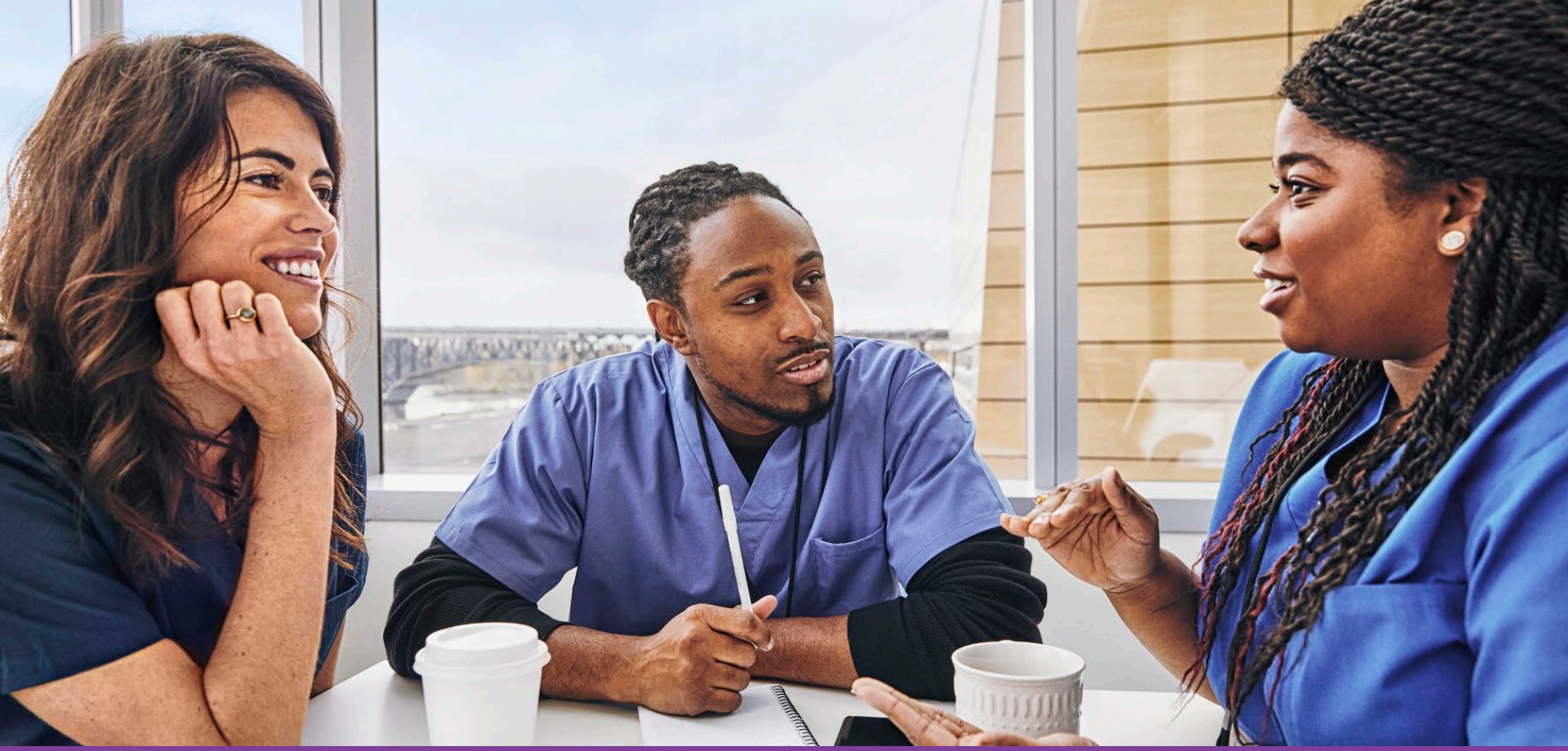

Aetna Better Health of Florida

June Monthly Claims Training

Denise E. Castro

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June 30, 2021

Learning objectives

As part of your Aetna Better Health of Florida's monthly claims training, we will

- Discuss Telemedicine Guidelines
- Review Telemedicine Requirements
- Discuss Telemedicine Billing
- Review EIS
- Clinical Payment, Coding and Policy Changes
- Discuss Change Healthcare Web Connect Tool
- Introduce Availity- New Provider Web Portal
- Explain Timely Filling Guidelines
- Inform the importance of EFT/ERA Registration

Telemedicine Guidelines

Telemedicine Guidelines

Who can provide telemedicine?

