


PROVIDER BULLETIN

 AETNA BETTER HEALTH® OF FLORIDA 261 N. University Drive Plantation, FL 33324 www.AetnaBetterHealth.com/Florida	Date:	February 04, 2020
	Purpose:	Provider Bulletin: Changes to Prior Authorization for Diabetic Supplies
	Subject:	Prior Authorization (PA) Requirement for HCPCS Codes A9276, A9275 and A9274
	Products:	Medicaid / Florida Healthy Kids/ Comprehensive Lines of Business
	From:	<u>Provider Relations</u>

Dear Providers,

Effective **April 1st, 2020**, Aetna Better Health of Florida will implement changes on the way that affect three (3) **HCPCS Codes for Diabetic supplies: A9276, A9275 and A9274.**

These codes will require Prior Authorization before supplies are distributed. **Please submit your request to our Prior Authorization department via fax: 860-607-8056.**

Please be aware that any codes that are not on the Medicaid Fee Schedules require Prior Authorization. Please refer to the Medicaid Fee Schedules at the link below.

https://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

We appreciate the excellent care you provide to our members. If you have any questions please feel free to contact us via e-mail: FLMedicaidProviderRelations@Aetna.com. You can also fax us at 1-844-235-1340 or call us through our Provider Relations telephone line: 1-844-528-5815.

Thanks for all you do!

Provider Relations Department

CONFIDENTIALITY NOTICE: This message is intended only for the user of the individual or entity to which it is addressed and may contain confidential and proprietary information. If you are not the intended recipient of the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited. If you received this communication in error, please notify the sender at the phone number above.

NOTICE TO RECIPIENT(S) OF INFORMATION: Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without express written consent of the person to whom it pertains of as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

www.aetnabetterhealth.com/florida

FL-20-02-01

Prior Authorization Form

MMA/FHK/Comprehensive/LTC

Prior Auth MMA/FHK Fax: 1-860-607-8056; Obstetrical (OB) Fax: 1-860-607-8726 Prior Auth Telephone: 1-800-441-5501
 Comprehensive/Long Term Care Requests Fax: 1-844-404-5455 Comprehensive/Long Term Care Telephone: 1-844-645-7371

A determination will be communicated to the requesting provider

- Visit ProPat Search Tool to research whether a service requires prior authorization: <http://www.aetnamedicaidportal.com/propat/Default.aspx>
- 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/FHK/Comprehensive members must be called in to the MMA/FHK Prior Authorization Department: Phone number 1-800-441-5501**

TYPE OF REQUEST

- *URGENT/EXPEDITED** (to be used when non-urgent/standard prior authorization could seriously jeopardize the life or health of a member, the member's ability to attain, maintain, or regain maximum function, or a delay in treatment would subject the member to severe pain that could not be adequately managed without the service requested—response within 2 calendar days for Medicaid and Comprehensive/LTC members; 3 calendar days for Florida Healthy Kids)
- *NON-URGENT/STANDARD** (for routine services – response within 7 calendar days for Medicaid and Comprehensive/LTC members; 14 calendar days for Florida Healthy Kids)
- OUTPATIENT**
- HOME HEALTH CARE**
- DME/Supplies**

PATIENT INFORMATION

Asterisk (*) indicates REQUIRED fields. Incomplete requests will delay the authorization process.

Please include pertinent clinical notes to expedite this request.

* Membership Type: MMA FHK Comprehensive LTC

*Patient Name: Last		First	MI	*Member ID/Medicaid ID:	*Date of Birth: / /
*PCP Name:	*Phone: ()	*Fax: ()	*PCP Contact Name:		

REQUESTING PROVIDER INFORMATION

*Requesting Provider Name:	*Requesting NPI:	*Requesting TIN:
*Requesting Contact Name:	*Phone: ()	*Fax: ()

SERVICING PROVIDER INFORMATION

Servicing Provider same as Requesting Provider (Please select if the Provider's information above is the same)

*Servicing Provider Name:	*FL Medicaid Provider#:	*Servicing NPI:	*Servicing TIN:
*Servicing Provider Contact Name:		*Phone: ()	*Fax: ()
*Servicing Facility Name:	*FL Medicaid Provider#:	*Facility NPI:	*Facility TIN:
*Servicing Facility Contact Name:		*Phone: ()	*Fax: ()

AUTHORIZATION REQUEST

*Start Date:	*End Date:	*Total Units/Visits (Total units should be based on CPT/HCPCS description of units):
*Have services already been rendered? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Procedure Codes:	*ICD- 10 Codes:	
Comments:		

CLINICAL INDICATIONS/RATIONALE FOR REQUEST: *DME, Home Health, Therapies and Infusions must have Rx attached.

To expedite a determination on your request for services, please attach clinical documentation/medical records to support your request. Please include the following: Conservative treatment tried and failed, applicable diagnostic testing with results and lab values and a medication list.

ATTESTATION: I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

*Provider Signature: _____

*Date: _____