater than 9% (poor control)
- Percentage of members with Hemoglobin A1c less than 8% (good control)
- LDL screening rates
- LDL-C control (Less than 100 mg/dL)
- Diabetic nephropathy testing
- Diabetes – eye examinations

Interventions

- By evaluating claims data, The Plan will collect data to verify Provider and member compliance with the guideline recommendations for the above components
- Educational information and individual Provider feedback will be provided where compliance rates do not meet benchmark goals
- All members with diabetes will be assessed for participation in the diabetes disease management program, to facilitate achievement of clinical outcome goals

Clinical Outcome Goals

- Hemoglobin A1C level < 8.0%
- Lipid control: LDL-C < 100 mg./dL Annual eye examination
- Urine albumin and serum creatinine testing annually

Asthma Clinical Practice Guidelines Purpose

In its efforts to improve Provider and member awareness of nationally established practice guidelines for common disease states, The Plan supports the clinical practice guideline for asthma outlined in 2007 by the National Asthma Education and Prevention Program of the National Institutes of Health.

Members and Providers may access the asthma clinical practice guideline in its entirety at

www.nhbli.nih.gov/guidelines/asthma/index.htm.

Physicians are encouraged to familiarize themselves with the guideline and to incorporate the guideline into their daily patient management. As with all guidelines, it is intended to offer evidence-based guidance for treating this disease, with the understanding that a physician's treatment plan for any particular patient will be individualized. It offers a consensus opinion on the standard of care, keeping in mind that variations from it are expected when a patient's particular clinical circumstances so require.

The Plan intends to select several standards from within the guideline each year for particular focus and will monitor rates of adherence to those standards (referenced below as a "monitored standard"). Again, it is understood that deviations from any particular standard may occur based on physician judgment. Nevertheless, the overall rates of compliance will be instructive, and it is The Plan's goal to improve overall compliance on those standards for appropriate patients.

Definitions

Asthma severity is classified in persons 5 years of age and older by assessing the level of impairment. The severity level is based on the child's/caregiver's recall of the 2-4 weeks just prior to the assessment.

- Severe persistent – continual daytime symptoms, frequent nighttime symptoms, and extreme limitation of normal activity

- Moderate persistent – daily daytime symptoms or symptoms more than one night per week, and some limitation of normal activity
- Mild persistent – daytime symptoms more than twice per week but less than once a day or symptoms more than two nights per month, and minor limitation of normal activity
- Intermittent – daytime symptoms less than or equal to two days per week and less than or equal to two nights per month, and no limitation of normal activity

Guideline components to be monitored

The Plan will monitor:

- The use of inhaled corticosteroids in asthmatic members age five and older with two or more emergency department visits and/or one inpatient admission for asthma in the past year
- The use of long-acting bronchodilators in asthmatic members age five and older with two or more emergency department visits and/or one inpatient admission for asthma in the past year
- The number of asthma-related emergency department visits annually in members age 5 and older
- The number of asthma-related inpatient admissions annually in members age five and older

Data tracking

The Plan will track all pharmacy claims for inhaled corticosteroids and inhaled long-acting beta agonists and record the following specifics for each claim:

- Member name
- Provider name/ whether Provider is PCP or specialist
- Panel size of Provider

The Plan will track claims for the two pharmaceutical agents above and compare claims per 1000 members against established benchmarks for utilization of these two agents (allowing for mail order claims for up to 90 days of medication per claim).

Clinical outcome goals

- Increased use of inhaled corticosteroids in asthmatic members
- Increased use of long-acting bronchodilators in asthmatic members
- Reduction in number of asthma-related emergency department claims for members
- Reduction in number of asthma-related inpatient claims for members

Congestive Heart Failure Clinical Practice Guidelines Purpose

Congestive Heart Failure (CHF) is a prevalent disease in elderly members and that prevalence is reflected in the Plan membership.

In an effort to improve Provider and member awareness of nationally established practice guidelines for common disease states, the Plan encourages Providers and members to use clinical practice guidelines as reference tools for giving and receiving care. Providers are encouraged to familiarize themselves with applicable guidelines and to refer to them in their daily patient management.

The Plan recognizes the guideline for CHF management developed by the American College of Cardiology (ACC). A complete copy of the guideline, may be found at: <http://content.onlinejacc.org/cgi/reprint/53/15/e1.pdf>.²

This is intended solely as a guide and information source. The Plan recognizes that any management plan should be individualized, and developed in coordination with the physician, healthcare team, patient, and family, as deemed necessary.

Guideline Components to be monitored

- Prescription fill rates of ACEI/ARB
- Prescription fill rates of beta blockers
- Annual lipid testing rates

Interventions

- By evaluating claims data, The Plan will collect data to verify member and Provider compliance with ACEI/ARB, beta blocker and lipid testing, as recommended by the guideline
- Educational information and individual Provider feedback will be provided where compliance rates do not meet benchmark goals
- All members with diabetes will be assessed for participation in the CHF disease management program to facilitate achievement of clinical outcome goals

Clinical Outcome Goals

- Increased use of ACEI/ARB increased use beta blockers

Aetna Better Health adopts nationally accepted evidence-based preventive services guidelines from the U.S. Preventive Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC). Where there is a lack of sufficient evidence to recommend for or against a service by these sources, or conflicting interpretation of evidence, we may adopt recommendations from other nationally recognized sources. These guidelines are available on our website at AetnaBetterHealth.com/Florida. Once on the site, go to >Providers>Practice Guidelines. We review guidelines every two years unless updates from recognized sources warrant more frequent review.

² "Please note that not all health insurance and group health plans cover all recommended services. Please check the member's benefit documents to determine whether their health insurance or group health plan covers these services"

Quality Improvement

Quality Improvement (QI) Program

In accordance with 42 CFR 438.204, 438.240 and accreditation standards, the Plan has a QI Program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its members. The Quality Management department monitors, evaluates and improves the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members through peer review, performance improvement projects (PIP), medical/case record audits, performance measures, surveys and related activities. Providers are expected to participate in the Plan's QI activities. To the extent required by applicable laws, regulations and the accreditation standards, the Quality Management department monitors and analyzes:

- Medical continuity and coordination of care to facilitate continuous and appropriate care for member and strengthen continuity and coordination of care among medical practitioners and providers
- Monitor the coordination and continuity of care across health care network settings and transitions in those settings. e.g.:
 - Medical record reviews:
 - Against documentation and record-keeping standards, including but not limited to the presence of medical and/or behavioral health consultant reports, home health continuing care plans and discharge summaries post hospitalization (for medical or behavioral diagnosis)
 - For HEDIS data collection
 - Access member satisfaction and monitor member complaints
 - Notification and movement of members from a terminated provider
- Utilization of services provided by hospitals, emergency rooms, physician services, mental health facilities, home health agencies, DME companies and pharmacies. This includes over- and under utilization of medical resources and high-volume, high-risk services and use of acute/chronic care services based on demographic and epidemiological distributions of members.
- Performance indicators such as HEDIS and state-defined measures
- Facility audits and medical record reviews to monitor services provided by PCPs and high-volume specialists (OB-GYNs)
- Continuity and coordination of care between medical providers (PCPs, specialists and behavioral health providers) and transition of care across health care settings and/or from one PCP to another (PCP changes)
- Results of annual provider and member satisfaction surveys
- Complaints and grievances
- Provider compliance with practice guidelines, including preventive health guidelines
- Findings and retrospective reviews of complaints regarding quality of care

The Plan reports on these monitoring activities through its QI committee structure, such as the Quality Management Oversight Committee, UM/QM Committee, Service Improvement Committee, Peer Review Committee and Credentialing Committee.

Measure	Definition	Target
Lead Screening for Children (LSC)	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	79.50%
Adults' Access to Preventive/Ambulatory Health Services (AAP) Total	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.	85.50%
Imm Adolescents (IMA) Combination 1 Immunizations	The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.	82.09%
Childhood Combination 10 Immunizations (CIS)	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	40.91%
Comprehensive Diabetes Eye Exam (CDC)	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: Eye exam (retinal) performed.	61.50%

Measuring Quality Performance

Healthcare Effectiveness and Information Data Sets (HEDIS)

The National Committee on Quality Assurance (NCQA) defines HEDIS as “a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans.” HEDIS is a performance measurement tool that is coordinated and administered by NCQA and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of managed care organizations. Results from HEDIS data collection serve as measurements for quality improvement processes, educational initiatives and preventive care programs.

