# PROVIDER BULLETIN

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| **AETNA BETTER HEALTH® OF FLORIDA**<br><br>261 N. University Drive<br>Plantation, FL 33324<br>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:** | **Provider Relations** |

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**

**Aetna Better Health® of Florida**
261 N University Drive
Plantation, FL 33324

# 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? ☐ Yes ☐ 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:** _____