Provider newsletter

Winter 2022

New vendor for paper claims and claims correspondence

Effective 2/14/2022 there is a new P.O. box address for paper claims and claim correspondence. We are replacing our current vendor, Change Healthcare (CHC), with Conduent Commercial Solutions, LLC, for services related to the receipt and imaging of all paper claims and claims correspondence. As a result, the address for sending paper claims and correspondence has changed. Please note that member ID cards may not be accurate until members receive a NEW ID card from us.

A key factor in getting claims processed in a timely manner is correct claims submission, and we provide multiple options for you to choose from, including the sending of paper claims through the mail.

Our NEW address, effective February 14, 2022:
Aetna Better Health of Florida
P.O. Box 982960
El Paso, TX 79998-2960

To assist us in processing and paying claims efficiently, accurately, and timely, we highly encourages practitioners and providers to submit claims electronically when possible.

In this issue

Member rights & responsibilities

We have adopted the Florida Member's Bill of Rights and Responsibilities. Members can request a copy of it from their doctor or from Member Services.

Our member rights

- Be treated with courtesy and respect.
- Always have your dignity and privacy considered and respected.
- Receive a quick and useful response to your questions and requests.
- Know who is providing medical services and who is responsible for your care
- Know what member services are available, including whether an interpreter is available if you do not speak English.
- Know what rules and laws apply to your conduct.
- Be given easy to follow information about your diagnosis, and openly discuss the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you.
- Participate in making choices with your provider about your health care, including the right to say no to any treatment, except as otherwise provided by law.
- Be given full information about other ways to help pay for your health care.
- Know if the provider or facility accepts the Medicare assignment rate.
- To be told prior to getting a service how much it may cost you.
- Get a copy of a bill and have the charges explained to you.
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any health emergency that will get worse if you do not get treatment.
- Know if medical treatment is for experimental research and to say yes or no to participating in such research.
- Make a complaint when your rights are not respected.
- Ask for another doctor when you do not agree with your doctor (second medical opinion).
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed.
- Have your medical records kept private and shared only when required by law or with your approval.
- Decide how you want medical decisions made if you can't make them yourself (advanced directive).
- To file a grievance about any matter other than a plan's decision about your services.
- To appeal a plan's decision about your services.
- Receive services from a provider that is not part of our plan (out-of-network) if we cannot find a provider for you that is part of our plan.
- Speak freely about your health care and concerns without any bad results.
- Freely exercise your rights without the plan or its network providers treating you badly.
- Get care without fear of any form of restraint or seclusion being used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of your medical records and ask that they be amended or corrected.
- Receive information on member's rights and responsibilities.
- To voice a complaint about care the organization provides.
- To make recommendations regarding the organization's member rights and responsibilities policy.

Our member responsibilities

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

- Give accurate information about your health to your plan and providers.
- Tell your provider about unexpected changes in your health condition.
- Talk to your provider to make sure you understand a course of action and what is expected of you.
- Listen to your provider, ask questions and follow instructions for care you have agreed to with your practitioner.
- Keep your appointments and notify your provider if you will not be able to keep an appointment.
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions.
- Make sure payment is made for non-covered services you receive.
- Follow health care facility conduct rules & regulations.
- Treat health care staff & case manager with respect.
- Tell us if you have problems with any health care staff.
- Use the emergency room only for real emergencies.
- Notify your case manager if you have a change in information (address, phone number, etc.).
- Have a plan for emergencies and access this plan if necessary for your safety.
- Report fraud, abuse and overpayment.

Notice of privacy practice

Aetna Better Health of Florida is required to keep our member's health information private. One of the ways we do this is by informing our providers about their role in the member's privacy rights. Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies an Aetna Better Health of Florida member.

Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas. Specifically, our network providers must:

- Maintain accurate medical records and other health information.
- Help verify timely access by members to their medical records and other health information.
- Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information, and member information.

Providers must follow both required and voluntary provision of medical records must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations. (**www.hhs.gov/ocr/privacy**).

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and member information, whether oral or written in any form or medium.

To help safeguard patient information, we recommend the following:

- Train your staff on HIPAA
- Consider the patient sign-in sheet
- Keep patient records, papers and computer monitors out of view
- Have electric shredder or locked shred bins available

For additional training or frequently asked questions, visit the U.S. Department of Health and Human Services website: **http://aspe.hhs.gov/admnsimp/final/pvcg**.