- All managed care organizations that are NCQA accredited perform HEDIS reviews at the same time each year.
- HEDIS is a retrospective review of services and performance of care from the prior calendar year.
- HEDIS consists of over 80 measures across domains of care that address important health issues and preventive care. These include:
 - Effectiveness of Care
 - Chronic Disease Management
 - Behavioral Health
 - Access/Availability of Care
 - Experience of Care
 - Utilization
- HEDIS data is collected through two primary methods:
 - Administrative data: comes from submitted claims and encounters year-round
 - Hybrid data: comes from chart collection/review typically performed February through May annually

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

Why does the Plan need to review medical records when it has claims data for each encounter?

Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values, blood pressure readings and results of tests that may not be available in claims/encounter data. Typically, an employee will call the physician’s office to schedule an appointment for the chart review. If there are only a few charts to be reviewed, the plan may ask the Provider to fax or mail the specific information.

How accurate is the HEDIS data reported by the Plans?

HEDIS results are subjected to a rigorous review by certified HEDIS auditors. Auditors review a sample of all medical record audits performed by the health plan, so the Plan may ask for copies of records for audit purposes. We also monitor the quality and inter-rater reliability of their reviewers to ensure the reliability of the information reported.

Is patient consent required to share HEDIS related data with the Plan?

The HIPAA privacy rule permits a Provider to disclose protected health information to a health plan for the quality – related health care operations of the health plan, including HEDIS, provided that the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164.506(c) (4).

May the Provider bill the Plan for providing copies of records for HEDIS?

Providers may bill the Plan for copies of medical records related to HEDIS, in accordance to the terms of the Provider's agreement.

How can Providers reduce the burden of the HEDIS data collection process?

We recognize that it is in the best interest of both the Provider and the Plan to collect HEDIS data in the most efficient manner possible. Options for reducing this burden include providing the Plan remote access to Provider electronic medical records (EMR) and setting up electronic data exchange from the Provider EMR to the Plan. For more information, please send an email to

FLMedicaidQualityDept@Aetna.com or contact your Provider Relations representative.

How can Providers obtain the results of medical record reviews?

The Quality Management department can share the results of the medical record reviews performed at your office and show you how your results compare to that of the Plan overall. For more information, please send an email to FLMedicaidQualityDept@Aetna.com or contact your Provider Relations representative.

Risk Management Program

Providers shall participate in and cooperate with The Plan risk management program. The Managed Care Plan shall require participating and direct service provider to report adverse incidents to the Managed Care Plans within twenty- four (24) hours of the incident. The Managed Care Plan must ensure that all participating and direct service providers are required to report adverse incidents to the Florida Healthy Kids immediately but not more than twenty-four (24) hours of the incident. Reporting will include information including the enrollee's identity, description of the incident and outcomes including current status of the enrollee. The Plan developed and implemented an incident reporting system to minimize injury/incidents to members, employees and visitors. The risk management program and incident reporting policy and procedures comply with §59A-12.012, Florida Administrative Code (Internal Risk Management Program for HMOs) and §641.55, Florida Statute (Internal risk management program for HMOs).

Adverse or Untoward Incident – an event, as defined in Chapter 395.0197(5) of the Florida statutes, over which Provider could exercise control which is more probably associated, in whole or in part, with the medical intervention rather than the medical condition for which such medical intervention occurred and which results in one of the following:

- a. Death;
- b. Brain or spinal damage;
- c. Permanent disfigurement;
- d. Fracture or dislocation of bones or joints;
- e. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility;
- f. Any condition that required specialized medical attention or surgical intervention resulting from non-emergency medical intervention, other than an emergency medical condition, to which the member has not given his/her informed consent; or
- g. Any condition that required the transfer of the member, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the member's condition prior to the adverse incident, including:
 - a. The performance of a surgical procedure on the wrong patient, a wrong surgical procedure or wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the member's diagnosis or medical condition;
 - b. Required surgical repair of damage resulting to a member from a planned surgical procedure where the damage was not a recognized specific risk, as disclosed to the Member and documented through the informed-consent process;
 - c. A procedure to remove unplanned foreign objects remaining from a surgical procedure; or
 - d. Any complaint or allegation of sexual misconduct and abuse or contact by Provider employee or agent of Provider.

If an adverse or untoward incident occurs to a member, Provider shall report the adverse or untoward incident (as defined under Florida law) to the Plan's risk manager within twenty-four (24) hours after its

occurrence. Provider shall (i) participate in and cooperate with the Plan's risk management program; (ii) provide such medical and other records without charge within ten (10) days of receipt of written notice; (iii) share such investigation reports and other information as may be required or requested by the Plan's risk manager to determine if an adverse or untoward incident is reportable as a "Code 15" to Florida Healthy Kids ; and (iv) in all other respects comply with and abide by this Manual. A Provider's failure to comply with these requirements may be deemed a material breach of the agreement, at the Plan's sole discretion.

When an incident occurs:

- Complete the **incident report form** (located in our Aetna Better Health of Florida website) immediately upon becoming aware of an adverse or untoward incident.
- Fill each blank on the form, using N/A when not applicable to the particular occurrence.
- Write legibly or type the information on the form.
- Describe the incident carefully. Be brief, but include important information, including who, what, where, when and how.
- Indicate the body part injured, the location and extent of injury and document fully, including lack of injury.
- Report any pertinent action taken in response to the occurrence.
- Obtain the name and location information for any witnesses, including employees.
- Sign and date the report. Include title/designation and contact phone number.
- Fax to our Risk Manager at **1-877-479-8564**.

For assistance in completing the incident report form, contact a Risk Manager at **954-858-3246**.

Incident reports are part of risk management files only and copies of incident reports must be maintained separately from member's medical records.

All incident reports will be reviewed, and date stamped upon receipt. Appropriate action will be initiated when indicated. Incident reports will not be used to penalize Providers; however, failure to report an adverse or untoward incident may result in further action.

Fee Schedule Maintenance and Reimbursement Determinations

The schedule of allowances represents the maximum reimbursement amount for each covered service that corresponds to any given medical service code. The basis of determining valid medical service codes are from Current Procedural Terminology (CPT), HCFA Common Procedural Coding System (HCPCS), or National Drug Codes (NDC). For covered services represented by a single code, the maximum reimbursement amount is the allowance amount determined by The Plan or the Provider's usual charge for the service, whichever is less. In many cases, the Plan allowances are based upon measures of relative value such as Average Wholesale Price (AWP), the Federal Resource Based Relative Value Scale (RBRVS), American Society of Anesthesiologists (ASA) units and Medicare laboratory and Durable Medical Equipment (DME) rates. Your Contract will outline the specific fee schedule methodology used to determine your rates.

Laboratory and Pathology Services

Laboratory and pathology services must be performed by a participating laboratory. The Plan maintains a contract with Quest and LabCorp to provide outpatient lab services for members. Quest and LabCorp provides all necessary supplies; request forms; specimen pick-up; accurate and prompt test results.

Laboratory and pathology services provided by an outside or reference lab that is not the applicable contracted laboratory Provider (LabCorp) will not be reimbursed to the Provider of service by The Plan. Laboratory and pathology services include but are not limited to clinical labs, nonclinical labs, pathology, and dermatology. If services are performed in office, the Provider may not bill the member/patient or for the laboratory/pathology services. LabCorp must be used for all Florida Healthy Kids members.

Although we maintain a contract with LabCorp to provide lab and path services, we recognize the need for urgent lab work to make a diagnosis or to treat the patient while in the Provider's office. When this situation occurs, Providers may bill and receive reimbursement for lab procedures. All lab procedures below will be reimbursed at 100% of Medicaid Allowable for non-participating providers or based on the Plan Participating Provider Agreement:

CPT	Code Description
36410	Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
36415	Collection of venous blood by venipuncture
36416	Collection of capillary blood specimen (e.g., finger, heel, ear stick)
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy

81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81025	Urine pregnancy test, by visual color comparison methods
82247	Bilirubin; total
82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)
82272	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening
82465	Cholesterol, serum or whole blood, total
82947	Glucose; quantitative, blood (except reagent strip)
82948	Glucose blood; reagent strip
83655	Lead
84520	BUN - Assay of urea nitrogen (HEDIS Code)
85002	Bleeding time test
85007	Blood count; blood smear, microscopic examination with manual differential WBC count
85008	Blood count; blood smear, microscopic examination without manual differential WBC count
85013	Blood count; spun micro hematocrit
85018	Blood count; hemoglobin (Hgb)
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count

CPT	Code Description
82465	Cholesterol, serum or whole blood, total
82947	Glucose; quantitative, blood (except reagent strip)
82948	Glucose blood; reagent strip
83655	Lead
84520	BUN - Assay of urea nitrogen (HEDIS Code)
85002	Bleeding time test
85007	Blood count; blood smear, microscopic examination with manual differential WBC count
85008	Blood count; blood smear, microscopic examination without manual differential WBC count
85013	Blood count; spun micro hematocrit
85018	Blood count; hemoglobin (Hgb)
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85610	Prothrombin time
86308	Heterophile antibodies; screening
86510	Skin test; histoplasmosis
86580	Skin test; tuberculosis, intradermal
87081	Culture, presumptive, pathogenic organisms, screening only
87804	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza
87880	Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A

All preadmission laboratory testing should be performed by a contracted lab. For members scheduled for elective admission, all preadmission diagnostic work-ups including lab, radiology, and supporting specialty consultations, must be referred to free-standing contracted Providers. If needed, lab services may be performed at that facility within seven (7) days of the event. Any laboratory service required prior to the seven (7) days must be performed as described above.