- ✓ Practitioners, including MDs, DOs, and physician extenders (physician assistants and advanced practice nurses)
- ✓ Clinic providers (county health departments, rural health clinics, and federally qualified health clinics)
- ✓ Behavioral Health providers -Behavioral health providers should contact ABHFL's behavioral health subcontractor, Beacon Health Solutions at (844) 513-4954 for coverage and billing guidelines.

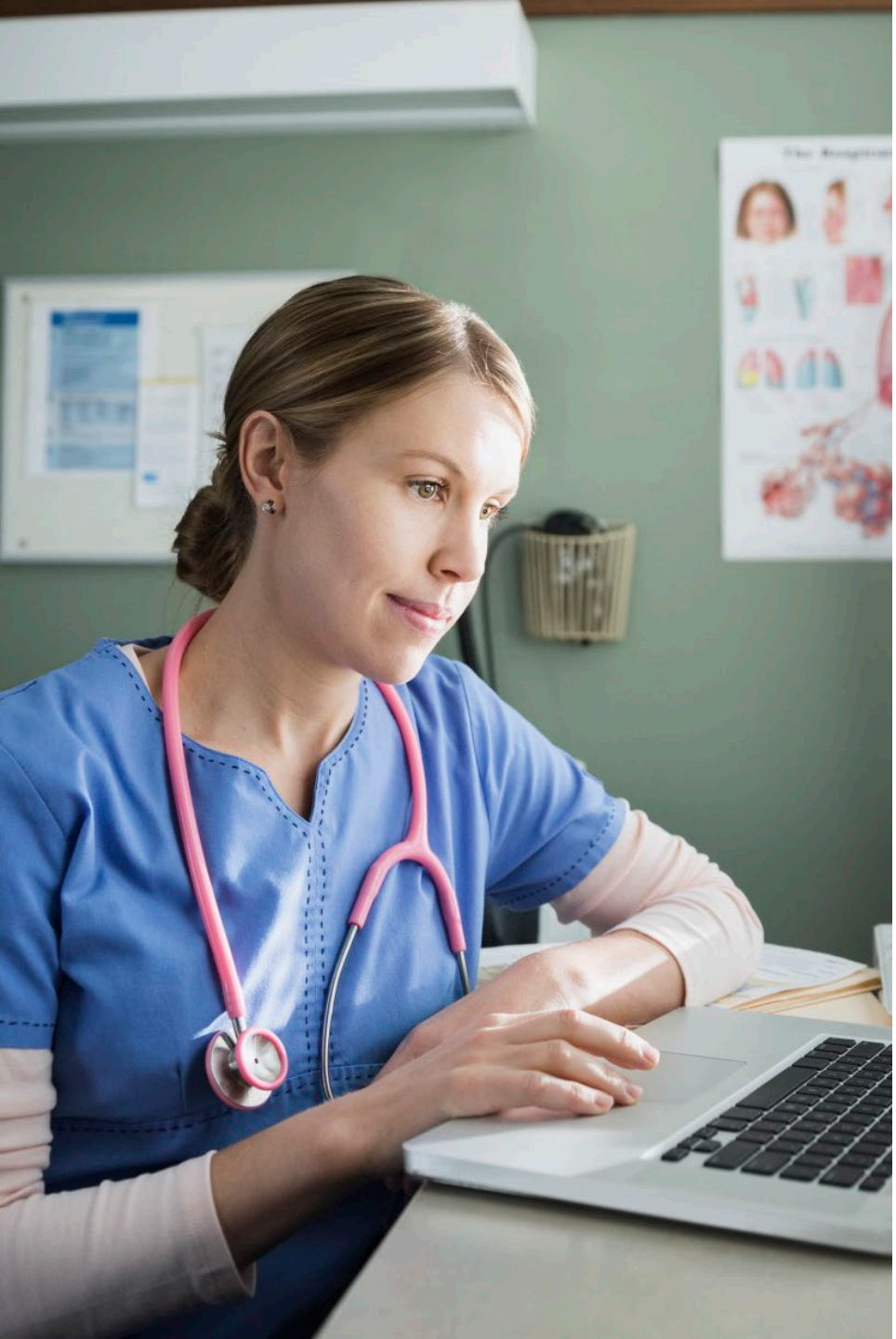
What services can be provided via telemedicine?

