Aetna Better Health of Florida

Monthly Provider Training

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July, 28, 2022

Learning Objectives

- Discuss Appeals and Dispute Submissions
- Review Depression Screening
- Discuss Availity
- Review Timely Filing Guidelines

Appeals & Complaints, Grievances and Disputes Submissions

G&A Summary

- **Provider Appeals** = Request to review the denial of or payment on a claim
  - NOTE: When submitting pre-service requests on behalf of a member you must have written consent. These requests are processed as a member appeals and subject to member appeal timeframes and processes.
- **Complaints/Grievances** = Dissatisfaction with anything else not related to a claim

- **Interfiling vs. Bundling**
  - **Interfiled** = submitting multiple unrelated claim denials for appeal in one packet.
  - **Bundling** = a submission of multiple claims with the same denial reason as one appeal. For example, code XXXX denies every time you submit a claim, or all claims for Jane Doe are denied.

- **Claim Resubmissions**
  - Resubmitted claims = claims that are being resubmitted for reprocessing, including but not limited to corrected claims, hard copy claims that were denied due to missing information

Appeals Submissions

As of March 1, 2022, Aetna Better Health will no longer accept Provider mail that is directed to our 261 N. University Dr. Plantation, FL 33324 office.

If you are submitting an interfiled appeal request (multiple unrelated claims) in one mailing you must use physical barriers (elastic, paper clip, binder clip, blank sheet of colored paper etc.) for each claim in the submission.

Appeals, Complaints and Grievances

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

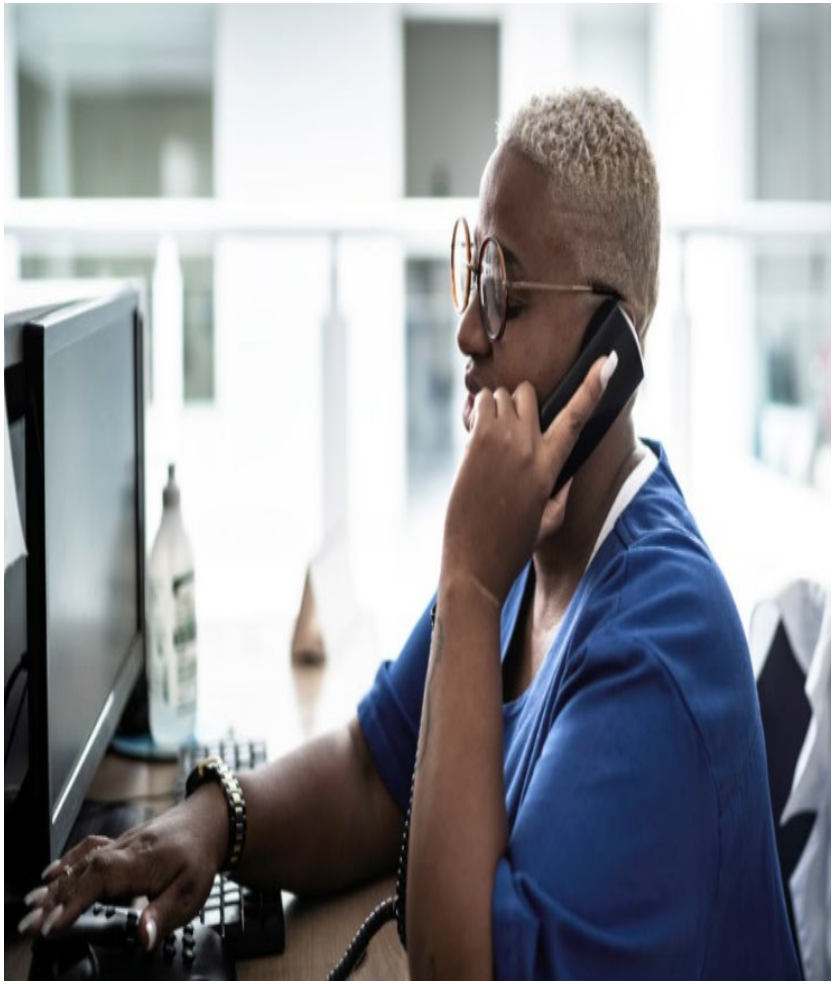
You may submit by fax to: 1-860-607-7894.

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

Medical necessity claim appeals must be submitted within sixty (60) calendar days from the claim denial or the resubmission denial.

Complaints/Grievances may be submitted at any time.



Disputes Submissions

Claim Resubmission for Reconsideration: Effective 2/14/2022

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

Aetna Better Health of Florida
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.

Form:

https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/florida/provider/pdf/abhfl_provider_claim_reconsideration_adjustment_form.pdf

Availity Link:
https://apps.availity.com/availity/web/public.elegant.login

Depression Screening

Depression Screening –FHK

Aetna Better Health of Florida (ABHFL) has adopted nationally accepted evidence-based preventive services guidelines (PSG) from the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention (CDC).

These guidelines are not meant to direct coverage or benefits determinations or treatment decisions.

Screening for depression is recommended in healthy children 12-17 year of age with normal risks.

ABHFL has added two new HCPCS Codes to report Depression Screening in order to comply with the Florida Healthy Kids (FHK) depression screening measurement requirements.

The codes below should be used for billing routine preventative depressive screening for children ages 12-17.

HCPCS Codes	Description	Reimbursement
G8431	Screening for depression is documented as being positive and a follow-up plan documented	$18
G8510	Screening for depression is documented as negative, a follow-up plan is not required	$18

Availity

Availity Provider Portal

Current Functionalities

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

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

https://apps.availity.com/availity/web/public.elegant.login

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Timely Filing 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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Questions? We have answers!

Call our Provider Services Department at 1-844-528-5815.

Thank you all!