CLIA Certification

Physician office laboratories must hold either a CLIA certificate or a CLIA waiver to perform laboratory tests for members. When billing for laboratory services, please be sure to include your CLIA number on the claim form.

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))

Clean claims

In order for a claim to be paid, it must be a clean claim. Per Rule 59G-1.010 (42), F.A.C., “clean claim” means a claim that:

- Has been completed properly according to Medicaid billing guidelines;
- Is accompanied by all necessary documentation required by federal law, state law, or state administrative rule for payment; and
- Can be processed and adjudicated without obtaining additional information from the provider or from a third party.

A clean claim includes a claim with errors originating in the claim system. It does not include a claim from a provider who is under investigation for fraud, abuse, or violation of state or federal Medicaid laws, rules, regulations, policies, or directives or a claim under review for medical necessity.

Aetna Better Health of Florida will comply with the following standards regarding timely claims processing:

- Aetna Better Health of Florida will pay 90 percent of clean electronic claims and claims for which all information requested by Aetna to continue processing the claim has been received within 15 Calendar Days.
 - Clean claims include claims for which all information requested by Aetna to continue processing the claim has been received
 - Claims currently pending response from Providers are not included.
 - Claims related to investigations for potential fraud, waste or abuse are not included.
- Aetna Better Health of Florida will pay 90 percent of clean paper claims within 20 Calendar Days.
 - Clean claims include claims for which all information requested by Aetna to continue processing the claim has been received
 - Claims currently pending response from Providers are not included.
 - Claims related to investigations for potential fraud, waste or abuse are not included.

How to file a claim

Select the appropriate claim form (refer to table below) and complete the claim form.

Service	Claim Form
Medical and professional services	CMS 1500 Form
Hospital inpatient, outpatient, skilled nursing and emergency room services	CMS UB-04 Form

Instructions on how to fill out the claim forms can be found on our website at:

AetnaBetterHealth.com/Florida.

- 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.
- Submit original copies of claims electronically or through the mail (do NOT fax). To include supporting documentation, such as members' medical records, clearly label and send to Aetna Better Health of Florida at the correct address. Claims may be submitted through:
 - Electronic Clearing House
 - Providers who are contracted with us can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent, and minimizes clerical data entry errors. Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.
 - Change Healthcare (Emdeon) is the EDI vendor we use
 - Contact your software vendor directly for further questions about your electronic billing.
 - Contact our Provider Relations department for more information about electronic billing.
 - All electronic submission will be submitted in compliance with applicable law including HIPAA regulations and Aetna Better Health of Florida policies and procedures.
- Through the mail:

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

Claim resubmission

Providers have 180 days from the date of service to resubmit a revised version of a processed claim. The review and reprocessing of a claim does not constitute reconsideration or claim dispute.

- Providers may resubmit a claim that:
 - Was originally denied because of missing documentation, incorrect coding, etc.
 - Was incorrectly paid or denied because of processing errors
- Include the following information when filing a resubmission:
 - Use the Resubmission Form located on our website
 - An updated copy of the claim, all lines must be rebilled. A copy of the original claim (reprint or copy is acceptable)
 - A copy of the remittance advice on which the claim was denied or incorrectly paid
 - Any additional documentation required
 - A brief note describing requested correction
 - Clearly label as "Resubmission" at the top of the claim in black ink and mail to appropriate claims address

Resubmissions may not be submitted electronically. Failure to mail and accurately label the resubmission to the correct address will cause the claim to deny as a duplicate.

Please note: Providers will receive an EOB when their disputed claim has been processed. Providers may call our CICR department during regular office hours to speak with a representative about their claim dispute. The CICR department will be able to verbally acknowledge receipt of the resubmission, reconsideration and the claim dispute. Our staff will be able to discuss, answer questions, and provide details about status. Providers can review our Secure Web Portal to check the status of a resubmitted/reprocessed and adjusted claim. These claims will be noted as “Paid” in the portal. To view our portal, please click on the portal tab, which is located under the Provider page, which can be found on the following website: AetnaBetterHealth.com/Florida.

Corrected or voided claim via paper

For Institutional claims, provider must include the original Aetna Better Health of Florida claim number and bill frequency code per billing standards.

Example:

Box 4 – Type of Bill: the third character represents the “Frequency Code”:

3a PAT. CNTL. #			4 TYPE OF BILL
b. MED. REC. #			117
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7

Box 64 – Place the Claim number of the Prior Claim in Box 64:

64 DOCUMENT CONTROL NUMBER
1234E567891

For Professional claims, provider must include the original Aetna Better Health of Florida claim number and bill frequency code per billing standards. When submitting a Corrected or Voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.

Example:

22. RESUBMISSION CODE	ORIGINAL REF. NO.
7	1234E567891

Any missing, incomplete or invalid information in any field may cause the claim to be rejected. **Please Note:** If the provider handwrites, stamps, or types “Corrected Claim” on the claim form without entering the appropriate Frequency Code (7 or 8) along with the Original Reference Number as indicated above, the claim will be considered a first-time claim submission. When processing a Corrected or Voided Claim, a Payment Reversal may be generated which may produce a negative amount, which will be seen on a later Remittance Advice than the Remittance Advice that is sent for the newly submitted corrected claim.

Correct coding initiative

Aetna Better Health of Florida follows the same standards as Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please feel free to visit:

www.cms.hhs.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/.

Aetna Better Health of Florida utilizes ClaimCheck as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection.

Clear Claim Connection is a web-based stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through ClaimCheck. It enables us to share with our providers the claim auditing rules and clinical rationale inherent in ClaimCheck.

Providers will have access to Clear Claim Connection through our website through a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed.

Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Correct coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure
- Are necessary to accomplish the comprehensive procedure
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure

Incorrect coding

Examples of incorrect coding include:

- "Unbundling" - Fragmenting one service into components and coding each as if it were a separate service
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate
- Down coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Aetna Better Health of Florida can request copies of operative reports or office notes to verify services provided. Please refer to your Current Procedural Terminology (CPT) Manual for further detail on all modifier usage.

Coordination of Benefits

Coordination of Benefits (“COB”) provision applies when a member has health care coverage under more than one plan. In the event that the Plan is the secondary payer, coordination of benefit claims must be submitted within ninety (90) days after final determination by the primary organization as evidenced by the primary carrier’s Explanation of Payment (EOP) or Explanation of Benefits (EOB) as required under applicable law and regulation. (See Florida Statute 641.3155(2)). All explanations of payment or denials from the member’s primary carrier must be provided with the claim.

Information should be sent to:

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

Claim Status

You may use the Plan’s Provider Portal at [AetnaBetterHealth-Florida.Aetna.com](https://www.aetna.com/Florida) to check the status of claims with dates of service within the last year (365 days) or by calling the Claims Inquiry Claims Research (CICR) department. To check the status of a disputed, resubmitted, and reconsidered claim, please contact the CICR department.

Online status through Aetna Better Health of Florida’s secure portal

Aetna Better Health of Florida encourages providers to take advantage of using our online Provider Secure Web Portal at [AetnaBetterHealth-Florida.Aetna.com](https://www.aetna.com/Florida) as it is quick, convenient and can be used to determine status (and receipt of claims) for multiple claims, paper and electronic. The Provider Secure Web Portal is located on the website. Providers must register to use our portal.

