Provider Newsletter

Summer 2025

Contents

aetna®

Aetna Better Health® of Florida

AetnaBetterHealth.com/Florida

FL-25-07-16

Member rights & responsibilities

In accordance with 42 CFR 438.100, Aetna Better Health of Florida is committed to treating members with respect and dignity at all times. Member rights and responsibilities are shared with staff, providers, and members each year. Members can request a copy of it from their doctor or from Member Services.

MEMBER RIGHTS

As a recipient of Medicaid and a member in a Plan, members have certain rights.

Members have the right to:

- Be treated with courtesy and respect.
- Always have your dignity and privacy considered and respected.
- Receive a quick and useful response to your questions and requests.
- Know who is providing medical services and who is responsible for your care.
- Know what member services are available, including whether an interpreter is available if you do not speak English.
- Know what rules and laws apply to your conduct.
- A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- Be given easy to follow information about your diagnosis, and openly discuss the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you.
- Participate in making choices with your provider about your health care, including the right to say no to any treatment, except as otherwise provided by law.
- Be given full information about other ways to help pay for your health care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Know if the provider or facility accepts the Medicare assignment rate.
- To be told prior to getting a service how much it may cost you.
- Get a copy of a bill and have the charges explained to you.
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any health emergency that will get worse if you do not get treatment.
- Know if medical treatment is for experimental research and to say yes or no to participating in such research.

- Make a complaint when your rights are not respected.
- Ask for another doctor when you do not agree with your doctor (second medical opinion).
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed.
- Have your medical records kept private and shared only when required by law or with your approval.
- Decide how you want medical decisions made if you can't make them yourself (advanced directive).
- To file a grievance about any matter other than a Plan's decision about your services.
- To appeal a Plan's decision about your services.
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan.
- Speak freely about your health care and concerns without any bad results.
- Freely exercise your rights without the Plan or its network providers treating you badly.
- Get care without fear of any form of restraint or seclusion being used as a means of coercion, discipline, convenience or retaliation.
- Receive information on beneficiary and plan information.
- Obtain available and accessible services covered under the Plan (includes In Lieu of Services (ILOS)). A right to make recommendations regarding the organization's member rights and responsibilities policy.

LTC Members have the right to:

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Receive services in a home-like environment regardless of where you live.
- Receive information about being involved in your community, setting personal goals and how you can participate in that process.
- Be told where, when and how to get the services you need.
- To be able to take part in decisions about your health care.
- To talk openly about the treatment options for your conditions, regardless of cost or benefit.
- To choose the programs you participate in and the providers that give you care.

MEMBER RESPONSIBILITIES

Aetna Better Health of Florida members, their families, or guardians are responsible for:

- Give accurate information about your health to your Plan and providers.
- Tell your provider about unexpected changes in your health condition.
- Talk to your provider to make sure you understand a course of action and what is expected of you.
- Listen to your provider, ask questions and follow instructions for care you have agreed to with your practitioner.
- Keep your appointments and notify your provider if you will not be able to keep an appointment.
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions.
- Make sure payment is made for non-covered services you receive.
- Follow health care facility conduct rules and regulations.
- Treat health care staff and case manager with respect.
- Tell us if you have problems with any health care staff.
- Use the emergency room only for real emergencies.
- Notify your case manager if you have a change in information (address, phone number, etc.).
- Have a plan for emergencies and access this plan if necessary for your safety.
- Report fraud, abuse and overpayment.

LTC Members have the right to:

- Tell your case manager if you want to disenroll from the Long-Term Care program.
- Agree to and participate in the annual face-to-face assessment, quarterly face-to-face visits and monthly telephone contact with your case manager.

Utilization management (UM) criteria, availability, decisions

Our utilization management policy
Our utilization management program helps our members get medically necessary health care services in the most cost- effective setting under their benefit package. We work with members and physicians to evaluate services for medical appropriateness, timeliness, and cost.

- Our decisions are based entirely on appropriateness or care and service and the existence of coverage, using nationally recognized guidelines and resources.
- We do not pay or reward practitioners, employees, or other individuals for denying coverage of care.
- Financial incentives do not encourage our staff to make denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.
- We do not encourage utilization decisions that result in under-utilization.

Medically necessary or medical necessity

"Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity.

In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided (FS 409.9131 (2) (b)).

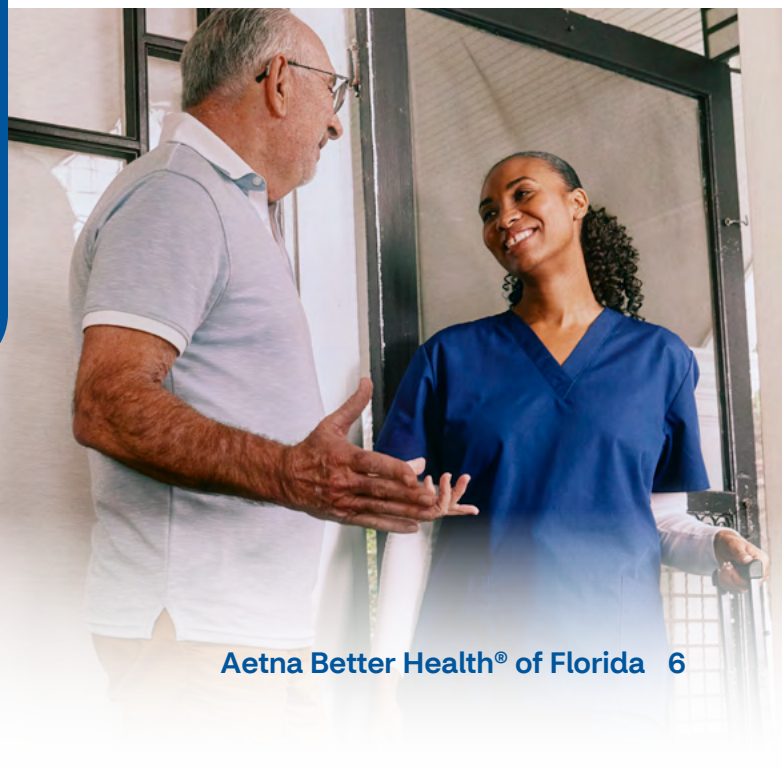
Providers may obtain service-specific coverage requirements and medical necessity criteria on the Listing of Medicaid Covered Services table or by calling Provider Engagement at **1-800-441-5501**.