Covered medical services include evaluation, diagnostic, and treatment recommendations for services included on the Agency's practitioner fee schedule to the extent telemedicine is designated in the American Medical Association's Current Procedural Terminology (i.e., national coding standards). All service components included in the procedure code must be completed in order to be reimbursed.

ABHFL reimburses services using telemedicine at the same rate detailed on AHCA's practitioner fee schedule or contracted percentage thereof.

Providers must append the GT modifier to the procedure code in the fee-for-service delivery system.

Telemedicine Requirements



Telemedicine Requirements

As a participating Aetna Better Health of Florida provider offering Telemedicine, you must meet the following requirements:

- Ensure the services provided are medically necessary and performed in accordance with the applicable Medicaid service policy. Ensure the patient and parent or guardian, as applicable, are present for the duration of the service provided using telemedicine except when using store and forward modalities.
- Ensure telemedicine is not used if it may result in any reduction to the quality of care or if the service delivered through this modality could adversely impact the recipient.
- Include Documentation regarding the use of telemedicine in the progress notes for each encounter with a recipient. All other documentation requirements for the service must be met as described in the coverage policy.
- Comply with the Health Insurance Portability and Accountability Act (HIPAA) when providing services; all equipment and means of communication transmission must be HIPAA compliant.
- Ensure that the recipient has compatible equipment and the necessary connectivity in order to send and receive uninterrupted video. Telephone or electronic-based contact with a Florida Medicaid recipient without a video component is not permitted.

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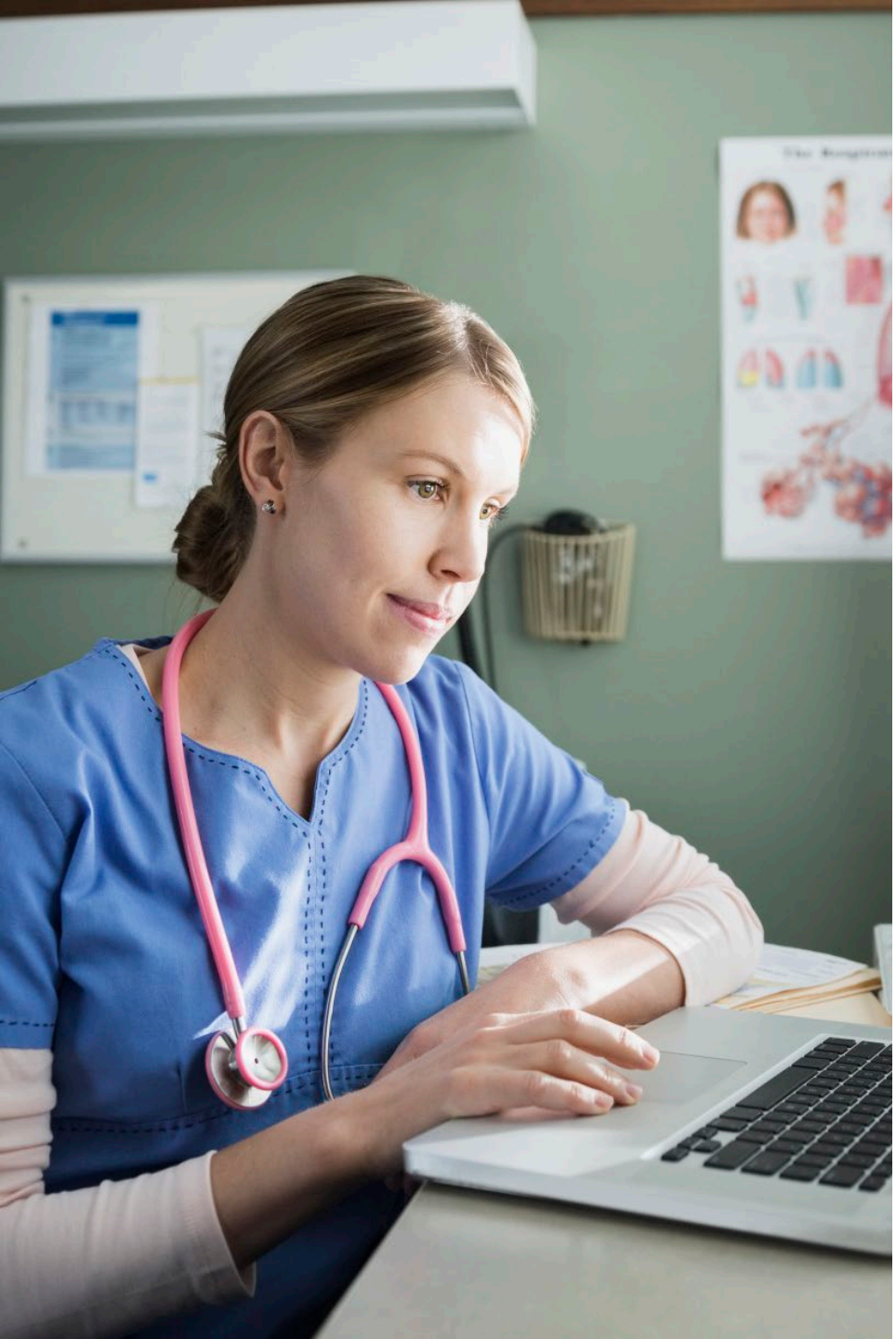

