



## SERVICES REQUIRING AUTHORIZATION

Prior Authorization is required for all Out-of-Network Services. The below services require prior authorization. Please submit supporting clinical documentation with your request so that we can determine medical necessity.

Any service authorizations/pending cases prescribed or authorized before the enrollee's effective date with CCP.

Community Care Plan  
MMA Prior Authorization List  
Effective 10/1/19

<b>ALL SERVICES RENDERED BY OUT OF NETWORK PROVIDERS REQUIRE PRIOR AUTHORIZATION FROM THE HEALTH PLAN. FOR BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES THAT REQUIRE PRIOR AUTHORIZATION PLEASE CONTACT: CARISK BEHAVIORAL HEALTH AT 1-800-294-8642</b>
<b>ADMISSION INPATIENT and FACILITY-BASED CARE</b>
ELECTIVE MEDICAL INPATIENT ADMISSION
ELECTIVE SURGICAL INPATIENT ADMISSION
INPATIENT REHABILITATION ADMISSION
NON-ELECTIVE (EMERGENCY) ADMISSION
NURSING FACILITY SERVICES
SKILLED NURSING FACILITY ADMISSION
<b>ADMISSION OBSERVATION</b>
ADMISSION / DISCHARGE SAME DAY
HOSPITAL OBSERVATION SERVICES (for any reason)
<b>COSMETIC/ PLASTIC/ RECONSTRUCTIVE PROCEDURES</b>
ADJACENT TISSUE TRANSFER/ REARRANGEMENT/ REPAIR INTEGUMENTARY SYSTEM
BARIATRIC SURGERY
BLADDER REPAIR/ RECONSTRUCTION PROCEDURES
BREAST SURGICAL PROCEDURES (excludes excisions or biopsies)
CANTHOPLASTY
CONSTRUCT BLADDER OPENING
CREATE TEAR SAC DRAIN
DERMATOLOGIC PHOTOCHEMOTHERAPY AND LASER TREATMENT
DESTRUCTION OF LESIONS
EYELID, EXCISION AND REPAIR
EYELID REPAIR PROCEDURES
FOOT and TOES RECONSTRUCTION
GASTRIC NEUROSTIMULATOR PROCEDURES
GASTRIC PROCEDURES (including laparoscopic surgery and revision of anastomosis)
HAND AND FINGERS RECONSTRUCTION

HEAD (SKULL, FACE, TMJ) RECONSTRUCTION
HEART DEFECT REPAIR (STRUCTURAL)
HUMERUS AND ELBOW RECONSTRUCTION
INTRALESIONAL INJECTIONS
KERATOPROSTHESIS
KNEE, ARTHROPLASTY
LIP/ PALATE REPAIR
MASTOID SURGERY
NECK AND THORAX RECONSTRUCTION
NOSE, REPAIR
OCULAR ADNEXA, STRABISMUS SURGERY
PALATE AND UVULA REPAIR
PELVIS and HIP RECONSTRUCTION
PENILE REPAIR
SKIN FLAPS AND GRAFTS
TESTICULAR PROSTHESIS INSERTION
<b>DENTAL CARE IN A FACILITY</b>
<b>Medically necessary dental services are authorized by the Prepaid Dental Health Plan (PDHP). CCP will be responsible for the prior authorization of the facility and ancillary medical services in the facility.</b>
<b>DIAGNOSTIC IMAGING AND LAB TESTING</b>
CT SCAN (Requirement waived for high performing PCPs)
CTA AND CALCIUM SCORING
GENETIC TESTING (no authorization is required for standard genetic tests performed on the pregnant enrollee)
MRI (Requirement waived for high performing PCPs)
PET SCAN
SLEEP STUDY
TRANSVAGINAL US NON-OB
<b>DIALYSIS</b>
HEMODIALYSIS AND PERITONEAL
<b>DURABLE MEDICAL EQUIPMENT</b>
<b>(Medical and surgical supplies do not require prior authorization if the supply is a FL Medicaid covered benefit and is provided by a participating provider)</b>
APNEA MONITOR
BONE GROWTH STIMULATOR
COCHLEAR DEVICE SYSTEM
CPAP AND BIPAP MACHINES