Second opinions

A member may request a second opinion from a provider within our network. Providers should refer the member to another network provider within an applicable specialty for the second opinion. Please note that there are no timeframes for referrals. If an Aetna Better Health of Florida provider is not available, Aetna Better Health will help the member get a second opinion from a nonparticipating provider at no cost to the member.

Aetna Better Health's timely filing guidelines

To avoid payments delays or untimely denials, follow Aetna Better Health's timely filing standards listed below.

Timely Filing Standards	
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 **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 crossover 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, medical records, ER records, attachments)	Provider must submit any additional information or documentation as specified, within **35 days** after receipt of the notification. Additional information is considered received on the date it is electronically transferred or mailed. Aetna Better Health cannot request duplicate documents. (F.S. 641.3155(2)(c)(2)

Grievance and appeals process reminder

Effective March 1, 2022, we will no longer accept provider mail that is directed to our 261 N. University Dr., Plantation, FL 33324 office. If you are submitting appeals for multiple claims in one mailing you must use physical barriers (elastic, paper clip, binder clip etc.) for each claim in the submission to maintain the original received date your request may be returned.

Claim resubmission for reconsideration

If you are mailing hard copy claims or claim resubmissions for reconsideration, please direct those to:

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

Resubmissions, reconsiderations and disputes should be clearly marked on the envelope and the first page of the request.

Appeals, complaints and grievances

Whenever possible please submit your appeal, complaint, or grievance electronically. It is preferred that you submit through the Availity provider portal using the direct application for Appeals, Complaints and Grievances: **https://apps.availity.com/availity/web/public.elegant.login** or you may submit by fax to: **1-860-607-7894**.

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

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

EFT/ERA

Not yet enrolled in EFT and ERA with us? Let's get you started.

Aetna Better Health of Florida values the quality care that health care providers give to our members, and it's our goal to provide prompt reimbursement for those services. In order to help you get reimbursed faster, we would like to encourage you to sign up for **electronic funds transfers (EFTs)** and **electronic remittance advices (ERAs)**. This service is provided at no cost to providers and includes numerous benefits.

EFT offers electronic payments deposited directly into providers' bank accounts. Benefits include:

- Elimination of paper checks
- Faster payment
- Improve payment consistency
- Accurate and secure transactions
- Send payment directly into your bank account
- Electronic traceability
- Reduces risk of lost or misrouted checks to the wrong address

Ready to get your direct payments? Fill out the Electronic Fund Transfer (EFT) form and email it to us at **FLFinanceEFTEnrollment@aetna.com**. *All information is confidential.*

ERA offers electronic filing that contain claim payment and remittance information sent to your office. Benefits include:

- Convenient payment and retrieval remittance information
- Match payments to advice quickly
- Eliminates the need for paper explanation of benefits (EOBs)

Ready to sign up for electronic remittances? Fill out the electronic remittance advice (ERA) form and email it to us at **FLMedicaidProvdierRelations@aetna.com** when completed.

For your convenience, we also added the EFT and ERA forms on our website **aetnabetterhealth.com/florida** where you can fill them out electronically. They are located under the "For Providers" main tab, "Resources" and "Claim's information".

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

- Aetna Alert Line: **1-888-891-8910**
- Special Investigation Unit (SIU) Hotline: **1-866-806-7020**
- Email the SIU: **FL-FraudandAbuse@aetna.com**
- Fax the SIU: **724-778-6827**
- FL Medicaid Program Integrity Office: **1-888-419-3456**
- AHCA OIG Complaint Form: **https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx**
- FL Attorney General's Office: **1-866-966-7226**
- Florida Medicaid Compliance: **954-858-3672**
- 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 **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.

ProgenyHealth neonatal care management

Aetna Better Health of Florida is happy to announce a partnership with ProgenyHealth, a company which specializes in neonatal care management services. This is an exciting opportunity. ProgenyHealth's care management program will enhance services to our members and support our mission to make a lasting difference in our members' lives by improving their health and well-being.

Under the agreement that began February 15, 2022, ProgenyHealth's neonatologists, pediatricians and neonatal nurse care managers will work closely with Aetna Better Health of Florida members, as well as attending physicians and nurses, to promote healthy outcomes for Aetna Better Health of Florida's premature and medically complex newborns.