Calling the Claims Inquiry Claims Research department

The Claims Inquiry Claims Research (CICR) department is also available to:

- Answer questions about claims
- Assist in resolving problems or issues with a claim
- Provide an explanation of the claim adjudication process
- Help track the disposition of a particular claim
- Correct errors in claims processing:
 - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization department directly).
 - Excludes rebilling a claim (the entire claim must be resubmitted with corrections).
 - Please be prepared to give the service representative the following information:
 - Provider name or National Provider Identification (NPI) number with applicable suffix if appropriate
 - Member name and member identification number
 - Date of service
 - Claim number from the remittance advice on which you have received payment or denial of the claim

Remittance Advice

Aetna Better Health of Florida generates checks weekly. Claims processed during a payment cycle will appear on a remittance advice (“remit”) as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to verify proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call our Provider Services department if you are interested in receiving electronic remittance advices.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health of Florida for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health of Florida due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna Better Health of Florida after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the Electronic Funds Transfer (EFT) Reference # and EFT Amount are listed along with the last four digits of the bank account the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The Benefit Plan refers to the line of business applicable for this remit. Tax Identification Number (TIN) refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
 - Member Name
 - ID
 - Birth Date
 - Account Number
 - Authorization ID, if obtained

- Provider Name
 - Claim Status
 - Claim Number
 - Refund Amount, if applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
 - The Code/Description area lists the processing messages for the claim.
 - The Remit Totals are the total amounts of all claims processed during this payment cycle.
 - The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claims by EFT. You must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. To enroll in EFT/ERA Registration Services (EERS) visit Change Health payer enrollment services website <https://payerenrollservices.com/>.

Change Healthcare Support Team can be contacted at 800-956-5190 Monday through Friday 8:00am to 5:00pm CST.

Please contact our Provider Relations department for additional questions or assistance with this process.

Editing Guidelines

The Plan uses multiple editing systems to process claims through its practice management application. These systems are configured to comply with applicable state and federal regulations, with respect to timely filing, coding combinations, maximum units, place of service and other editing guidelines. Claim denials resulting from editing that conflict with contractual obligations will be reviewed by our Clinical Editing Review Committee and a payment determination will be made based on the Provider's agreement and correct coding initiatives.

A reduction in payment as a result of claims policies and/or editing procedures is not an indication that the service is a non-covered service.

Note: Claims processed after the implementation date, regardless of date of service, will process according to the most recent version. No retrospective claim payment changes are made for processing changes that are a result of new editing rules.

High Dollar Claims (with expected payable amounts over \$50,000)

All claims submitted to The Plan with an **expected payable amount** of over \$50,000 ("high dollar") require the accompaniment of an itemized statement. High dollar claims not accompanied by itemization are subject to denial. If a hospital provider receives such a denial, the claim should be marked as a resubmission and resubmitted with the itemization for processing.

The purpose of the itemization review is to identify items billed under routine services in an inpatient setting that are not separately billable. Such items include but are not limited to:

- Minor medical and surgical supplies such as Band-Aids, cotton balls, Q-tips, swab sticks, drapes, saline solutions irrigation/flush, syringes, gloves, drapes, bed linen, gowns
- Other identified nursing charges
- IV nursing care, procedural charges for an IV flush and or administration is considered a routine cost
- Equipment permanently stored or housed in a room such as a cardiac/heart monitor in the intensive or cardiac unit (ICU/CCU), a blood pressure (BP) monitor or respiratory, ventilation and oxygen equipment
- Continuous pulse oximetry monitoring in critical care or step down units
- Personal items such as: slippers, lotions, powders, deodorant, admission kits (except MD), tooth brushes, denture care kits or under pads

Anesthesia Unit Billing Guidelines

When billing Anesthesia services be sure to submit claims with the total anesthesia service time. The Plan's claims payment system will automatically convert the service time into units. Any portion of a 15 minute increment equals one unit.

Include the appropriate HCPCS modifiers. These modifiers identify monitored anesthesia and whether a procedure was:

- Personally performed
- Medically directed, or
- Medically supervised

HCPCS Codes for Drugs and National Drug Code (NDC) Requirements

Providers who bill HCPCS codes for drugs must enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug in the shaded area of item 24. Begin entering the information above 24 A. Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.

The NDC is required on claims for drugs, including Medicare-Medicaid crossover claims for drugs. See Chapter 4 in the Florida Medicaid Provider General Handbook for instructions for crossover claims for J3490, Unclassified Drugs, and J9999, Not Otherwise Assigned, Antineoplastic Drugs.

Florida Medicaid will only reimburse for drugs for which the manufacturer has a federal rebate agreement per Section 1927 of the federal Social Security Act [42 U.S.C. 1396r-8].

The current list of manufacturers who have drug rebate agreements is available on AHCA's website at <http://ahca.myflorida.com>. Click on: Medicaid, scroll down to —What is Occurring in Medicaid, II and then click on —Current List of Drug Rebate Manufacturers

The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and **the last two digits are the package size.**

Note: Aetna Better Health recommends using the NDC number on the box (outer packaging) if the medication comes in a box with multiple vials.

If you are given an NDC that is less than 11 digits, add the missing digits as follows:

For a 4-4-2 digit number, add a 0 to the beginning For a 5-3-2 digit number, add a 0 as the sixth digit For a 5-4-1 digit number, add a 0 as the tenth digit

Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point.

The Unit Qualifiers are:

F2 – International Unit

GR – Gram ML – Milliliter UN – Unit

Retroactive Eligibility Changes

Eligibility under a benefit contract may change retroactively if:

- We receive information an individual is no longer a patient.
- The individual's policy/benefit contract has been terminated.
- The eligibility information we receive is later determined to be false.

If you have submitted a claim(s) affected by a retroactive eligibility change, a claim adjustment may be necessary. The reason for the claim adjustment will be reflected on the remittance advice.

Balance Billing

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 Agreement. Payment made to Providers constitutes payment in full by Aetna Better Health of Florida for covered benefits, with the exception of Member Expenses. For Covered Services, Providers shall not balance bill Members any amount in excess of the contracted amount in the Agreement. An adjustment in payment as a result of Aetna Better Health of Florida's claims policies and/or procedures does not indicate that the service provided is a non-Covered Service, and Members are to be held harmless for Covered Services. For more information on balance billing, refer to the Florida Statutes 641.3154 and 641.3155 (5)a.(8). Additionally, Providers shall not charge Members for missed appointments.

Electronic Data Interchange (EDI) Claim

Electronic claim submission to the Plan payers is easy to establish. Contact your practice management system vendor or clearinghouse to initiate the process. Electronic claim submissions will be routed through Change Healthcare (Emdeon) who will review and validate the claims for HIPAA compliance and forward them directly to the Plan.

Providers can also submit directly to Change Healthcare (Emdeon). Emdeon will provide the electronic requirements and set-up instructions. Providers should call **1-800-215-4730** or go to www.emdeon.com for information on direct submission to Change Healthcare (Emdeon).

EDI claim submitters should review the electronic claim submission requirements below:

EDI Specifications: The 837 claim transaction is utilized for electronic professional and institutional claims and encounters. We use the ASC X12N 837 Professional Health Care Claim and the ASC X12N 837 Institutional Health Care Claim implementation guides. The official implementation guides for claim transactions are available electronically from the Washington Publishing Company website at www.wpc-edi.com.

This document contains clarifications and payer specific requirements related to data usage and content with submitting an EDI claims to the Plan. Please note that this document is intended to list only those elements where payer specific requirements or clarifications apply.

1. Specific Payer Edits at Change Healthcare (Emdeon): All EDI claims submitted through Change Healthcare (Emdeon) will be subject to these specific payer edits (unless indicated for one transaction only) that are in place at Emdeon. Submitters will receive these types of rejections on their level 1 payer rejection reports.

- The insured id must be at least two characters in length, or the claim will reject
- To allow zero dollar line charges and zero dollar claim charges
- The billing Provider ID may not contain a value of 999999999 or the claim will reject
- If the procedure code begins with 0, then anesthesia minutes are required, or the claim will reject.
- Excluding procedure code is 01995 or 01996 then service units are required, and the anesthesia minutes should contain 00 or the claim will reject. If the procedure code begins with a 0 and ends with T, then service units are required, and the anesthesia minutes should contain 00 or the claim will reject.
- If the procedure code does not begin with a 0, then service units are required, and the anesthesia minutes should contain 00 or the claim will reject.
- The discharge hour must contain a numeric value of 00-23 or 99 if the batch type contains an inpatient value of x10, x11x14 or x17 and the statement period from date is equal to the statement period thru date.

2. EDI Acknowledgement and Reject Reports: For every claim filed electronically, the provider should monitor whether or not that claim has been rejected by reviewing EDI acknowledgement and reject reports on a regular basis. The following reports should be monitored regularly:

- **Initial reject report (Change Healthcare (Emdeon) report Rpt 05 or equivalent vendor report) -** This is a report that shows claims rejected by Change Healthcare (Emdeon) that were not forwarded to Mail Handlers Benefit Plan. These claims should be corrected and re-submitted electronically.