The policy on payment for services

The policy on payment for services helps ensure that the UM decision-making process is based on consistent application of appropriate criteria and policies rather than financial incentives.

- UM decisions are based only on appropriateness of care and service and the existence of coverage
- We do not reward practitioners, providers or other individuals conducting utilization review for issuing denials of coverage or service care.
- The compensation that we pay to practitioners, providers and staff assisting in utilization related decisions does not encourage decisions that result in underutilization or barriers to care or service.

The UM staff is available to discuss specific cases or UM questions by phone by calling **1-800-441-5501** (Medicaid), **1-844-645-7371** (Comprehensive Long-term Care) or **1-844-528-5815** (Florida Healthy Kids); **(TTY: 711)**, from 8 AM to 7 PM ET. UM staff is available twenty-four hours a day, seven days a week (24/7).



Referrals

The primary care provider (PCP) is responsible for coordinating the provision of specialist services. The specialist and PCP work together to coordinate medical care for the member.

Why are referrals important?

- Support coordination of care between PCP and specialist
- Promote the right care at the right time
- Ensure enrollees receive preventive, primary care services, not just specialty care

No PCP referral is required for the following direct-access services: chiropractic, dermatology (five visits/year), routine podiatric care, optometry, behavioral health, and OB/GYN. PCP referrals are required for all other specialist services.

Referrals can be done electronically via availity secure portal at:
https://apps.availity.com/web/onboarding/availity-fr-ui/#/login

If a paper version is preferred, it can be downloaded and printed from our website under Authorizations at: **Referral form (PDF)**

Specialists will coordinate the provision of specialist services with the PCP in a prompt and efficient manner and furnish a written report within 10 business days of the specialist services. Specialists will refer the member back to the PCP if they determine the member needs the services of another specialist.

Clinical Practice Guidelines

The Plan's employees make clinical decisions regarding members' health based on the most appropriate care and service available. The Plan makes these decisions based on appropriate clinical criteria. The criteria used in the decision-making process will be provided upon request by contacting the Member Services Representative number listed on the back of the member's ID card. Criteria may be viewed on **www.aetnaBetterHealth.com/Florida** or a hard copy may be requested.

Aetna Better Health adopts evidence based clinical practice guidelines (CPG) from national recognized sources. These guidelines have been adopted to promote consistent application of evidence-based treatment methodologies and made available to practitioners to facilitate improvement of health care and reduce unnecessary variations in care.

Aetna Better Health reviews the CPGs every two years or more frequently if national guidelines change within the two- year period. CPGs that have been formally adopted can be found on the Aetna Better Health website **www.aetnaBetterHealth.com/Florida**.

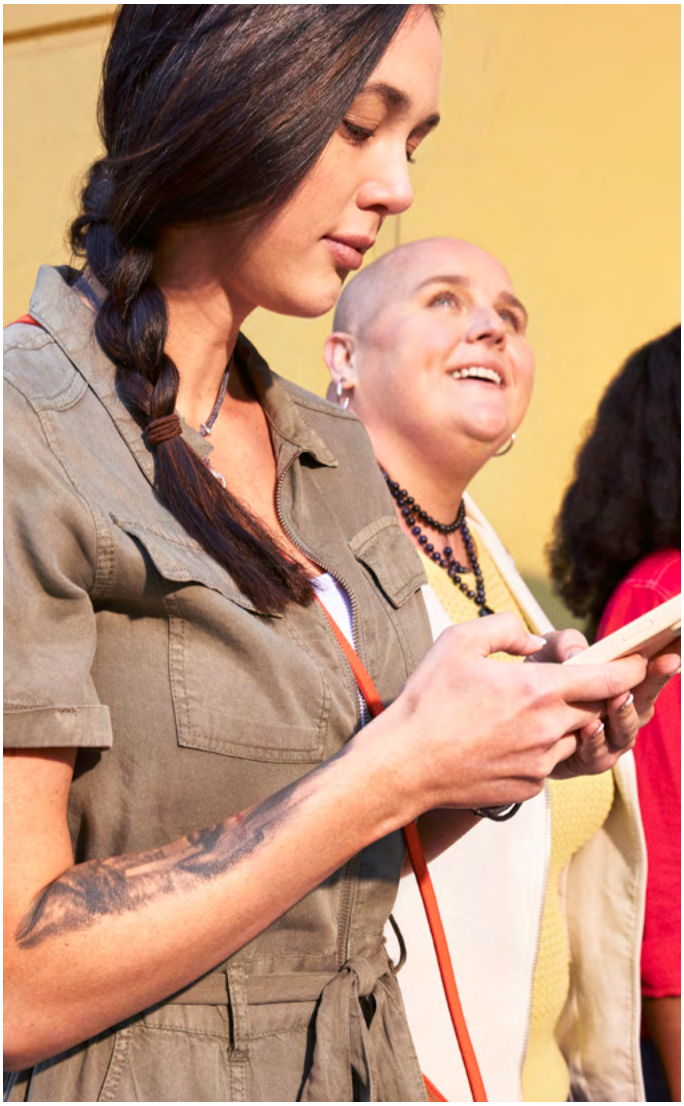
The CPGs are provided for informational purposes only and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider's clinical judgment regarding the appropriate treatment of a patient in any given case.