COUGH STIMULATING DEVICE
CHEST WALL OSCILLATION SYSTEM
DIABETIC SHOES
HOSPITAL BEDS
INSULIN PUMPS AND SUPPLIES
OXYGEN DELIVERY SYSTEMS
PATIENT LIFTS
SPEECH GENERATING DEVICE AND REPAIR
UNLISTED DURABLE MEDICAL EQUIPMENT
WHEELCHAIRS (MANUAL AND ELECTRIC, INCLUDING ACCESSORIES)
WOUND VAC PUMPS
<b>ELECTIVE INVASIVE PROCEDURES</b>
ABLATE HEART DYSRHYTHM FOCUS (ELETROPHYSIOLOGICAL PROCEDURES)
ABLATE INFERIOR TURBINATE
ABORTION PROCEDURES (elective)
ADJUST BONE FIXATION DEVICE
ANAL PRESSURE RECORD
ANAL/ URINARY EMG
ARTHROSCOPY ALL BODY AREAS
AV SHUNT/ ANASTOMOSIS PROCEDURES
BRONCHOSCOPIC PROCEDURES
CAPSULE ENDOSCOPY
CARDIAC CATHETERIZATION
CARDIOVERSION, ELECTRICAL - INTERNAL
CARPAL TUNNEL SURGERY
CATARACT SURGERY (Medically necessary cataract surgery will be authorized by 20/20 EyeCare network. CCP will be responsible for the prior authorization of the facility and ancillary medical services)
CHEMODENERVE ECCRINE GLANDS
CHOLECYSTECTOMY, LAPAROSCOPIC
CIRCUMCISION (AUTH REQUIRED IF AGE > 12 weeks old)
CORONARY THERAPEUTIC SERVICES
CYSTOMETROGRAM
CYSTOSCOPY AND TREATMENT
DENERVATION
DISCECTOMY/ VERTEBRAL BODY RESECTION
ELECTRICAL STIMULATION, OPERATIVE

ELECTROMYOGRAPHY and NERVE CONDUCTION VELOCITY TESTING
ENDOCERVICAL CURETTAGE
ENDOSCOPY, SURGICAL (SINUS, ESOPHAGUS, SMALL INTESTINE, STOMA)
EPIDURAL INJECTION FOR LYSIS
EPIDURAL INJECTION FOR PAIN
ESOPHAGOGASTRIC FUNDOPLASTY
EXCISION CYSTIC HYGROMA, AXILLARY/ CERVICAL
GRAFT PROCEDURES ON MUSCULOSKELTAL SYSTEM (GENERAL)
HEMORRHOIDECTOMY
HERNIA REPAIR (open and laparoscopic)
HYPERBARIC TREATMENT (Wound care center only)
HYSTERECTOMY (with sterilization form)
HYSTEROSCOPY
IMPLANT AND REVISION OF NEUROELECTRODES
IMPLANT COCHLEAR DEVICE
IMPLANT CORNEAL RING
IMPLANT CRANIAL BONE GRAFT
IMPLANT EYE SHUNT
IMPLANT INFUSION PUMP
INSERTION OF TUNNELED INTRAPERITONEAL CATHETER
LAMINOTOMY/ LAMINECTOMY
LAPAROSCOPY OF ABDOMEN, PERITONEUM, OMENTUM
MOHS SURGERY
MYOMECTOMY
NEPHRECTOMY
OPTIC NERVE, DECOMPRESSION
ORAL SURGERY
ORCHIECTOMY, ORCHIOPEXY
OVIDUCT/ OVARY, LAPAROSCOPY
PROCTOPEXY, LAPAROSCOPIC
PENILE IMPLANT (REMOVAL ONLY)
PROSTATE PROCEDURES
PTERYGIUM SURGERY
SHOULDER SURGERY/ REPAIR/ REVISION/ RECONSTRUCTION
SKIN GRAFTING PROCEDURES
SPIDER VEIN AND ENDOVENOUS THERAPY
SPINAL IMPLANT/ PUMP/ ANALYZE