- **Initial accept report (Change Healthcare (Emdeon) Envoy Report Rpt 04 or equivalent vendor report)** - This is a report that shows Emdeon accepted the EDI claim and forwarded it for processing.
- **Payer rejects report (Change Healthcare (Emdeon) Report Rpt 11 or equivalent vendor report)** - This report states why The Plan rejected the claim. These claims should be corrected and re-submitted electronically.

Monitoring your EDI reports

Please note that claims appearing on the **initial reject report** have not met the initial clearinghouse criteria approved by the Plan and have not been sent to the Plan for adjudication. Any claims appearing on this report must be corrected and re-submitted electronically as soon as possible to avoid timely filing issues.

It is also important to note that a claim can pass the clearinghouse edits and be displayed on the initial accept report, but still be rejected. Claims rejected will appear on the **payer reject report**. Any claims appearing on this report should be corrected and re-submitted electronically as soon as possible to avoid timely filing issues.

Timely Filing - The Plan must accept a claim within its timely filing limit or it will be denied for untimely filing. If you are not receiving the described clearinghouse and payer reports on a regular basis, please contact your clearinghouse or Change Healthcare (Emdeon). A provider can avoid timely filing issues through understanding and regular monitoring of EDI Reports. This process will help to ensure all rejected claims are re-filed timely and electronically.

Common rejection reasons

Review the following tips for assistance with resolving the most common rejections received by providers. The most common claim reject reason is "Member not found." **Use the Aetna Better Health secure provider portal, aetnabetterhealth-florida.aetna.com, Emdeon, or an integrated solution through your vendor or clearinghouse to verify/validate member's eligibility prior to submitting claims.**

- **Member Identification Number** - Submit the 10 or 11 digit number as displayed on the patient's ID card.
- **Patient Date of Birth** - Submit a valid date of birth for the patient.
 - Do not send "00" for the month or date
 - Do not send dummy dates such as "17760704"
 - Do not send a date of birth greater than the date of service
- **A claim** will be rejected if a valid date of birth does not match the date of birth on file in the system. If this is the case, please verify the patient date of birth with the patient or policyholder.
- **Date Format** - Submit all dates in the following format CCYYMMDD unless otherwise specified.
 - Submit valid dates of service
 - Do not submit future dates of service
- **Monetary Amount Format** - Include the decimal point in all monetary amounts unless otherwise specified.
 - Do not submit negative dollar amounts
- **Coding Detail** - Consider the following when verifying service codes and/or modifiers that have been rejected.

- Submit service codes and modifiers appropriate to the age and gender of the patient
- Submit service codes and modifiers appropriate to the date of service
- Submit service codes to their greatest level of specificity

Corrected or voided EDI claims

Corrected and/or Voided Claims are subject to Timely Claims Submission (i.e., Timely Filing) guidelines.

To submit a Corrected or Voided Claim electronically:

- Loop 2300 Segment CLM composite element CLM05-3 should be '7' or '8' – indicating to replace '7' or void '8'
- Loop 2300 Segment REF element REF01 should be 'F8' indicating the following number is the control number assigned to the original bill (original claim reference number)
- Loop 2300 Segment REF element REF02 should be 'the original claim number' – the control number assigned to the original bill (original claim reference number for the claim to be replaced.)
- Example: REF*F8*Aetna Better Health of Florida Claim number here~
- These codes are not intended for use for original claim submission or rejected claims.

EDI assistance

The Clearinghouse - typically, your first point of contact for resolving an EDI issue is your practice's specific clearinghouse or vendor.

Change Healthcare (Emdeon) - The Change Healthcare (Emdeon) customer service center can track all EDI submissions received by them. Emdeon also maintains the status message returned on an EDI claim from the health plan. This information is readily available for forty-five (45) days after the submission. Information on older submissions is also available but will require being forwarded to their research division for follow-up. Change Healthcare (Emdeon) customer support can be reached at **1-877-469-3263**.

Additionally, Change Healthcare (Emdeon) has a new web-based application, Vision for Claim Management that compiles claim information received and generated during claim filing and processing. It is in an easy to use application for tracking EDI claim submissions. For more information and registration for Vision for Claim Management, go to: http://transact.emdeon.com/editrx_services.php.

Electronic remittance advice

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.

The benefits of an 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)

Electronic fund transfer

Electronic fund transfer offers electronic payments deposited directly into providers' bank accounts.

The benefits of an EFT

- An EFT can improve the consistency of your payments and provide fast, accurate and secure payments directly into your bank account.

EFT/ERA Registration Services (EERS)

All 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. If a provider's tax identification number (TIN) is active in multiple states, a single registration will auto-enroll the payee for multiple Aetna Medicaid payers. Registration can also be completed using a national provider identifier (NPI) for payment across multiple accounts.

How to Enroll

To enroll in EERS, please visit Change Health payer enrollment services website:

<https://payerenrollservices.com/>

- 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).

How to disenroll

Contact the Change Healthcare Support Team and let them know that you would like to withdraw an enrollment.

Change Healthcare Support Team can be contacted at 800-956-5190 Monday through Friday 8:00am to 5:00pm CST.

Billing Encounters and Claims Overview

An encounter or a claim is an interaction between a patient and Provider (MCO, HMO, rendering physician, pharmacy, lab, etc.) that delivers services or is professionally responsible for services delivered to a patient. Encounters can be reimbursed to the provider for fee for service or capitation by the health plan.

Providers required to bill on the CMS-1500 Claim Form or Professional EDI submission:

Physicians	Durable Medical Equipment Early Intervention Services
Ambulance, Land and Air Ambulatory	
Surgical Centers Assistive Care Providers	Federally Qualified Health Centers Hearing Aid Specialists
Birth Centers	
Child Health Check-Up Providers	Home and Community-Based Waiver Home Health
Children at Risk Targeted Case Management Chiropractors	Independent Laboratories Licensed Midwives
Community Mental Health Services	
Providers County Health Departments	
Advanced Registered Nurse Practitioners Therapy Providers	

Providers required to bill on the UB-04 Claim Form or Institutional EDI submission:

Freestanding Dialysis Centers Hospitals
Hospital-Based Skilled Nursing Facilities Hospice
Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Nursing Facilities

In support of Health Insurance Portability and Accountability Act (HIPAA) and its goal of administrative simplification, we encourage physicians and medical Providers to submit claims electronically. Electronic claims submission can have a significant, positive impact on the productivity and cash flow for your practice.

Our Claims Inquiry Claims Research (CICR) department is responsible for claims adjudication; resubmissions and claims inquiry/research.

Aetna Better Health of Florida is required to process claims in accordance with Medicare and Medicaid claim payment rules and regulations.

- Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD- 10CM) codes, and code to the highest level of specificity. Complete and accurate use of The Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk Adjustment Processing System. Important notes: The ICD-10 CM codes must be to the highest level of specificity: assign three- digit codes only if there are no four-digit codes within that code category, assign four-digit codes only if there is no fifth-digit sub-classification for that subcategory and assign the fifth-digit sub-classification code for those sub-categories where it exists
- Report all secondary diagnoses that impact clinical evaluation, management, and treatment.
- Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical/case record provides adequate documentation for assignment of a more specific code
- Aetna Better Health of Florida is authorized to take whatever steps are necessary to ensure that the provider is recognized by the Agency and its agent(s) as a participating provider of Aetna Better Health of Florida and that the provider's submission of encounter data is accepted by the Agency

Review of the medical/case record entry associated with the claim should obviously indicate all diagnoses that were addressed were reported.

Again, failure to use current coding guidelines may result in a delay in payment and rejection of a claim.

Member Grievances and Appeals

Member Appeal Rights

An **appeal** is a formal complaint about a service that is denied. An **appeal** may be filed within sixty (60) days of receiving the notice of adverse benefit determination. If the appeal is filed orally (except for an expedited appeal), it must be followed up with a written notice within ten (10) business days of calling in the appeal.

A Healthy Kids member may file an appeal, or a Provider or authorized representative acting on the members behalf with written authorization, may file an appeal.

The address and telephone number to contact the Grievance and Appeals department is:

Aetna Better Health of Florida
Attention: Appeals and Grievance- Florida Healthy Kids
PO Box 81139
5801 Postal Road
Cleveland, OH 44181
1-844-528-5815 (toll free)

You can contact Member Service department to file a grievance or appeal and request the form by calling **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time. The Plan and/or the Provider must give the member reasonable assistance in completing the forms and other steps, including but not limited to providing interpreter services and interpreter capability.

