AETNA

ABH FLORIDA

TAPE: FL MMA/LTSS NEW PROVIDER ORIENTATION PART 2

Female Narrator: [00:00:01] Welcome to part two of our new provider orientation. In this section, we will cover prior authorizations and referrals. All hospital admissions and observation stays require authorization. When a member is admitted, hospitals are required to call Aetna's Authorization Department within 24 hours of the admission for both scheduled and emergency admissions. A provider may also request a peer-to-peer review with the medical director. This request must be received within two business days of the issuance of a verbal denial. If a concurrent peer-to-peer review request is received after the two business days, the treating physician will be advised to follow the appeal process.

[00:00:47] Providers can submit electronic prior authorizations for medically necessary services by logging into our secure provider portal on Availity. Please remember that emergencies do not require prior authorization. Providers can check the status of a prior authorization request by logging into Availity or calling Utilization Management. Not sure whether your procedure requires prior authorization? No worries. You can always review our ProPat Lookup Tool on our secure provider portal.

[00:01:19] If you are unable to submit your prior authorization request electronically, you can submit your request by telephone or fax. The prior authorization form can be found on our website, in the authorization section under the For Providers tab. If you are attaching clinical records or scripts, please fax your request using the list shown here.

[00:01:43] All services for the LTSS program require review and approval by the case manager. Please take note of the additional requirements shown here.

[00:01:56] PCPs are responsible for coordinating specialty services. A PCP referral is not required for the following direct access services. Chiropractic, dermatology, routine podiatric care, optometry, behavioral health, and OBGYN. A PCP referral is required for all

other specialty services. Referrals can be submitted electronically via our secure provider portal.

[00:02:27] In this section, we'll review important claims-related information. Change Healthcare is our contracted vendor for EFT and ERA transactions. EFT and ERA enrollment forms can be found on our website in the Claims Information section under the Resource Tab. Please follow the submission instructions on the forms and allow ten to fifteen business days for processing.

[00:02:55] Please refer to the claims and encounter submission protocols and standard section of the provider manual for information on filing clean claims and to ensure prompt payment. We also encourage you to review the claims information section under the Resource Tab of our website. For more assistance, simply reach out to our Claims Inquiry, Claims Research Team.

[00:03:21] Resubmitted claims may be sent electronically or by mail. When filing a resubmission, please write resubmission at the top of the claim, and submit all claim lines, not just the line being corrected. When submitted a corrected or voided paper claim, please be sure to use the correct format as shown here.

[00:03:44] Balance billing is prohibited in the State of Florida. Providers are required to accept payment from Aetna for covered services provided to our members in accordance with the reimbursement terms outlined in the provider agreement. For more information on balance billing, please refer to the applicable Florida Statutes.

[00:04:05] Providers are required to return identified overpayments to the plan within 60 calendar days after the overpayment is identified. Payment must be returned to the address provided along with written notice explaining the reason for returning the payment. If the plan identifies that a claim is overpaid, the provider will receive a letter requesting a refund of the funds. Providers can access and view their overpayment recovery detail under the Tasks section of our secure provider portal.

[00:04:34] If a provider does not agree with a denial for lack of medical necessity, the provider can request a reconsideration of the decision by providing additional information by phone, fax, or mail or by requesting a peer-to-peer review with the medical director who made the decision.

[00:04:52] Also, reconsideration of prior authorization decisions must be received within five business days of the date the denial of

coverage determination was issued, received prior to services being rendered, and received prior to the receipt of a claim or request for an appeal.

[00:05:10] This concludes part two of your new provider orientation. Please proceed to part three, quality management and compliance, and cultural competence in mandated reporting.

[00:05:21] [End of tape]