Telemedicine Requirements

- Have Fraud, Waste and Abuse Policies and Procedures specific to telemedicine that address:
  - Authentication and authorization of users;
  - Authentication of the origin of the information;
  - The prevention of unauthorized access to the system or information;
  - System security, including the integrity of information that is collected, program integrity and system integrity; and
  - Maintenance of documentation about system and information usage.
- Have available Audio/Video Equipment (real time 2-way audio/video live communication only).
- Ensure equipment and operations comply with technical safeguards in 45 CFR 164.312.
- Provide training to clinical personnel on Telemedicine Requirements.
- Supervision requirements within a provider's scope of practice continue to apply for services provided through telehealth.

Providers are required to sign an attestation indicating all telemedicine requirements have been met.

The Telemedicine Requirements can be found in the provider manual at https://www.aetnabetterhealth.com/florida/providers/provider-manual

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Billing

Telemedicine Billing

ABHFL will reimburse each service once per day per recipient, as medically necessary, at the rates detailed in the table below or the contracted percentage thereof.

Service	Procedure Code	Modifier Required	Medicaid Reimbursement Rate	
			Maximum Fee*	Maximum Facility Fee**
Store-and-forward	G2010	CR	$7.69	$5.66
Telephone Communications - *Existing* Patients	99441	CR	$9.05	$8.05
	99442	CR	$17.65	$16.10
	99443	CR	$25.80	$23.94
Telephone Communications - *New* Patients	99441 CG	CR	$9.05	$8.05
	99442 CG	CR	$17.65	$16.10
	99443 CG	CR	$25.80	$23.94
Remote patient monitoring	99453	CR	$11.77	N/A
	99454	CR	$39.15	N/A
	99091	CR	$37.12	N/A
	99473	CR	$7.02	N/A
	99474	CR	$9.51	$5.44
	99457	CR	$32.36	$19.80
	99458	CR	$26.48	$19.80

On the AHCA practitioner fee schedule, this represents the fee schedule increase rate, which is the base Florida Medicaid rate with a 4% increase included for all ages. **The facility fee is the reimbursement rate for a practitioner performing services in one of the following places of service: outpatient hospital-off campus (19), inpatient hospital (21), outpatient hospital-on campus (22), emergency room hospital (23), or ambulatory surgical center (24), according to Medicare's designation.

Key Reminders

- Place of Service = always use 02
- Modifiers= Use CR for phone only, Use GT for phone and video.
- Claim Service Location (Box 32- CMS 1500 Form)
  - PCPs that have multiple service locations should list the location that the member is assigned to.

EIS

Early Intervention Services

Aetna Better Health of Florida covers services under the Early Intervention Services (EIS) program for Florida's infants and toddlers from birth to 36 months of age who have EIS services authorized in their Individualized Family Support Plan and rendered through an Early Steps Program-approved provider.

- All services listed in the Florida Medicaid Early Intervention Services (EIS) Coverage Policy

- Child Targeted Case Management Services (TCM) as specified in the Florida Medicaid Child Health Services Targeted Case Management Coverage and Limitations Handbook (T1017TL)

- Therapy services listed in the Florida Medicaid Physical, Occupational, and Speech Language Pathology coverage policies when billed with the TL modifier (beginning April 1, 2020)

The TL Modifier must be billed as the primary modifier in order to ensure that claims are paying with the correct reimbursement fee when billing Early Intervention Services. Therapy services billed without the TL modifier in the first position will not be treated as an EIS-related claim and may result in the claim being denied or paid incorrectly.