The benefits of this partnership to you:

- The support of a team who understands the complexity and stress of managing infants in the NICU and will work with you to achieve the best possible outcomes
- A collaborative and proactive approach to care management that supports timely and safe discharge to home
- A company that believes in sharing best practices and works with NICUs nationwide to improve the health outcomes of our next generation

Families will have a dedicated case manager who will give support and education to members in the program. Also, they will be able to access an extensive online library and an "on-call" staff member available 24/7. For our hospitals, ProgenyHealth will serve as a liaison for Aetna Better Health of Florida providing inpatient review services and assisting with the discharge planning process to ensure a smooth transition to the home setting.

Your process for notifying Aetna Better Health of Florida of infants admitted to a NICU or special care nursery will change on February 15, 2022. Please notify ProgenyHealth directly of admissions via FAX at **1-877-855-2431** and their clinical staff will contact your designated staff to perform utilization management and discharge planning throughout the inpatient stay.

If you wish to learn more about ProgenyHealth's programs and services, call **1-888-832-2006** or visit **progenyhealth.com**.

Keeping directory information up to date

Help us keep your practice information updated in the directory. Having a correct listing is a prerequisite for proper handling of your claims and is important in ensuring uninterrupted care for our members. The following elements are critical to the accuracy of your listing:

- Street address
- Phone number
- TTY number
- Website
- Email address
- Languages spoken
- Board certified
- Ability to accept new patients
- Ages of patients seen
- Hospital affiliations
- Handicap accommodations (parking, restroom, exam room and equipment)
- Close to public transportation
- Office hours
- Special training like cultural competency

If you have any changes/updates let us know by:

Mail:
Aetna Better Health of Florida
Network Operations
261 N University Drive
Plantation, FL 33324

Call: **1-800-441-5501**
Fax: **1-844-235-1340**
Email: **FLMedicaidProviderRelations@Aetna.com**

Behavioral health provider update

Behavioral health integration – March 1, 2022

Please be advised that as of March 1, 2022, Aetna Better Health of Florida will no longer contract with Beacon Health Options (Beacon) for the management of our members' behavioral health services.

Effective March 1, 2022, we will be transitioning to an integrated medical and behavioral management model and will contract with Behavioral Services Network (BSN) for its behavioral health and substance abuse provider network. Through this new approach, we will be handling behavioral health clinical and operational functions, including care management, utilization management, and claims. Incorporating behavioral health into our current infrastructure improves efficiencies between the health plan, providers, and enrollees.

For PCPs and medical specialists

To access our contracted behavioral health providers, please visit **AetnaBetterHealth.com/Florida** or contact Provider Services, 8 AM to 7 PM, Monday through Friday at **1-844-645-7371** or email **FLMedicaidProviderRelations@aetna.com**.

For contracted behavioral health specialists

Authorization requests prior to March 1, 2022:

For requests prior to March 1, 2022, Beacon will continue to process authorizations. Please continue to submit your authorization requests to Beacon.

Authorization requests on or after March 1, 2022, all behavioral health services that require prior authorization for Aetna Better Health of Florida members must be submitted to us. Prior authorization requirements and criteria may change. Providers can review the provider manual for any additional guidance. Please visit **https://medicaidportal.aetna.com/propat/Default.aspx** to check for codes that require prior authorization.

A provider may obtain the required prior authorization at **http://aetnabetterhealthflorida.aetna.com** or contacting Utilization at **1-800-441-5501**.

You can also fax prior authorization requests to:

- Florida Healthy Kids: **1-833-365-2493**
- Medicaid and Comprehensive Long Term Care: **1-833-365-2474**

Claims for dates of service prior to March 1, 2022:
For dates of service prior to March 1, 2022, Beacon will continue to process claims. Please continue to submit behavioral health claims to Beacon Health Options.

Electronic Claims
Payer EDI: 43324

Paper Claims
Beacon Health Options
Attn: Claims and Correspondence
PO Box 1870
Hicksville, NY 11802-1870

Claims for dates of service beginning March 1, 2022:

Electronic Claims
Payer EDI: 128FL
Real Time Payer ID: ABHFL

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

Continuity of care

Enrollees will not experience an interruption in service(s) or care coordination. Aetna Better Health of Florida will honor any ongoing treatment that is currently being provided or that was previously authorized by Beacon for the duration of the authorization or up to 60 days, whichever is first, following the transition on March 1, 2022. Continuity of care applies to Aetna Better Health of Florida participating and non-participating providers.