Pharmacy restrictions and preferences, how to access our Preferred Drug List (PDL) and Formularies

You can access our Preferred Drug List and Formularies at www.aetnabetterhealth.com/florida/drug-formulary.html

Medicaid plans use the Florida Medicaid PDL. You can check the PDL to see if we cover your medication. You can also check a list of recent updates to the PDL on their site.

FHK has a searchable PDL you can check for your or your child's medication. You can also check the updates section on this page. It lists the recent changes to the FHK PDL.



Please note, the formulary can change at any time, due to the ever-changing world of medicine.

If you have any questions regarding the formulary, contact us at the toll-free numbers below or visit our website.

- Medicaid / LTC Provider Relations: **1-800-441-5501 (TTY:711**
- Florida Healthy Kids Provider Engagement: **1-844-528-5815 (TTY:711)**

Utilization Management Processes Methodology and Tools

UM Medical Necessity Criteria

To support prior authorization decisions, Aetna Better Health of Florida uses nationally recognized, and community developed, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Prior authorization staff that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to Aetna Better Health of Florida policies and procedures.

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health of Florida uses the following medical review criteria. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health of Florida's population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria.

The National Quality Advisory Committee reviews clinical criteria used to make medically appropriate and benefit coverage determinations and provides feedback to the National Quality Oversight Committee. The following evidenced-based clinical criteria are utilized to evaluate the necessity of physical and behavioral health care and were evaluated during 2024:

- Criteria required by applicable state or federal regulatory agency
- MCG guidelines
- Aetna Medicaid Pharmacy Guidelines
- Level of Care Utilization System (LOCUS) – behavioral health services for adults
- Children and Adolescent Service Intensity Instrument (CASII) behavioral health services for children and adolescents
- American Society of Addiction Medicine (ASAM) – substance use services
- Aetna Clinical Policy Bulletins (CPB's)
- Aetna Clinical Policy Council Review

Guidelines are revised as necessary to ensure consistency with the health plan clinical practice guidelines, policy, new medical technology, and current standards of practice in the community.

If the MCGs state "current role remains uncertain" for the requested service, the next criteria in the hierarchy, Aetna Better Health of Florida CPBs, should be consulted and utilized. Medical, dental, and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

Progeny Health

Supporting Your Maternity Patients Between Office Visits

Aetna Better Health of Florida® has teamed up with ProgenyHealth®, a leading expert in Maternity & NICU Care Management, to provide continuous support for your maternity patients between routine prenatal and postpartum appointments. Our collaborative program ensures ongoing monitoring, early risk identification, complex case management, and care coordination from notification of pregnancy through 12 months postpartum.

How Our Case Management Program Benefits Your Pregnant Patients:

- **Ongoing Monitoring:** We screen members early and often to identify any changes throughout their pregnancy and the postpartum period that might indicate rising risk due to clinical factors, mental health issues, or social determinants of health. Our Nurse Case Managers and Social Workers provide personalized support to women with high and medium risk factors.
- **Care Navigation:** ProgenyHealth's specialized team supports your patients by navigating health plan benefits, connecting them with providers or specialists, and providing a mobile app for care right at their fingertips.
    - » **Health Plan Benefits:** Assistance in navigating programs for pregnant individuals that are already covered under their health insurance plan, such as access to mental health resources, coverage for durable medical equipment, or helping to find in network providers and specialists.
    - » **Mobile App:** Provides curated articles on pregnancy and postpartum, parenting tips, and a checklist of important to-do list items for each trimester.
    - » **NICU Case Management:** In the event of a NICU admission after birth, ProgenyHealth provides specialized NICU case management focused on care for both the baby and family.
- Solving for Social Issues: ProgenyHealth connects patients to trusted community-based programs that focus on maternal and infant health. We assist patients experiencing food and housing insecurity, support health literacy by offering prenatal and postpartum education, and help with any roadblocks families face with access to care.

ProgenyHealth serves a diverse array of women, infants, families, and physician teams to drive positive outcomes related to maternal and infant health before, during and after pregnancy.

Recent Success Story: Mandy, 32 years old

Issue: Mandy, pregnant with her first baby and recently diagnosed with HIV, was homeless and engaging in risky behavior to make ends meet. She was also missing her OB visits due to transportation issues and financial strain.

Intervention: A ProgenyHealth Case Manager made numerous calls to local emergency shelters to find one where Marta would not be denied entry based on her lack of identification documentation. The Case Manager also confirmed that the shelters were medically equipped to help support Marta's newborn baby.

Outcome: Marta confirmed with the ProgenyHealth Case Manager that she was able to seek emergency shelter to keep her baby and herself safe and was able to return home after the storm.

Referring Your Patients is Simple:

- **Review the Program:** Learn more about the ProgenyHealth Maternity Program.
  Encourage Patient Engagement: Hand out our flyer to your patients and encourage them to download the app.
- **Submit the Florida Medicaid Pregnancy Notification Form:** send a completed Florida Medicaid Pregnancy Notification Form via sFax to **1-860-607-8726**.
- Give us a call at **1-855-231-4730** or send an email to **maternity@progenyhealth.com**. Together, we can provide exceptional care and support for expectant mothers throughout their pregnancy and postpartum journey.

Availity Provider Portal

The Availity Provider Portal (Availity Essentials) is our preferred and trusted source for payer information. It gives you the info, tools and resources you need to support the day-to-day needs of your patients and office. The Provider Portal helps you spend less time on administration so you can focus more on patient care.

You get a one-stop portal to quickly perform key functions you do every day. Availity also allows providers to directly communicate with Aetna's clinical and administrative staff through the Contact Us application.