Authorization Requirements

Aetna Better Health will not require prior authorization for Early Intervention Services and Targeted Case Management for Early Steps Providers (T1017 TL), or Physical, Occupational, or Speech Therapy services when rendered by a provider on the EIS Provider Master List and billed with the TL modifier.

Early Intervention Services

Telemedicine Guidance for Early Intervention Services and Therapy Services

Aetna Better Health will reimburse for the delivery of early intervention screenings and evaluations (initial and follow-up) via telemedicine when the service is delivered in accordance with federal and state law requirements (e.g., multidisciplinary team requirements can be met through live, two-way audio and video capabilities). The service must be completed in its entirety, as detailed in the EIS coverage policy and fee schedule.

We will also reimburse for evaluation, diagnostic, and treatment recommendations for services included on the respective therapy services fee schedule to the extent services can be delivered in a manner that is consistent with the standard of care and all service components designated in the American Medical Association's Current Procedural Terminology and the Florida Medicaid coverage policy is provided.

To receive reimbursement for telemedicine the EIS and therapy provider must bill modifier GT with POS 02. For more information review the EIS AHCA Bulletin. https://ahca.myflorida.com/Medicaid/pdffiles/provider_alerts/2020_04/Update_Telemedicine_Guidance_EIS_20200427.pdf

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Clinical Payment, Coding, and Policy Changes

Colorectal Cancer Screening Tests – DNA Based

Multitarget stool DNA testing (Cologuard™):
• Should be reported with the appropriate screening diagnosis

• Is limited to once per 3 years

• Is covered for routine purposes only for certain ages/adult members (between 50 years of age and 85 years)

• Should be reported with the correct bill type when billed on an outpatient hospital facility claims.

Deny when billed with any bill type other than 0130-013Z (Hospital outpatient)

0140-014Z (Hospital-laboratory services provided to non-patients)

0850-085Z (Critical access center outpatient Part B)

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Obstetrics and Gynecology Policy-Planned Cesarean Delivery Less than 39 Weeks of Gestation

According to the American College of Obstetricians and Gynecologists, cesarean delivery requested by the mother should not be performed before a gestational age of 39 weeks in the absence of other indications for early delivery since there is a higher risk of respiratory morbidity, including transient tachypnea of the newborn, respiratory distress syndrome, and persistent pulmonary hypertension, for elective cesarean delivery compared with vaginal delivery when delivery is earlier than 39–40 weeks of gestation.

CPT Code	Description
59510, 59514 or 59515	Cesarean delivery when billed and a diagnosis of encounter for cesarean delivery without indication is present on the claim line and a diagnosis indicating a gestational age of less than 39 weeks is also present on the claim line is subject of denial.

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Laboratory/Pathology Policy

Clinical Laboratory Improvement Amendment (CLIA) Waived Tests

- The Clinical Laboratory Improvement Amendment (CLIA) is a program administered by the Secretary of Health and Human Services to assure that laboratories which examine materials derived from the human body for diagnosis, prevention, or treatment purposes, consistently provide accurate results. CLIA waived tests are determined by the Federal Drug Administration (FDA) or Centers for Disease Control and Prevention (CDC) to be so simple that there is little risk of error. Modifier QW (CLIA waived test) can only be appended to procedures designated as CLIA waived tests on the clinical laboratory fee

COVID-19 Testing and Specimen Collection

- Only one type of COVID-19 test (antibody/non-CDC/nucleic acid detection) per day should be performed within the same category of test; multiple like tests on the same date of services are duplicative.
- COVID-19 specimen collection services (nasopharyngeal, oropharyngeal or respiratory samples) should be reported in conjunction with COVID-19 laboratory testing.
- Nucleic-Acid Testing-Positive nucleic-acid based tests for SARS-CoV-2 generally confirm the diagnosis and do not have to be repeated. Negative nucleic-acid tests may be repeated if the suspicion of COVID-19 is high but is not recommended on the same day

CPT Code	Description
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) when billed with 0224U (Antibody; severe acute respiratory syndrome coronavirus 2, includes titer(s), when performed) by any provider.
U0004	(COVID-19 lab test non-CDC high throughput) when billed with U0002 (COVID-19 lab test non-CDC) by any provider.
U0003	(COVID-19 infectious agent detection by nucleic acid, high throughput) when billed with 87635 (COVID-19 Infectious agent detection by nucleic acid) by any provider.
C9803, G2023 or G2024	(Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2)) when billed and a SARS-CoV-2 virus test has not been billed on the same day or the following two days by any provider.