The appeals coordinator will send an acknowledgement letter within (5) business days of getting an appeal. The appeal will be reviewed as expeditiously as the member’s health requires or in a reasonable amount of time, not to exceed thirty (30) calendar days for a member appeal or sixty (60) days for a provider post service appeal.

An “expedited appeal” can be requested if the provider or member feels that waiting 30 days for a decision could put the member’s life, health or ability to attain, maintain, or regain maximum function in danger. This can be done by phone or in writing, but you need to make sure to ask for the appeal to be expedited. We may not agree that the appeal needs to be expedited, but we will let you know of our decision. If we do not expedite the appeal, it will be processed under normal time frames. If we do expedite the appeal, we will advise of the decision within seventy-two (72) hours after receiving the expedited appeal request.

For decisions that involve an appeal of a denial that is based on medical necessity, a grievance regarding the denial of an expedited resolution of an appeal, or a grievance/appeal that involves clinical issues, the decision maker will be someone other than the person involved in making the initial determination, and who has the clinical expertise in the members condition or disease. If an extension is necessary, The Plan will notify the member of the delay, which is not to exceed fourteen (14) calendar days.

The Member or their representative will have an opportunity to review the case file, including medical records and any other documents and records.

How to ask for services to continue

If a member was receiving a service that was reduced, suspended or terminated, they have the right to keep getting those services until a final decision is made in an appeal.

For an appeal

File the appeal with Aetna Better Health of Florida not later than ten (10) days from the date the Notice of Adverse Benefit Determination letter was mailed OR no later than 10 days after the first day our action will take place, whichever is later. The appeal can be requested by phone but must be followed up with a request in writing. **The member MUST tell us they want their services continued.**

Member Complaint Rights

Complaint - Any oral or written expression of dissatisfaction by an enrollee submitted to the Managed Care Plan or to a state agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or Managed Care Plan employee, failure to respect the enrollee's rights, Managed Care Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the Managed Care Plan's Contract. A complaint is a subcomponent of the grievance system.

Grievance - An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or Managed Care Plan employee or failure to respect the enrollee's rights.

All provider complaints will be thoroughly investigated using applicable regulatory and contractual provisions, collecting all pertinent facts from all parties and applying the plan's written policies and procedures. The plan will also ensure that the appropriate decision makers with the authority to implement corrective action are involved in the provider complaint process. The plan shall provide a written notice of the outcome of the review to the provider.

All complaints disputing the policies, procedures or any aspect of the administrative functions of the plan can be oral or written. The complaint must be filed no later than 90 calendar days from the date the provider becomes aware of the issue generating the complaint. Provider policy-related complaints may be filed in writing.

A member may file a complaint/grievance. Complaints can be filed either orally or in writing. The address and telephone number to contact the Appeals and Grievance department is:

Aetna Better Health of Florida
Attention: Appeals and Grievance - Florida Healthy Kids
PO Box 81139
5801 Postal Road
Cleveland, OH 44181
1-844-528-5815 (toll free)

You or the member can contact the Member Services Department to file a grievance and request the form by calling **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time. The plan and/or the Provider must give the member reasonable assistance in completing the forms and other steps, including but not limited to providing interpreter services and interpreter capability.

The Member or their representative will have an opportunity to review the case file, including medical records and any other documents and records.

The following individuals can be designated by the member to assist a member in filing a grievance or appeal:

- The Health Plan
- Legal Guardian of a member
- Provider rendering services to a member

If an extension is necessary, The Plan will notify the member of the delay, which is not to exceed fourteen (14) calendar days.

Medical Necessity Reconsideration

The Plan is not obligated to pay for unauthorized services. If the Provider does not agree with the determination and the matter cannot be resolved informally, the Plan maintains a reconsideration process through which all Providers (physician, facility, or ancillary) may request reconsideration (on behalf of a member) of a medical management issue or benefit determination.

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

- A Peer-to-Peer Review with the Medical Director who made the decision may be requested by calling the Peer-to-Peer coordinator at **1-954-858-3219**.
- A request for reconsideration may be made by providing additional information by phone at **1-800-447-3725**, by fax at **1-860-607-8056** or by mail to:

Aetna Better Health of Florida
Florida Medical
9675 NW 117th Ave, Suite 202
Miami, FL 33178-1228

Reconsiderations of prior authorization decisions must be received within five (5) business days of the date the denial of coverage determination fax was sent, prior to services being rendered and 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 issuance of the verbal denial.

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.

Aetna Better Health of Florida will inform providers through this Provider Manual and other methods, including periodic Provider newsletters, training, provider orientation, the website and by the provider calling their Provider Services Representative about the provider complaint system processes.

Dedicated provider relations staff are available to answer questions, assist in filing a provider complaint and review/resolve any issues that the providers may have. Requests and inquiries are responded within 72 hours or 3 business days by sending an acknowledgment letter. A provider may also contact the Provider Relations team, via the following email: FLMedicaidProviderRelations@aetna.com or by calling at **1-844-528-5815**, Monday – Friday 8:00 AM to 5:00 PM Eastern Time.

Both network and out-of-network providers may file a dispute verbally or in writing direct to Aetna Better Health of Florida to resolve any dispute. Providers can file a verbal dispute with Aetna Better Health of Florida by calling Provider Relations department at **1-844-528-5815**, Monday – Friday 8:00 AM to 5:00 PM Eastern Time. To file a dispute in writing, providers should write to:

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

The provider may also be asked to complete and submit the dispute form with any appropriate supporting documentation. The dispute form is accessible on Aetna Better Health of Florida's website, via fax or by mail.

If the dispute is regarding claim resubmission or reconsideration, the dispute may be referred to the Claims Inquiry Claims Research (CICR) department. For all disputes, Aetna Better Health of Florida will notify the provider of the dispute resolution by phone, email, and fax or in writing. A provider may also contact the Provider Relations team, via the following email:

FLMedicaidProviderRelations@Aetna.com

Dedicated staff is available to answer questions, assist in filing a provider complaint and resolve any issues. Requests and inquiries are responded to within 72 hours or 3 business days.

Provider Non-claim related complaints

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. Provider complaints are an expression of dissatisfaction not related to an action. Provider complaints must be filed within 45 calendar days from when the provider became aware of the issue for issues not related to claims or within 45 calendar days from the dispute resolution. All provider complaints concerning claims issues are processed and resolved in accordance with s. 641.3155, F.S. and s. 408.7057, F.S. There is no second level consideration for cases denied for untimely filing. If the provider feels they have filed their claim within the appropriate time frame, they may submit proof. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a

representative of Aetna Better Health of Florida, or similar receipt from other commercial delivery services. All disputes concerning claims payment issues must be filed in writing.

To file a provider complaint, please submit it via e-mail FLAppealsandGrievances@Aetna.com or write to:

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

The Provider Relations department assumes primary responsibility for coordinating and managing Provider complaints, and for disseminating information to the Provider about the status of the complaint.

An acknowledgement letter will be sent within three (3) business days summarizing the complaint, including the expected date of resolution and instructions on how to:

- Revise the complaint within the timeframe specified in the acknowledgement letter
- Withdraw a complaint at any time until Grievance Committee review

If the complaint requires research or input by another department, the Provider Relations department will coordinate with the Appeals and Grievances department. The Appeal and Grievance department will forward the information to the appropriate department and coordinate with the affected department to thoroughly research each complaint using applicable statutory, regulatory, and contractual provisions and Aetna Better Health of Florida's written policies and procedures, collecting pertinent facts from all parties.

Aetna Better Health of Florida will provide a status update on the complaint every 15 calendar days will resolve all provider complaints within 60 calendar days of receipt of the complaint and will notify the provider of the resolution within 3 business days of the decision.

The Plan has a process for participating providers to resolve issues between the participating provider and the Plan that may result in a change in network status of the provider, as such network status change relates to the Plan's review of the providers professional competency and/or conduct or clinical quality. A provider may be denied continued participation status for quality concerns based on the competence or professional conduct of a provider, which affects or could affect the health or welfare of a patient or patients.

Examples of such quality concerns include but are not limited to:

- Evidence of substandard treatment rendered to patients
- Malpractice judgments/settlements
- In any instance where corrective action will be required to be reported to the National Provider Data Bank (NPDB)
- In any instance where a Provider's Contract with Aetna Better Health is terminated for cause under the terms of the Contract
- Current Medicare or Medicaid sanctions
- Loss of accreditation or certification status if a facility or ancillary provider

Prior to taking any final action to deny continued participation status to a provider for quality concerns, the provider will be entitled to pursue the appeal process.

