


# PROVIDER BULLETIN

 <b>AETNA BETTER HEALTH® OF FLORIDA</b> 261 N. University Drive Plantation, FL 33324 <a href="http://www.AetnaBetterHealth.com/Florida">www.AetnaBetterHealth.com/Florida</a>	<b>Date:</b>	January 31, 2020
	<b>Purpose:</b>	<b>Provider Bulletin: Prior Authorizations for Custodial and Skilled SNF Provider</b>
	<b>Subject:</b>	Prior Authorization Process Reminder
	<b>Products:</b>	Medicaid and Comprehensive (LTC) Lines of Business (Region 6, 7 & 11)
	<b>From:</b>	<u>Provider Relations</u>

Dear Provider,

This communication is to inform you that Aetna Better Health of Florida Medicaid has separate processes when requesting a Prior Authorization for Custodial Care at a Skilled Nursing Facility (SNF) and for Skilled Nursing Facility services for Acute Rehabilitation.

Please review the attached notice that contains information about our authorization process.

We appreciate your continued service to our members. Please feel free to contact us via e-mail [FLMedicaidProviderRelations@aetna.com](mailto:FLMedicaidProviderRelations@aetna.com), fax 1-844-235-1340 or speak to a Provider Relations Representative: (MMA) 1-800-441-5501, (LTC) 1-844-645-7371, or (FHK) 1-844-528-5815.

Sincerely,

Provider Relations

**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

## Prior Authorization

### Custodial Care Authorizations

*This is applicable to members who are not receiving skilled services and are waiting for LTC benefits*

- Aetna Better Health of Florida Medicaid requires that you **complete the attached Prior Authorization form and fax along with the PASRR, DCF 2506a, ACHA 3008, and Cares Assessment forms to: 1-860-607-8056**
- Authorization requests may be approved for 1 month at a time, up to 120 days, provided that the requested documentation is submitted and the nursing facility is actively working with the member and state to obtain LTC
- All authorization requests must be for continuous dates unless there is a reasonable explanation for a gap, such as the member being hospitalized
- The date of admission and prior coverage payer information are required
- Retrospective requests must be submitted to the Health Plan within 90 days of initial service date (start date); if you do not submit your request within 90 days, you will need to submit with the claim and complete clinical records
- Aetna Better Health will respond with a determination as quickly as possible, however the turnaround time for a Standard Determination is 7 calendar days and for Retrospective Requests, 30 calendar days

### Skilled SNF/Rehabilitation Authorizations

- All requests for a SNF for rehabilitation (skilled) **admissions must be called into Aetna at 1-800-441-5501**. Choose the Provider option to be routed to Prior Authorization
- ***Aetna Better Health requires an initial telephone notification so that we can expedite your request***
- **Members should not be transferred to a skilled facility for rehabilitation without prior authorization from the health plan**
- Upon call in, you will be asked to fax clinical documentation and the PASSR to Concurrent Review for an expedited review, **1-844-878-3583**
- Aetna will make every effort to return a determination within 24 hours of your request for authorization

# 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**

- |  |  |
|--|--|
| <input type="checkbox"/> <b>*URGENT/EXPEDITED</b> (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) | <input type="checkbox"/> <b>OUTPATIENT</b>       |
| <input type="checkbox"/> <b>*NON-URGENT/STANDARD</b> (for routine services – response within 7 calendar days for Medicaid and Comprehensive/LTC members; 14 calendar days for Florida Healthy Kids)  | <input type="checkbox"/> <b>HOME HEALTH CARE</b> |
|  | <input type="checkbox"/> <b>DME/Supplies</b>     |

**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: \_\_\_\_\_