Change Healthcare Web Connect Tool

Web Connect Tool

We are pleased to announce the availability of our new and improved solution for verifying member information and submitting claims to Aetna Better Health.

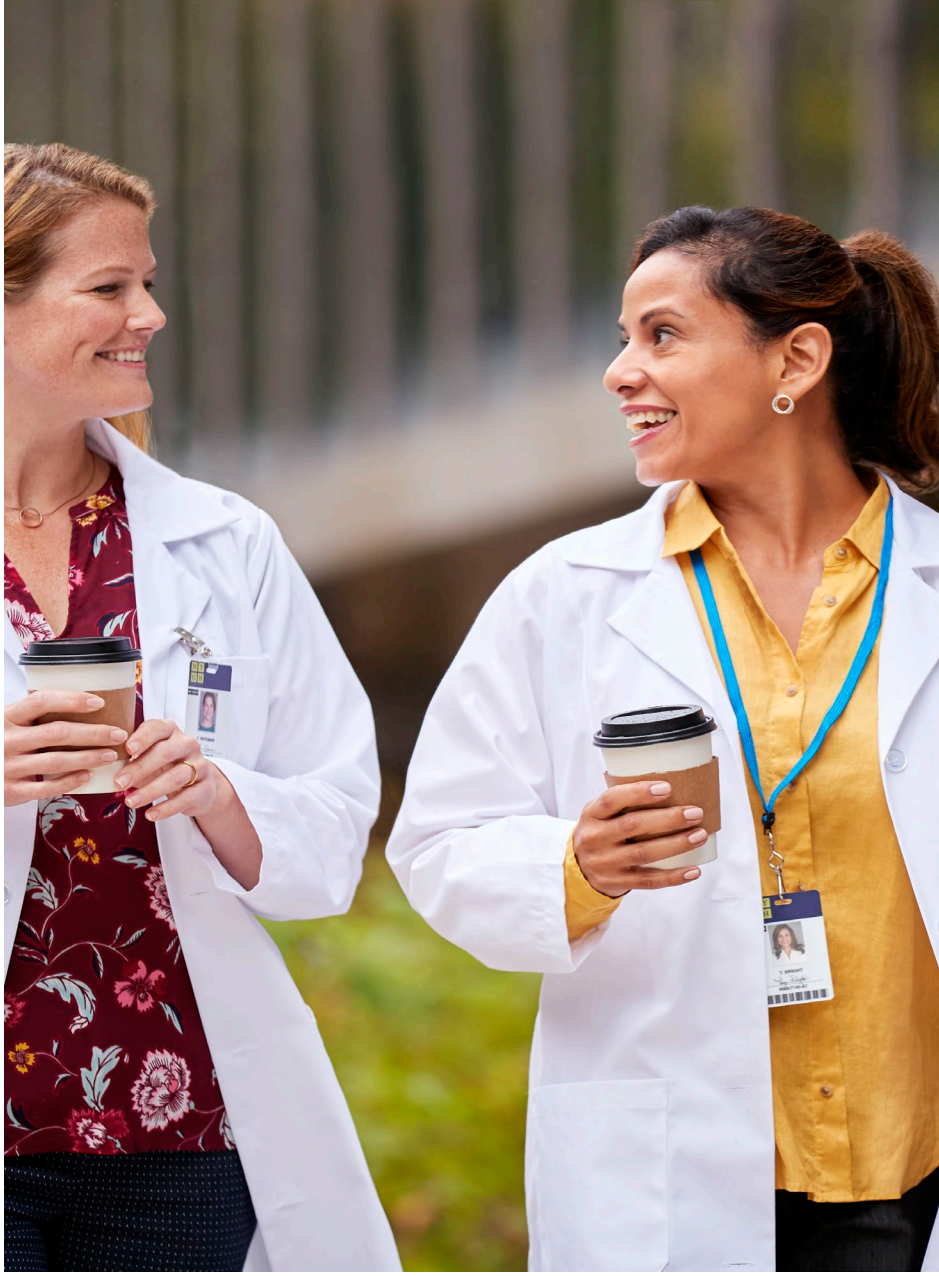
Within the next month, ConnectCenter will replace Emdeon Office, giving you a more reliable, more complete way to submit claims, all at no cost to you. Get started TODAY!