To access the Provider Portal visit:
https://www.aetnabetterhealth.com/florida/providers/portal.html

Providers support capabilities offered through Availity include the ability for providers to:

- Claim Submissions
- Claim Status Inquiries
- Payer Space
- Contact Us Messaging
- Appeals & Grievance
- Appeals & Grievance Status
- Panel Rosters
- Specialty Pharmacy Prior Authorization
- Prior Authorization Submission
- Prior Authorization Status
- Eligibility and Benefits • Reports & PDM

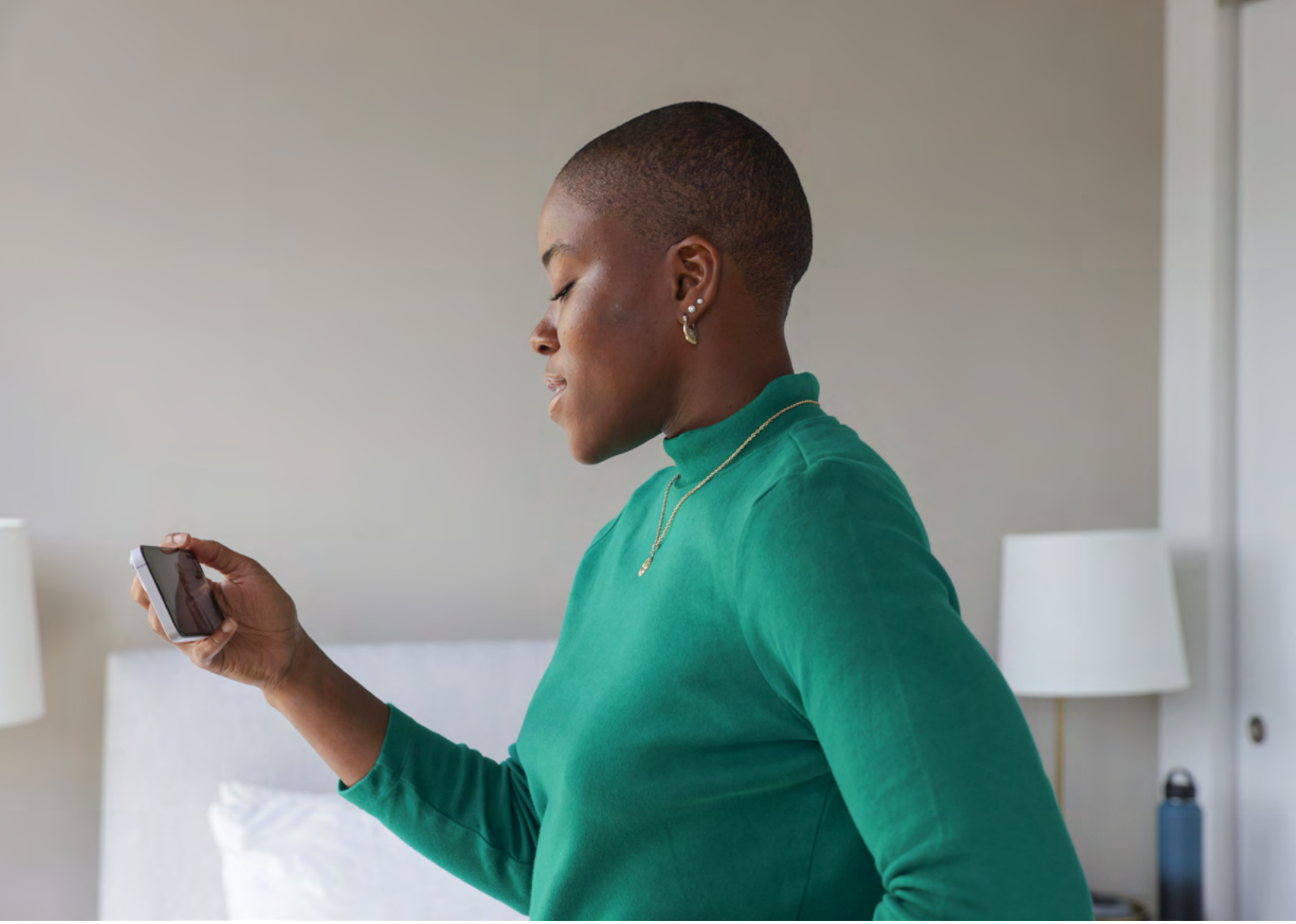
Still not registered? If your organization isn't registered with Availity, we strongly recommend that you get started today by:

1. Visit the portal registration page:

- https://availity.com/Essentials-Portal-Registration

2. Call Availity for assistance at:

- **1-800-282-4548**



Explore the training site to register for a live webinar session, review recording, and access additional resources. Availity Essentials – Live Webinars

Help is available!
Any issues related to Availity contact them directly via the Contact-Us button on the website or by calling one of the phone numbers below depending on your question/inquiry/issue.

Availity Essentials, Essentials Plus, or EDI Clearinghouse Customers:

If you have an Availity Essentials, Essentials Plus, or EDI Clearinghouse account and cannot log in to submit a ticket, call 1-800-282-4548 for support.

Availity Essentials PRO (RCM) Customers:

If you have an Availity Essentials Pro account and cannot log in to submit a ticket, call **1-877-927-8000** for support.

Contact Us

We have different helplines, depending on the Line of Business.

Telephonic:

- **Managed Medical Assistance (MMA)**
  Call **1-800-441-5501 (TTY: 711)**. We're here for you 8 AM to 7 PM, Monday through Friday.
- **Florida Healthy Kids (FHK)**
  Call **1-844-528-5815 (TTY: 711)**. We're here for you 7:30 AM to 7:30 PM, Monday through Friday.
- **Long-Term Care (LTC)**
  Call **1-844-645-7371 (TTY: 711)**. We're here for you 8 AM to 7 PM, Monday through Friday.

24 – Hour Nurse Line:

- MMA: 1 800 441 5501 (TTY:711)
- LTC: 1 800 645 7371 (TTY: 711)
- FHK: 1 844 528 5815 (TTY:711)

Email:

Provider Engagement: FLProviderEngagement@aetna.com
Provider Contracts: FLMedicaidContracting@aetna.com
Grievance and Appeals: FLAppealsandGrievances@aetna.com

Online Form:

The contact us form allows you to add the proper/required information from the start, so you don't have to spend valuable time tracking down the help you need. As an added benefit for us both, we have ensured that any request or inquiry made through this form is routed to the appropriate department depending on the reason of the inquiry. You can also include up to 5 files with your inquiry if needed.

