

Aetna Better Health of Florida prior authorization rules for Florida Medicaid and Healthy Kids

Prior authorization (PA) is required for some out-of-network providers, outpatient care and planned hospital admissions. We don't require PA for emergency care. You can find a current list of the services that need PA on the Provider Portal. You can also find out if a service needs PA by using ProPAT, our online prior authorization search tool.

For more details, see the Prior Authorization section of the Aetna Better Health of Florida provider manual. Requesting providers, including outpatient hospitals, must complete the Prior Authorization Request Form and fax it to the appropriate number below. You can find the form on the Aetna Better Health of Florida Prior Authorization webpage.

Prior Authorization Telephone-MMA:	**1-800-441-5501**
Prior Authorization Telephone-FHK:	**1-844-528-5815**
Physical Health Prior Authorization Fax:	**1-860-607-8056**
Obstetrics Prior Authorization and Notification Fax:	**1-860-607-8726**
Behavioral Health Prior Authorization Fax-MMA:	**1-833-365-2474**
Behavioral Health Prior Authorization Fax-FHK:	**1-833-365-2493**
Pharmacy Management Prior Authorization:	**1-866-847-8279**
Availity: https://apps.availity.com/availity/web/public.elegant.login	

**** Inpatient hospitalizations requests can be submitted through Availity or called in.

IMPORTANT: Members should refer to their Member Handbook for information regarding covered health care services.

Provider Type:

Ambulance transport (non-emergency) *For Medicaid members only	Non-participating providers
Air Ambulance (non-emergency)	Ophthalmology/optometry
Behavioral health facility admissions	Oral surgery
Dental services	Outpatient rehabilitation
Facility authorization for chemotherapy	Rehabilitation facility inpatient admission
High tech radiology services	Reproductive endocrinology
Hospital admission	Skilled nursing facility admission
Hospital observation	Substance abuse
Hospital outpatient services	Short term residential admissions
Neuropsychology	Vent/sub-acute, long-term care admission

Service/Procedure (Regardless of place of treatment):

Automatic implantable cardioverter defibrillator	Hospice services – home and Inpatient
Blepharoplasty	Hyperbaric treatments
Bone growth stimulators	Infertility assessment/treatment
Breast surgery for benign condition	Infusion/home/office drug-replacement
Chemotherapy medication regimens	Laparoscopic hysterectomy
Clinitron bed	Liquid oxygen
Cosmetic surgery	Manipulation under anesthesia
Crisis stabilization	Mental health partial hospitalization
Customized wheelchairs	Psychological/neuropsychological testing
Diagnostic nuclear medicine & nuclear cardiology	Pain management
Durable Medical Equipment (rentals, items greater than $500 allowable, items not listed on the Medicaid fee schedule)	Panniculectomy/abdominoplasty PET scans
Echo stress	Power mobility devices (power wheelchair and scooters)
Enhanced external counter pulsation	Radiation oncology/hematology/oncology
Esophagoscopy flexible transoral mucosal resection	Rehabilitation therapies (PT/ST/OT)
Evaluation of speech fluency	Removal of keloid/lipomas
Experimental/investigational services	rhinoplasty/septoplasty
Extracorporeal shock wave therapy/orthotripsy	Sclerotherapy for varicose veins
Gastric bypass/banding	Sleep studies
Genetic testing	Specialty imaging
Home health services	Spinal fusion
Home ventilators	Substance abuse intensive outpatient therapy
	Transplant evaluations/transplants

General information

- Requests for prior authorization must be submitted by the member's Primary Care Physician (PCP).
- Prior authorization is the process of collecting information and assessing whether proposed services are appropriate for the member and will be covered by an organization.
- Requests for prior authorization must be received before rendering services.
- Failure to contact the member's health plan for prior authorization will relieve the health plan or members from any financial liability for the applicable service(s), if those services are rendered.
- This material is provided for informational purposes only. It is not intended to direct treatment decisions.

- Utilization review is the process of determining whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage.
    - Please use **aetnabetterhealth.com/florida** to validate all procedure codes prior to rendering services to confirm prior authorization guidelines are met.
- Members should refer to their Member Handbook for information regarding covered health care services.