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Aetna Webinar FAQ

Q: When can we expect to see claim statuses in Availity?
A: Claim status will show in Availity once the claim is finalized.

Q: **Do we need to use Availity for claim submissions?**
A: Availity is Aetna's provider portal, which provides functionality for the management of patients, claims, authorizations and referrals. To submit claims via Availity, go to the button labeled "Medicaid Claim Submission – Office Ally." Here, you can submit claims through your Office Ally account or through your own clearinghouse, so long as it has a reciprocal relationship with Office Ally. To avoid incurring fees in setting up an Office Ally account, please use the Aetna link.

Q: With a clean claim, how long will the payout take?
A: Ninety percent (90%) of all clean claims must be paid within fourteen (14) days of the date of receipt. We do check runs on Monday, Wednesday and Friday and generally payout within a week.

Q: Will there be copays or out-of-pocket cost for patients?
A: As a value-added benefit, outpatient services for members will have no copayment.

Q: Are patients assigned to a PCP and do they have to see that PCP like they did with SoonerCare Choice?
A: No, members are not required to see their PCP for care.

Q: Is Propat the tool used to see if a procedure requires PA? Where do we find Propat?
A: On the provider portal, Availity, there is a link to Propat where you can search a code and the system will let you know if an authorization is needed or not.

Q: How do I find out who my provider representative is?
A: Please reach out to ABHOKProviderEnagement@AETNA.com.

Q: Will services that didn't require PAs prior to the change require PAs now?
A: No, we do not require PAs on services that did not require PAs with OHCA.

Q: **Can you confirm the dates that PAs will be waived?**
A: ABHOK will be waiving all PAs from April 1-30, 2024.

Q: **When are PAs that were previously approved by OHCA going to expire?**
A: ABHOK will be honoring previously approved PAs for 120 days from April 1, 2024, however, we may request additional documentation.

Q: What is the typical turnaround for PAs?
A: Aetna will decide standard PA requests within seventy-two (72) hours of receipt of the request or as expeditiously as the enrollee's health requires

Q: When a concurrent PA is submitted, how long will it take to get approval or denial?
A: Aetna will decide standard PA requests within seventy-two (72) hours of receipt of the request or as expeditiously as the enrollee's health requires. If the provider indicates, or Aetna is aware, that adhering to the standard seventy-two (72) hour timeframe could jeopardize the enrollee's life, health or ability to attain, maintain or regain maximum function, Aetna will make an authorization decision as expeditiously as necessary and, no later than twenty-four (24) hours after receipt of the request for service. All inpatient behavioral health PA requests will be decided within twenty-four (24) hours.

Q: **Is it correct that behavioral health rehabilitation in an outpatient setting (H2017) does not require a PA?**
A: Correct, no authorization is required.

Q: Do health centers need to submit T1015 codes? Are plans changing billing procedures?
A: Our codes have been mapped to pay codes how OHCA pays claims. Please continue to code claims as you have done in the past for Medicaid.

Q: How do we go about correcting a denial of a claim? Who do we ask?
A: If the result is a denial, the provider has a couple options. One is to request reconsideration. A second option is to resubmit with any issues corrected, i.e., adding missing provider info such as rendering taxonomy.

Q: Do we or do we not need a PA for case management and psychosocial rehab?
A: Aetna Better Health is waiving PA from April 1-30, 2024. In general, outpatient services or services provided at a CCBHC do not require a prior authorization. Services that do require authorization include inpatient, residential, PHP, day treatment, ECT and ABA. Psych testing does not require a PA. We do not require a PA for urgent recovery services, MAT or PACT services.

Q: There is a good deal of confusion regarding PAs for outpatient behavioral health. Do we or do we not need a PA for case management and psychosocial rehab?
A: Aetna Better Health is waiving PAs from April 1-30, 2024. In general, outpatient services or services provided at a CCBHC do not require a prior authorization. Services that do require authorization include inpatient, residential, PHP, day treatment, ECT and ABA. Psych testing does not require a PA. We do not require a PA for urgent recovery services, MAT or PACT services.

Q: Re pediatric ST/OT, the other MCOs are honoring our previous approved authorizations until they expire. Will Aetna also be doing this or only allowing be 120 days?
A: We will allow 120 days of the amount that has been approved starting from April 1, 2024. At the close of 120 days, if more services are needed, you will need to provide additional clinicals.

Q: **Your auth department is approving ST based on 4 units = 1 visit, but speech is billed 1 unit = 1 visit. I just want to make sure auths are not being entered as the letter is stating 100 units/25 visits approved for ST.**
A: One visit equals 60 minutes for PT/OT. For ST, one visit is 15 minutes. Please keep in mind that everything is based on codes.

Q: We need a portal that shows us these modified authorizations. We can't assume ALL rollover authorizations will have the same end date. Claims are tied to these auths and will most certainly result in denied claims.
A: Please know that we have received all PAs from OHCA that were approved prior to April 1, 2024. Once the service is complete, and you file the claim, it will be paid. You will not be able to see them in the system, but if you find a discrepancy, please reach out to us.

Q: Your PA form online currently does not include a location for the modifier. Is that going to be fixed? And 97530 CPT code can be used for both OT and PT.
A: On the PA claim form, select the appropriate form, then you will add the procedure codes and the service type in the next box.

Q: If there is an active PA, what happens if a member wants to change provider?
A: PAs follow members. You should not have to do anything on your end if the member changes providers.

Q: Can we submit multiple units per day?
A: Use Propat for clarification. If you still need additional clarification, please reach out to our provider engagement team.

Q: Humana has said they are giving us 90 days to get credentialed and to continue to see the clients that have approved PAs. Is this true with Aetna?
A: As part of continuity of care, Aetna Better Health is waiving PAs for the first 30 days. After that, non-contracted providers can continue to see members during the first 90 days.

Q: For adults over 21, do they need pre-auth for PT, OT or ST or do they get an automatic 15 visits per year without prior auth?
A: Yes, therapy services will require a PA.

Q: Regarding the benefit for spinal-related outpatient PT for members older than 21, will you please clarify the outpatient PT visit cap for outpatient PT for patients over 21 needing spinal related treatment? If there is not a cap, what is the benefit?
A: Typically, chiro services are not covered for members over 21, but spinal manipulations to treat chronic lower back pain are covered as the exception. The limitation is 12 services/visits per year.