Inquiry Reason - Options

- Claims Inquiry or Disputes
- Grievances & Appeals
- Delegated Group Updates
- New Contract Request
- Provider Enrollment or Adds to an Existing Par Group
- Provider Demographic Data Update
- Provider Terms, Leaving Practice, Retiring, Closing Practice
- Status Inquiry of previous email submission
- Other

*Additional options will be added as we work through this new process!

Direct link:
https://medicaidportal.aetna.com/mcainteractiveforms/ProviderForms/ProviderRequestForm.aspx?p=FL

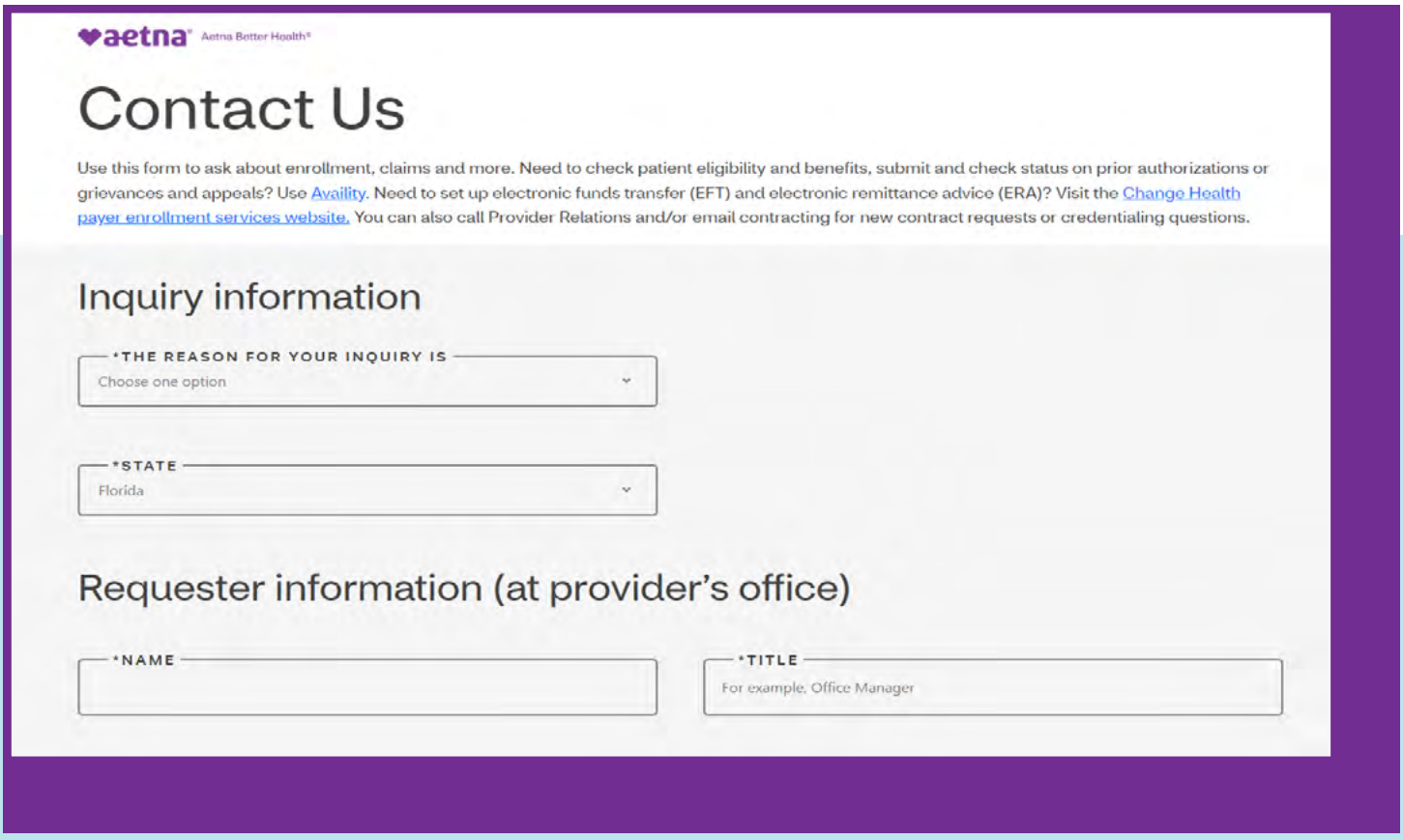
Frequently Asked Questions

What happens after I submit a request?

- Once the form is submitted an email confirmation will be generated with all the details about your request.
- Within 48 hours a case number will be assigned.
- Inquiries will be answered as quickly as possible by our support teams.

When should I use this form?

Demographic changes, updates or terms; new provider adds to existing group contracts; terming providers due to office closures, retirement, and leaving medical group; large add/change/term files; W-9 submissions.



Provider Notices and Newsletters

Receiving updates that impact you and our members is very important!

ABHFL regularly updates and uploads Provider Bulletins in order to keep all providers with the most updated information. Provider manuals are reviewed and updated on a quaterly basis. Newsletters are issued during Summer and Winter each year.

- Provider notices, trainings, and newsletters are easy to access on our ABHFL website: **ABHFL Provider Page**

All communications are delivered to providers via fax and email. We also upload the invitation on our ABHFL website for your convenience.

It is important that we have your most updated fax and email information on file in order for you to receive all of our communications timely.

Need to update your information?