If the Credentialing Committee has made the determination to not renew a provider's reappointment for reasons based on quality concerns, the provider shall be notified in writing by the Medical Director of the

decision and the reasons for it. The provider may request an appeal, within thirty (30) days of receipt of the decision letter. The provider must make this request to the Medical Director in writing.

Provider claim related complaints

The Plan's process for provider complaints concerning claims issues will be in accordance with s. 641.3155, F.S. and will identify staff for providers to contact via telephone, electronic mail, regular mail, or in person, to ask questions, file a provider complaint and resolve problems. Disputes between the Plan and the provider may be resolved as described in s. 408.7057, F.S.

For provider disputes, providers must follow the Timely Filing Guidelines indicated on the table below. Disputes filed after the time indicated on the Timely Guidelines Grid will be denied for untimely filing. There is no second level consideration for cases denied for untimely filing. If the provider feels they have filed their case within the appropriate time frame, they may submit proof. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of Aetna Better Health, or similar receipt from other commercial delivery services. All disputes concerning claims payment issues must be filed in writing.

Providers have forty-five (45) days to file a written complaint for issues not related to claims payment. Within three (3) business days of receipt of a complaint, the provider will be notified verbally or in writing that the complaint has been received with an expected date of resolution. Provider complaints will be resolved within ninety (90) days of receipt. Written status notification will be provided after fifteen (15) days and every fifteen (15) days thereafter if the complaint remains open. A final disposition notification will be provided within three (3) business days of the resolution.

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))

Dedicated provider relations staff is available to answer questions, assist in filing a provider complaint and review/resolve any issues that the providers may have. Requests and inquiries are responded within 72 hours or 3 business days by sending an acknowledgment letter. A provider may also contact the Provider Relations team, via the following email: FLMedicaidProviderRelations@aetna.com or by calling **1-844-528-5815**, Monday – Friday 8:00 AM to 5:00 PM Eastern Time.

To file a dispute in writing, Providers should write to:

Aetna Better Health of Florida
Attention: Florida Healthy Kids – Grievance and Appeal Department
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Overpayment Recovery

Should an overpayment be made to any provider, the provider is required to return the overpayment to the Plan within 60 calendar days after the date in which the overpayment was identified. Payment must be returned to the address below, along with written notice explaining the reason for the return of payment. 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 are able to access and view their overpayment recovery detail through our website at aetnabetterhealth-florida.aetna.com under the “Tasks’ section.” If there are any questions about the information in the notice, on the website or concerns about an explanation of payment entry for a negative amount, please email the Plan’s Provider Relations Department at FLMedicaidProviderRelations@aetna.com or via mail to:

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

Oversight of the provider complaint system processes

The Appeals and Grievances department has the responsibility for oversight of the provider complaint system processes. The Appeal and Grievance Manager has overall responsibility for management of the provider complaint system processes and reports to the Director of Operations. This includes:

- Documenting individual complaints in the G&A database
- Coordinating resolutions
- Maintaining the appeal and grievance database
- Tracking and reviewing complaint and appeal data for trends in quality of care or other service-related issues
- Reporting all data to the Provider Advisory Committee (PAC) and Quality Management Oversight Committee (QMOC)

Aetna Better Health of Florida’s Provider complaint system processes are integrated into our quality improvement program. Our Quality Management (QM) responsibility of the grievance system processes

includes:

- Review of individual complaints
- Aggregation and analysis of complaint and appeal trend data
- Use of the data for quality improvement activities including collaboration with credentialing and re-credentialing processes as required
- Identification of opportunities for improvement
- Recommendation and implementation of corrective action plans as needed

The Aetna Better Health of Florida Appeal and Grievance Manager will serve as the primary contact person for the complaint system processes with the Aetna Better Health of Florida Appeal and Grievance Coordinator serving as the back-up contact person. The Member Services department, in collaboration with the QM department and Provider Relations Department, is responsible for informing and educating members and providers about a member's right to file a complaint, grievance, appeal, or State Fair Hearing and for assisting members in filing a complaint, grievance, or appeal throughout the Member Grievance System and the Provider Complaint System.

Providers receive this information via the Provider Manual during provider orientations, within the Provider Agreement and on Aetna Better Health of Florida's website.

Credentialing and Recredentialing

Aetna Better Health of Florida uses current NCQA standards and guidelines for the review, credentialing, and re-credentialing of providers and uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource for all provider types. The Universal Credentialing DataSource was developed by America's leading health plans collaborating through CAQH. The Universal Credentialing DataSource is the leading industry-wide service to address one of providers' most redundant administrative tasks: the credentialing application process.

The Universal Credentialing DataSource Program allows providers to use a standard application and a common database to submit one application, to one source, and update it on a quarterly basis to meet the needs of all of the health plans and hospitals participating in the CAQH effort. Health plans designated by the providers obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the provider for the same standard information. Providers update their information on a quarterly basis to verify data is maintained in a constant state of readiness. The CAQH gathers and stores detailed data from more than 600,000 providers nationwide. All new providers, (with the exception of hospital-based providers) joining Aetna Better Health of Florida, must complete the credentialing process and be approved by the Credentialing Committee.

Aetna Better Health of Florida is authorized to take whatever steps are necessary to ensure that the provider is recognized by the Agency and its agent(s) as a participating provider of Aetna Better Health of Florida and that the provider's submission of encounter data is accepted by the Agency;

A satisfactory level II background check pursuant to s. 409.907, F.S., for all treating providers not currently enrolled in Medicaid's fee-for-service program, in accordance with the following:

- Aetna Better Health of Florida will verify Medicaid eligibility through the background screening system.
- Aetna Better Health of Florida will not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.
- Individuals already screened as Medicaid providers or screened within the past 12 months by another Florida agency or department using the same criteria as the Agency are not required to submit fingerprints electronically but will document the results of the previous screening
- Individuals listed in s. 409.907(8) (a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency's background screening website.
- For additional and detailed information please visit the AHCA website:
http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/index.shtml.

Providers must provide business transaction disclosures within 35 days of the date of request by CMS, AHCA, or FHKC that includes information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the previous five-year period.

Practitioner re-credentialing process

We reassess a provider's qualification practice and performance history every three (3) years, depending on state and federal regulations and accrediting agency standards. This process is seamless to providers who are due for re-credentialing and whose applications are complete within CAQH. We'll send providers (whose applications aren't complete within CAQH) three reminder letters. The letters will ask them to update their re-credentialing data. If they do not respond to the letters, we'll call them.

Providers are re-credentialed every three (3) years and must complete the required reappointment application. Updates on malpractice coverage and state medical licenses are also required (where applicable). Please note you may NOT treat members until you are credentialed. Providers must also be board certified where applicable.

Licensure and accreditation

Health delivery organizations such as skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as indicated.

How can I check the status of my re-credentialing application?

Call our Provider Relations department at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time.

How do I add a new provider to my group?

Go to the **Join the Network** section of our website to start the application process.

Office site visits are made to network practitioners after receiving a member's complaint to evaluate the physical accessibility, physical appearance, adequacy of waiting and examining room space, the medical record keeping practices are also evaluated to assess methods used to maintain confidentiality of member information and for keeping information in a consistent, organized manner ready for accessibility. No site visit is required for complaints regarding availability or medical records keeping.

The Aetna Better Health Office Assessment criteria are stated in the practitioner agreements and business criteria of the practitioner agreements. The medical record keeping practice standards are stated in the Aetna Better Health Medical Records Criteria that are distributed to practitioners.

Discrimination laws

Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- The Americans With Disabilities Act
- Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law
- The False Claims Act (31 U.S.C. §§ 3729 et. Seq)
- The Anti-Kickback Statute (section 1128B(b) of the Social Security Act)

- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164

In addition, our Aetna Better Health network providers must comply with all applicable laws, rules, regulations, and, as provided in applicable laws, rules and regulations, network providers are prohibited from discriminating against any member on the basis of health status.

The Plan shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider, who is acting within the scope of provider's license, or certification under applicable state law solely on the basis of such license or certification in accordance with s. 1932(b) (7) of the Social Security Act (as enacted by s. 4704[a] of the Balanced Budget Act of 1997). The Plan shall not discriminate against any provider serving high-risk populations or those that specialize in conditions requiring costly treatments.

Pharmacy

The Formulary

The purpose of The Plan's formulary is to encourage use of the most cost-effective drugs. The formulary is necessary because the cost of prescription drugs, especially specialty drugs, is rising faster than other health care costs. Some of the reasons for this trend include:

- More advertising for newer high-cost drugs
- An aging population that uses more drugs
- The high cost of research and development for new drugs

Without a formulary, The Plan members would end up paying more for health care coverage, due in part, to rising drug costs. Our formulary allows us to continue providing cost-effective pharmacy benefits.