SPINE FUSION
STERILIZATION PROCEDURES (with sterilization form)
STRESS TEST (THALLIUM, CARDIOLYTE ETC.)
THORACOSCOPY, DIAGNOSTIC OR SURGICAL
TOTAL DISC ARTHROPLASTY (artificial disc)
TRANSCATH STENT TO CAROTID ARTERY/ INCLUDING ANGIOPLASTY
TRANSCATH PERM OCCLUSION/ EMBOLIZATION PERC, OF CNS
TRANSESOPHAGEAL ECHOCARDIOGRAPHY
TYMPANOSTOMY
UTERINE FIBROID EMBOLIZATION
<b>HOME HEALTH</b>
HOME RESPIRATORY THERAPY VISITS
HOME HEALTH AIDE VISITS
HOMEMAKER SERVICE
PERSONAL CARE SERVICES
PRIVATE DUTY NURSING
SKILLED NURSING VISITS
SOCIAL WORKER HOME VISITS
<b>HOSPICE</b>
HOSPICE INPATIENT
HOSPICE OUTPATIENT AT HOME/ ALF/ SNF
<b>MATERNITY</b> (Requirement Waived for High Performing OB Providers)
DELIVERY (SCHEDULED CESAREAN AND INDUCTIONS)
OBSTETRICAL CARE — PRE-NATAL PROCEDURES (Prenatal sonograms do not require prior auth)
<b>NUTRITION SERVICES</b>
NUTRITIONAL COUNSELING
NUTRITIONAL SUPPLEMENTS/ NUTRITIONAL FORMULAS/ ENTERAL NUTRITION
<b>ORTHOTICS AND PROSTHETICS</b>
CRANIAL ORTHOSIS
LIMB AND TORSO PROSTHETICS
ORTHOTICS/ PROSTHETICS
PROSTHETIC CUSTOM EYE, SURFACING & FITTING

<b>THERAPY AND INTEGRATIVE MEDICINE SERVICES</b> <b>(PT/ OT/ ST/ RT evaluations do not require prior authorization)</b>
ACUPUNCTURE
CARDIAC REHAB
CHIROPRACTIC SERVICES (Prior authorization required for Expanded Benefit Only — Limitations apply)
EQUINE THERAPY
MASSAGE THERAPY (Expanded Benefit—limitations apply)
OCCUPATIONAL THERAPY
PHYSICAL THERAPY
RESPIRATORY THERAPY
SPEECH THERAPY
<b>TRANSPLANT</b>
ALL TRANSPLANT SERVICES, INCLUDING EVALUATIONS
<b>TRANSPORTATION</b>
AIR AMBULANCE

### **PRIOR AUTHORIZATION FOR NEW ENROLLEES TO CCP**

Enrollees become effective in CCP either via a voluntary process (the individual elects the CCP) or by an assigned process by AHCA when an individual does not choose a Medicaid managed care program.

For both voluntary and assigned enrollees, written documentation of prior authorization of ongoing services will be honored for up to sixty (60) days after the effective date of enrollment in CCP or until CCP’s PCP reviews the enrollee’s treatment plan, whichever comes first. Services need to have been pre-arranged prior to enrollment in CCP. These services include:

- a) Prior existing orders (including Home Health and Durable Medical Equipment)
- b) Prior appointments, surgeries
- c) Prescriptions (including prescriptions at non-participating pharmacies)

CCP will not delay authorization if written documentation is not available in a timely manner.