1. Contact our provider relations department via email **FLProviderEngagement@aetna.com**

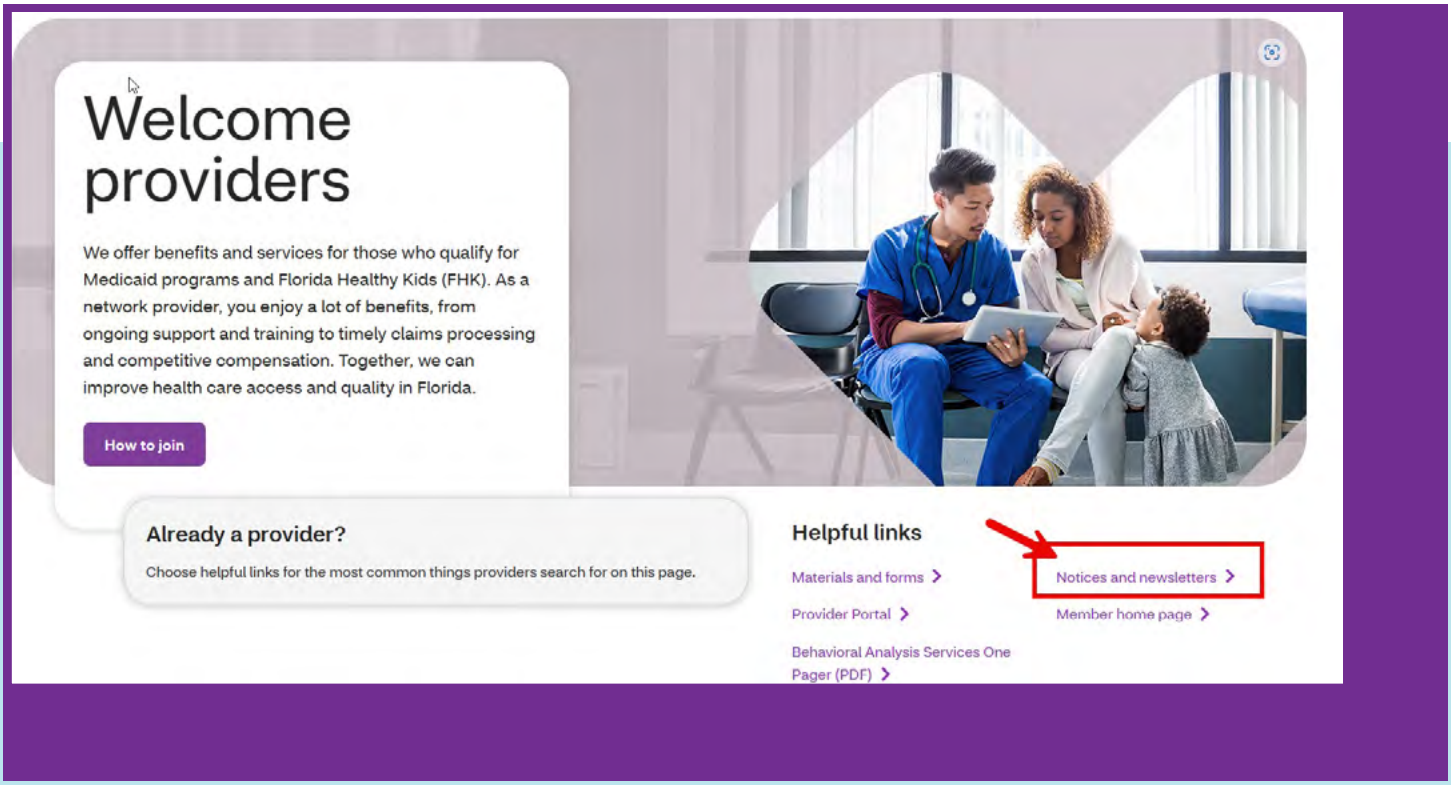
2. Complete the ABHFL Provider Data Change Form: **https://www.surveymonkey.com/r/AETPDCF**

3. Call us!

MMA: **1-800-441-5501 TTY (711)**

LTC: **1-844-645-7371 TTY (711)**

FHK: **1-844-528-5815 TTY (711)**



Simplifed

SimpliFed, a leader in virtual breastfeeding and baby feeding support is now in network with all Aetna for Better Health patients. Starting during pregnancy and continuing up to a year postpartum, SimpliFed's team of consultants and providers meet with families to discuss early feeding difficulties, maternal well-being, returning to work and much more.

Patients can be easily referred electronically, at no extra cost to providers or clinics. Other benefits include:

- An easy referral process with clear, step-by-step directions and automation
- Customizable workflows that integrate into your clinic's 28-week order set
- Bi-directional communication with EMR systems to ensure you're always in the loop
- Improved patient adherence and outcomes that contribute to meeting clinical quality measures

If you're interested in referring your patients to SimpliFed, please contact Suzy Goldenkranz at **suzy@simplifed.com**

EFT/ERA Registration Services (EERS)

EERS offers our providers a more streamlined way to access payment services. It gives you a standardized method of electronic payment and remittance while also expediting the payee enrollment and verification process.

EFT makes it possible for us to deposit electronic payments directly into your bank account. Some benefits of setting up an EFT include:

- Improved payment consistency
- Fast, accurate and secure transactions

ERA is an electronic file that contains claim payment and remittance info sent to your office. The benefits of an ERA include:

- Reduced manual posting of claim payment info, which saves you time and money, while improving efficiency
- No need for paper Explanation of Benefits (EOB) statements

WEBSITE:

ECHO Health Provider Login

EFT/ERA ENROLLMENT:

ECHO Health

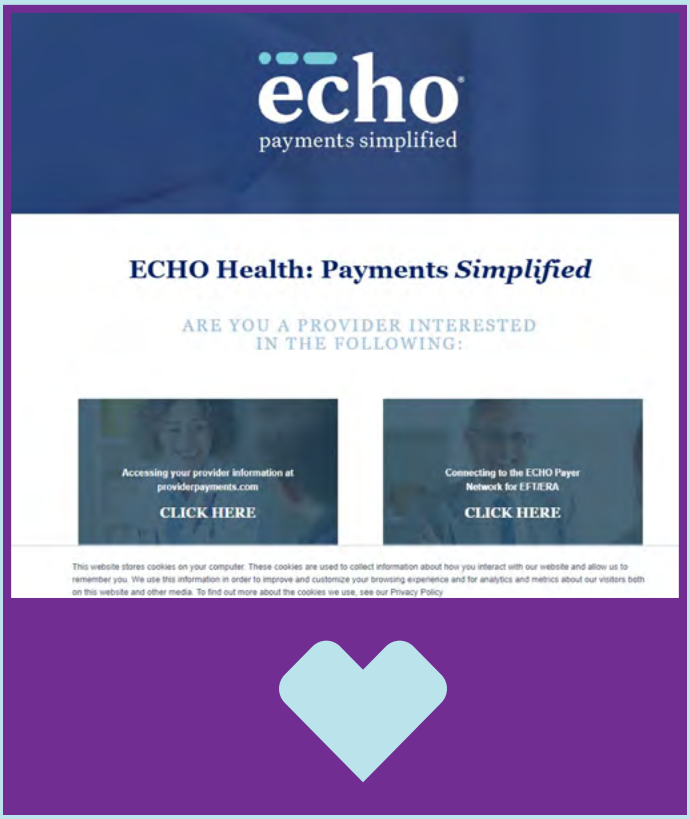
SUPPORT TEAM

ECHO Health, Inc

If you need assistance, contact ECHO Health at:

allpayer@echohealthinc.com

1-888-834-3511



Network Contracting

Effective 02/01/2025 Aetna Better Health of Florida operates in the following Region(s):

Comprehensive (MMA/LTC) - D - Tampa, E - Orlando, I – Miami Dade.

Serious Mental Illness (SMI) Specialty Service - D - Tampa, E - Orlando, I – Miami Dade.

HIV/AIDS Specialty Service - D - Tampa, E - Orlando, I – Miami Dade.

Florida Healthy Kids (CHIP) – Statewide (all 67 counties)

To determine if Aetna Better Health of Florida is accepting new providers in a specific region, please contact our Provider Services Department at:

1-800-441-5501 (MMA)

1-844-645-7371 (LTC)

Completed initial credentialing applications, contracts and network forms can be submitted in multiple ways:

FAX: 1-860-262-9414

EMAIL: FLMedicaidContracting@aetna.com

MAIL: Aetna Better Health of Florida ATTN
Aetna Network Team PO BOX 818043
Cleveland, OH 44181-8043

Fraud, Waste and Abuse

Aetna Better Health of Florida has an aggressive, proactive fraud, waste, and abuse program that comply with state and federal regulations. Our program targets areas of healthcare related fraud and abuse including internal fraud, electronic data processing fraud and external fraud.

A Special Investigations Unit (SIU) is a key element of the program. This SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste, or abuse to appropriate State and federal agencies as mandated by Florida Administrative Code. During the investigation process, the confidentiality of the patient and people referring the potential fraud and abuse case is maintained. Aetna Better Health of Florida uses a variety of mechanisms to detect potential fraud, waste, and abuse.

All key functions including Claims, Provider Engagement, Member Services, Medical Management, as well as providers and members, shares the responsibility to detect and report fraud. Review mechanisms include audits, review of provider service patterns, hotline reporting, claim review, data validation, and data analysis.

Reporting suspected fraud, waste, and abuse

Fraud, Waste and Abuse training is provided by the health plan annually to all subcontractors, providers, and vendors. Participating providers are required to report to Aetna Better Health of Florida all cases of suspected fraud, waste, and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud, waste, or abuse in the following ways:

- ABH-FL Fraud hotline: **1-855-415-1558 (TTY:711)**
- SpecialInvestigationUnit(SIU) Hotline: **1-800-338-6361**
- Email the SIU: **FL-FraudandAbuse@Aetna.com**
- Fax the SIU: **1-860-975-9719**
- FL Medicaid Program IntegrityOffice: **1-888-419-3456**
- Medicaid Fraud and Abuse ComplaintForm: **https://apps.ahca.myflorida.com/mpi-complaintform/**
- FL AttorneyGeneral's Office: **1-866-966-7226**
- CVS Health Ethics Line: **1-877-287-2040**, **Ethics.BusinessConduct@CVSHealth.com**
- By visiting our website: **AetnaBetterHealth.com/Florida/fraud-abuse**.

Doula Provider

As part of our dedication on improving maternal health outcomes through proven methods, we have partnership on the G.R.O.W Doula Program to support these efforts.

Did you know?