The Plan formularies are developed and maintained by a committee of doctors and pharmacists. The Pharmacy & Therapeutics (P&T) Committee studies new drugs and new information for existing drugs. The Pharmacy & Therapeutics (P&T) Committee develops its formulary recommendations by considering the clinical efficacy, safety, and cost-effectiveness of a product. They keep up-to-date on the newest developments in medicine, and they continually improve our formularies based on the latest research, including the following (where applicable):

- Drug labeling
- Clinical outcome studies from peer-reviewed published medical literature
- Standard drug reference compendia
- Regulatory status
- Evidence-based guidelines published by medical associations, government agencies or national commissions
- Views of professionals in relevant clinical areas
- Other related factors

The P&T Committee makes recommendations for – how drugs will be covered on the formulary based on the following criteria:

- **Efficacy:** Preferred drugs must be as good as, or superior to, other currently available alternatives for most of the population.
- **Safety:** Preferred drugs must be as safe as, or safer than, other currently available alternatives.
- **Health Outcomes (when available):** Preference is given to drugs which have been shown to improve overall health outcomes.
- **Drug Interactions:** Preferred drugs must have similar or less potential for drug interactions compared to other currently available alternatives.
- **Pharmacokinetics:** Consideration is given to drugs with evidence showing that less frequent dosing increases patient compliance and outcomes.
- **Contraindications:** Consideration is given to drugs that do not have factors which would restrict their use of specific patient populations.
- **Cost:** When two or more drugs produce similar clinical results, cost is taken into account in determining whether a drug makes it onto our formulary. **Note:** Formulary decisions are based on cost differences only after safety, effectiveness, possible side effects, and therapeutic need have been established.
- **Generic availability:** Decisions to add generics to the formulary are based on safety, cost, established equivalence to the brand name, and compliance with existing drug contracts.

Comments and suggestions on the formulary are welcomed and should be directed to the Plan's Pharmacy department. Doctors may submit a written request to have a medication added to the formulary by contacting Provider Relations at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time. At a minimum, written requests should include:

- Advantages and disadvantages of the drug compared to current formulary alternatives
- Indications for use, efficacy and a review of side effects

We do not require that doctors only prescribe preferred formulary drugs. However, members may save time and money if a prescribed drug is on The Plan formulary. In most cases, there are at least two formulary alternatives to choose from.

You can find the formulary, including any restrictions and preferences, database-e on our website at [AetnaBetterHealth.com/Florida](https://www.AetnaBetterHealth.com/Florida). Click on the searchable formulary link to view the formulary. The formulary applies only to outpatient prescription medications dispensed by participating pharmacies. It does not apply to inpatient medications or the medications obtained from and/or administered by doctors, unless exceptions are noted, all dosage forms (e.g., tablet, capsule, liquid, topical) and strengths -of a formulary drug are included.

New drugs may be added, and existing drugs may be removed throughout the year. A summary of the most recent formulary changes can be found on our website at [AetnaBetterHealth.com/Florida](https://www.AetnaBetterHealth.com/Florida). Click on the Pharmacy tab, then click on the Preferred Drug List & Formulary Updates tab to view the Healthy Kids Formulary Updates. In addition to the drug limitations and restrictions called out in the formulary, certain classes of drugs (such as those for cosmetic uses) may not be covered. Members should refer to their benefit document, or call Member Services at the number on their ID card, to determine which drugs are excluded under their benefit plan.

Doctors may request an exception to the formulary. In fact, doctors can request a coverage exception for any drug that he/she considers to be medically necessary by following the steps outlined under the section of this document entitled "Processes for Requesting a Medication Coverage Exception."

Prior Authorization

One of The Plan's tools to help manage rising prescription drug costs is to require prior approval, or authorization, before drugs are covered. Drugs which require prior authorization are often not suggested as the first-line treatment option, and/or may have limited diagnoses for which they are recommended. Prior authorization may also be required for drugs that are very expensive. The prior authorization program helps to ensure that drugs are used in a safe, appropriate and cost-effective manner.

The P&T Committee determines which drugs require prior authorization and the criteria for coverage. Drugs that require prior authorization will be rejected at the member's pharmacy until The Plan has reviewed the necessary clinical information provided by the doctor and approves coverage.

Step Therapy (Auto-PA)

Step therapy is a form of prior authorization. It involves an electronic review of a member's drug history to ensure that appropriate generic or first-line drugs have been tried already. If the member has already tried the preferred drug(s), the claim will be processed as normal with the appropriate copayment. If the preferred drug(s) are NOT in the member's drug history, the claim will reject at the pharmacy and the doctor will need to provide additional clinical information to the health plan for further review.

Which drugs require prior authorization or step therapy?

You can identify drugs that require prior authorization or step therapy by referring to our printable formulary document, on our website at [AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida). Each of these resources is available on our website. Prior authorization and step therapy criteria and specific coverage request forms can also be found on our website at [AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida). The drugs that have a step therapy requirement are noted on the preferred drug list with an Auto PA requirement.

Generic Substitution/Therapeutic Interchange

Depending on a member's benefit plan, **generic substitution** may be required for brand-name drugs where the U.S. Food and Drug Administration has determined that the generic is equivalent to the brand. However, this requirement is based on the availability of the generic and state regulations regarding drug product selection. If a doctor states that the brand is required, or a member requests the brand when a generic equivalent is available, The Plan may cover the brand name drug.

The Plan requires the doctor to submit a completed "Multisource Drug and Miscellaneous Prior Authorization" form indicating that the member has had an adverse reaction to the generic drug or has had, in the prescriber's medical opinion, better results when taking the brand-name drug. For Florida Healthy Kids, the Plan requires the submission of a completed MedWatch form along with the "Non-Formulary Medications" form. There may be additional requirements for coverage of a brand name drug. These requirements may be found on our website at [AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida).

Specialty Drugs

Specialty drugs are defined by the Plan. They are typically high-cost drugs, including, but not limited to, the oral, topical, inhaled, inserted or implanted, and injected routes of administration. Characteristics of specialty drugs are:

- Used to treat and/or diagnose rare and complex diseases
- Require close clinical monitoring and management
- Frequently require special handling
- May have limited access or distribution

Specialty drugs require prior authorization and are subject to quantity limits, unless otherwise indicated. Refer to the formulary to identify specialty drugs and to determine if prior authorization and/or quantity limits apply. The formulary is available on our website at [AetnaBetterHealth.com/Florida](https://www.aetna.com/betterhealth/florida). The Plan has contracted with CVS Specialty Pharmacy to provide most of our specialty drugs. Once authorization has been approved, a doctor can call a prescription in to CVS Specialty Pharmacy at **1-866-693-4445**. Members should refer to their health plan documents or call Member Service at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time, with any questions regarding specialty drug coverage.

Pharmacy benefit information

The Plan members can get personalized, real-time prescription drug pricing information, by calling Member Services at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time. They can easily complete the following actions:

- Determine their financial responsibility for a drug, based on their pharmacy benefit
- Initiate the exceptions process for drugs that have restrictions
- Order a refill for an existing, unexpired mail-order prescription

- Find the location of an in-network pharmacy
- Conduct a pharmacy proximity search based on ZIP code
- Determine potential drug-drug interactions
- Determine a drug's common side effects and significant risks
- Determine the availability of generic substitutes

Informed consent for psychotropic medications

Documentation of the express written and informed consent of the member's authorized representative prescriptions for psychotropic medication (i.e., antipsychotics, antidepressants, antianxiety medications, and mood stabilizers) prescribed for a member under the age of thirteen (13) years. In accordance with s. 409.912(16), F.S., the Plan will ensure the following requirements are met:

- The prescriber must document the consent in the child's medical record and provide the pharmacy with a signed attestation of the consent with the prescription.
- The prescriber must ensure completion of an appropriate attestation form. Sample consent/attestation forms that may be used and pharmacies may receive are located at the following link: http://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml.
 - The completed form must be filed with the prescription (hardcopy or imaged) in the pharmacy and held for audit purposes for a minimum of six (6) years.
 - Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form.
 - Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form.
 - The informed consent forms do not replace prior authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescents under the age of eighteen (18) years.

Providers should call their Provider Relations representative at **1-844-528-5815**, Monday – Friday 7:30 AM to 7:30 PM Eastern Time, with any questions related to the Plan's Pharmacy benefits.