To become a participating provider with Aetna Better Health of Florida

If you are interested in becoming a participating provider with us for behavioral health, please go to **www.bsnnet.com/index.php/join-us** to complete the Request to Join form. If you have questions, you may email us at **info@bsnnet.com** or speak to a provider relations specialist at **305-907-7470**.

As we prepare for this transition, please call Provider Services at **1-844-645-7371** with any questions.

Health literacy and equity

What is health literacy?

The Patient Protection and Affordable Care Act of 2010, Title V, defines health literacy as the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.

Anyone who provides health information and services to others, such as a doctor, nurse, dentist, pharmacist, or public health worker, also needs health literacy skills to:

- Help people find information and services
- Communicate about health and healthcare
- Process what people are explicitly and implicitly asking for
- Understand how to provide useful information and services
- Decide which information and services work best for different situations and people so they can act

The U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) offers a free online course in health literacy. **Effective Communication Tools for Healthcare Professionals** – is an online, go-at-your-own-pace training that has helped more than 4,000 health care professionals and students improve patient-provider communication.

Take the course any time, night or day, to improve your ability to communicate with patients. Learn how to overcome barriers that can keep patients from taking their medications according to your instructions, going to the emergency room when they would be better served in primary care or otherwise preventing them from getting the full benefit of the quality care you provide.

Medically underserved patients may have particular difficulty communicating with their health care providers. If you treat patients who are low income, uninsured, and/or whose English proficiency is low, this course can help you:

- Acknowledge cultural diversity and deal sensitively with cultural differences that affect the way patients navigate the health care system
- Address low health literacy and bridge knowledge gaps that can prevent patients from adhering to prevention and treatment protocols
- Accommodate low English proficiency and effectively use tools that don't rely on the written or spoken word

What is health equity?

"Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification."

— World Health Organization

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

— Robert Wood Johnson Foundation

Medicaid's path to health equity

- A common framework to help us move in the same direction to achieve the greatest impact
- Communication creates rapport and respect and communication and empathy create connection at work and in the community
- Personal and organizational values and action impact healthcare delivery
- Assessing needs and reacting to them with proven strategies is key to improvement
- Knowledge and skill integration will improve outcomes
- Measuring effort and effectiveness helps to think, respond and act
- Quality care that addresses social determinants can also be affordable care

Health literacy and education

Building rapport and trust with individuals and their providers is essential for engagement and creating improved community conditions lead to member retention and optimum health outcomes.

(continued on next page)

Health literacy and equity – continued

How can health literacy be achieved?

- Listening
- Learning
- Embracing national standards and current research
- Multiple touch points (FTF, apps, calls, home visits)
- Numerous and understandable communication methods
- Member and provider advisories
- Peer education and service provision

For more information on health equity, visit our website at **www.aetnabetterhealth.com/florida/providers/education**.

Clinical payment, coding and policy updates/reminders

Aetna Better Health of Florida would like to inform you that we regularly augment our clinical, payment and coding policy positions as part of our ongoing policy review processes. In an effort to keep our providers informed, please see below for policy updates/reminders.

Florida Medicaid policies

According to our policy which is based on Florida Medicaid guidelines:

1. **Early intervention services (EIS)** – early intervention services are limited to members from birth to three years (36 months) of age.
2. **Immunizations** – immunization and vaccine product procedure codes must be reported with a corresponding administration code for members.
3. **Radiology and nuclear medicine services** – fetal umbilical artery doppler velocimetry ultrasounds are allowed up to twice per pregnancy. Additionally, fetal middle cerebral artery doppler velocimetry ultrasounds are also allowed up to twice per pregnancy.

Physical health standard prior authorization (PA) request form

As we continue to improve processes, Aetna Better Health of Florida announces that effective February 28, 2022, a new physical health standard prior authorization (PA) request form is available for all providers to use. The new form is located on our website: **www.aetnabetterhealth.com/florida/providers/provider-auth** under the *For Providers, Authorization's* tab.

You can visit our ProPat Search Tool to research whether a service requires prior authorization: **www.aetnamedicaidportal.com/propat/Default.aspx**.

Note: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services rendered must be a covered health plan benefit and medically necessary with prior authorization as per plan policy and procedures.

All inpatient and observation hospital admissions for MMA/Florida Healthy Kids/Comprehensive members must be called in to the MMA/Florida Healthy Kids Prior Authorization Department at 1-**800-441-5501**.