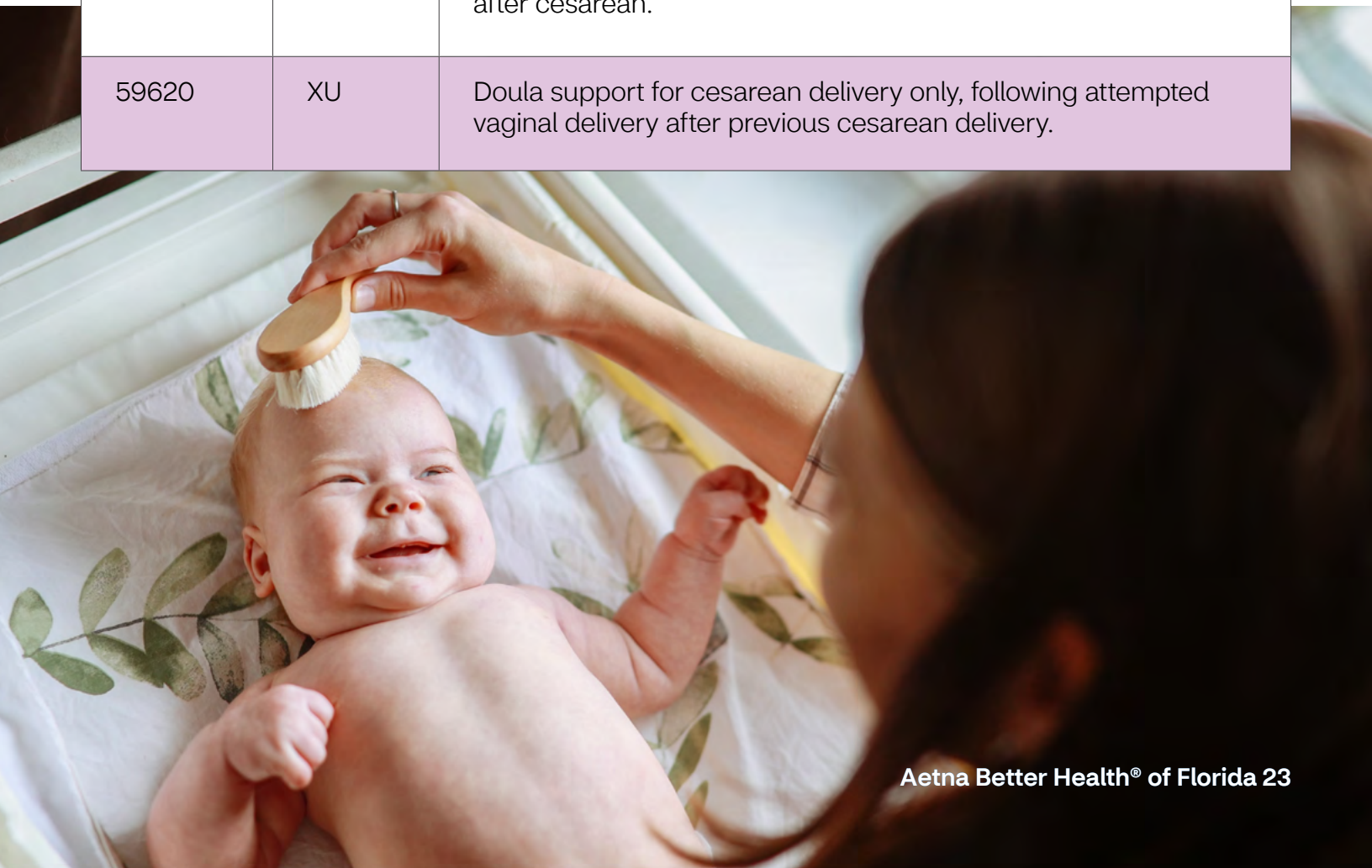
- Credentialing is NOT required if the Doula is not registered nurse/midwife or has a master's level certification.
- Prior Authorization (PA) is NOT required for participating Doulas providers rendering services for Aetna Better Health of Florida members.
- Out of network providers require Prior Authorization (PA) for all Doulas rendering services.

Aetna Better Health of Florida supports Doula services through expanded benefits to members at no charge.

Approved Doula Service Codes and Diagnosis

CODES	MODIFIED	DESCRIPTION
S9442		Birthing classes, non-physician provider, per session
S9443		Lactation classes, non-physician provider, per session
S9444		Parenting classes, non-physician provider, per session
S9445	TS	Prenatal education (patient education non classified, non-physician)
S9445		Postpartum education (patient education non classified, non-physician)
S9446		Prenatal patient education, not otherwise classified, non-physician provider, group, per session
S9446	TS	Postpartum patient education, not otherwise classified, non-physician provider, group, per session

59400	XU	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	XU	Doula support for vaginal delivery only
59510	XU	Standard doula benefit with support at cesarean delivery; Global code: routine obstetric care including antepartum care, C-section delivery, and postpartum
59514	XU	Doula support during Cesarean delivery only. 1 per delivery
59610	XU	Standard doula benefit with support at VBAC delivery; Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery Codes Used
59612	XU	Doula support for VBAC delivery only, with or without episiotomoy, and/or forceps
59618	XU	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care after failed attempt at vaginal delivery after cesarean.
59620	XU	Doula support for cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery.



Doula Provider

THERE ARE 2 IMPORTANT PHARMACY CHANGES THAT HAVE TAKEN PLACE IMPACTING OUR MMA AND FHK POPULATIONS.

THE FIRST PHARMACY CHANGE IMPACTS THE MMA POPULATION.

Effective June 30, 2025, all NEW requests for GLP-1 preferred drugs (Ozempic, Trulicity, Victoza) must go though standard Prior Authorization (PA) review.
Auto Prior Authorization will NO longer apply. All requests will be reviewed using NEW AHCA GLP-1 criteria and will require documentation of T2D diagnosis and A1C lab work. This will ensure that GLP-1 preferred drugs are being used for diabetes and not weight loss (not covered).

Effective August 1, 2025, all CURRENT members utilizing GLP-1 preferred drug will require a NEW Prior Authorization using AHCA criteria.
Members and prescribers will be notified of change 30 days in advance. All providers with members utilizing GLP-1 preferred drug contact our prior authorization department to obtain a new authorization in order to have a smooth transition.

AHCA Drug Criteria link: Drug Criteria | Florida Agency for Health Care Administration

THE SECOND PHARMACY CHANGE IMPACTS THE FHK POPULATION.

Effective July 1, 2025, ONE TOUCH will NO longer be our preferred test strips and kits due to manufacturer availability.

TRUE METRIX will NOW be our preferred test strips and kits for NEW FHK utilizers.

Members, pharmacies and providers have been alerted of this change. This change only affects FHK population, MMA already prefers both True Metrix and One Touch.

There will be four (4) National Drug Codes for strips and 3 for meter that will be covered under FHK. The Relion products are only available at Walmart.

List of preferred National Drug Code (NDC)

NATIONAL DRUG CODE	NAME
56151146001	TRUE METRIX TES GLUCOSE
56151146004	TRUE METRIX TES GLUCOSE
56151146101	RELION TRUE TES METRIX
56151146104	RELION TRUE TES METRIX
56151147002	TRUE METRIX KIT METER
56151149002	TRUE METRIX KIT METER AIR
56151149102	RELION TRUE KIT METER AIR