You will be able to use your ConnectCenter and Emdeon Office accounts at the same time until 5/31/2021.

You will be able to setup a new account in just seconds. Once you have received your new credentials, you may immediately begin checking eligibility.

Claim submission will be available to you within one business day of setting up your account. Be sure to bookmark the new login page: https://physician.connectcenter.changehealthcare.com/#/site/home?payer=214558

Link: https://physician.connectcenter.changehealthcare.com/#/register/step1/PQCGR5mGCwgELkrDndrXQaA6NIakfqyNVLp3Qt-1Q-sI6IP6mLTz8Qf_jaeJUM9-



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Availity

Availity Provider Portal- Live 1/19/2021

Current Functionalities

- ✓ Payer Spaces
- ✓ Claim Submission Links (CHC)
- ✓ Contact Us messaging
- ✓ Claim Status Inquiry
- ✓ Appeal & Grievance Submissions
- ✓ Reports (Ambient)
- ✓ Prior Authorization – Submission and Status Lookup

Future Functionality Releases

Q2 2021
- Eligibility and Benefits

Q3 2021
- Remit PDF
- Enhanced Panel Roster
- Enhanced G&A Tool

Our communications will be transitioning from fax blast to via email in the near future. Keeping our providers informed is our priority. If you have not yet reached out to us to ensure we have your most recent email address, we ask that you do so now!

How to submit your most updated email address to us?

It's simple, just follow one of these steps:

1. Complete the following survey monkey: https://www.surveymonkey.com/r/W8QDMS7
2. Send us an Email at: FLMedicaidProviderRelations@Aetna.com
    - Your email subject line should include the title and + NPI #. Example (Email Address Update + 12345678).

Be on the lookout over the next few months for co-branded emails directly from Availity as new products roll out and training plans are developed.

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Timely Filling Guidelines

Timely Filing Requirements

Providers should submit timely, complete, and accurate claims to the Aetna Better Health of Florida. Untimely claims will be denied when they are submitted past the timely filing deadline. Unless otherwise stated in the provider agreement, the following guidelines apply.

Provider / Claim Type	Guideline
Plan Participating Providers	Provider shall mail or electronically transfer (submit) the claim within **180 days** after the date of service or discharge from an inpatient admission. (F.S. 641.3155)
Non-Participating Providers	Provider shall mail or electronically transfer (submit) the claim within **365 days** after the date of service or discharge from an inpatient admission. (SMMC Contract) (Section VIII.D)(E)(2)
Plan as Secondary Payor	When the Managed Care Plan is the secondary payer, the provider must submit the claim within **ninety (90) calendar days** after the final determination of the primary payer. (SMMC Contract) (Section VIII)(E)(1)(h)
Medicare Crossover	When the Managed Care Plan is the secondary payer to Medicare, and the claim is a Medicare cross over claim, these must be submitted within **36 months** of the original submission to Medicare. (SMMC Contract) (Section VIII)(E)(2)(d)(2)
Corrected Claims	Provider shall mail or electronically transfer (submit) the corrected claim within **180 days** from the date of service or discharge from an inpatient admission. (F.S. 641.3155)
Return of requested additional information (itemized bill, ER records, med records, attachments)	A provider must submit any additional information or documentation as specified, within **thirty-five (35) days** after receipt of the notification. Additional information is considered received on the date it is electronically transferred or mailed. Aetna Better Health cannot request duplicate documents. (F.S. 641.3155(2)(c)(2)

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EFT/ERA Registration

EFT and ERA Registration

Aetna Better Health provider portal has moved into the Availity system effective January 2021.

Providers will be taken to our health plan website where the EFT and ERA forms are housed when clicking on the EFT and ERA applications.

Why should Providers Register?

- Save time and money with these electronic tools
- Electronic remittance advice (ERA) provides claims payment explanations in HIPM· compliant files.
- Electronic funds transfer (EFT) puts payment right into your account.
- Explanations of Benefits (EOBs) are on our secure provider website. Patient cost estimator is available on our provider portal on Availity.

We highly encourage providers to register for EFT and ERA. Please call our Provider Services Department at 1-844-528-5815 for assistance or your assigned Network Consultant.

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Questions? We've got answers.

Just call our Provider Services Department at 1-844-528-5815 .

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