Florida Health Care Plans®

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PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To comply with the CMS Interoperability and Prior Authorization final rule, Florida Health Care Plans is required to annually report aggregated prior authorization metrics on our website. Specifically, this includes a list of all medical items and services (excluding drugs) that require prior authorization, as well as data on prior authorization requests for those items and services (e.g., approvals, denials, etc.) over the previous calendar year. Publicly reporting these metrics promotes transparency and accountability, helps patients understand prior authorization processes, and enables providers to evaluate payer performance. In addition, metrics can be used to compare plans, programs, and payers. For questions on the data below, contact: 2450 Mason Avenue, Daytona Beach, FL 32114 - 800-352-9824.

Reporting Period: 2025

These are the medical items and services for which we require prior authorization (excluding drugs)

The following are the most commonly requested non-emergency, services that require Prior Authorization by FHCP:

Note: The following listing is subject to change.

1. Cardiac Catheterization;
2. Cardiac Rehabilitation;
3. Certain Diagnostic studies and/or procedures:
    a. Breast MRI's;
    b. CT Colonography (aka Virtual Colonoscopy);
    c. Certain Genetic Testing;
    d. PET Scans;
    e. Pill Cams;
    f. Sestamibi Scans; and
    g. Stereotactic Breast Biopsies.
4. Certain Injections and Infusion Therapy;
5. Certain Provider Administered Drugs;
6. Certain Durable Medical Equipment (including but not limited to):
    a. Alternating Pressure Relieving Mattresses;
    b. Bone Growth Stimulators;
    c. Mattress Gel Overlays;
    d. Mattress Replacement Systems;
    e. Pumps and Pads;
    f. Wheelchair Cushions; and
    g. Wound Vacs.
7. Clinical Trials;
8. Hyperbaric Oxygen Therapy;
9. Lymphedema Therapy;

10. Medical Braces/Prosthetics (See the “Covered Medical Services” and “Exclusions and Limitations” Sections);
11. Oncology Chemotherapy;
12. Oral Surgery (See the “Covered Medical Services” and “Exclusion and Limitations”
    a. Sections);
13. Physical Medicine and Rehabilitation Services;
14. Plastic Surgeon (See the “Covered Medical Services”and “Exclusions and Limitations” Sections);
15. Pulmonary Rehabilitation;
16. Radiation Oncology Therapy;
17. Second & Third Medical Opinions;
18. Second & Third Surgical Opinions;
19. Services provided by a Mid-wife in the Home;
20. Services provided at Non-Contracted Hospitals;
21. Services provided by Non-Contracted Providers;
22. Services provided for, and related to Organ and Bone Marrow Transplants;
23. Skilled Nursing / Rehabilitation Facilities Admissions;
24. Surgeries: All surgeries, elective, and non-elective (including Emergency Surgery whenever possible), inpatient or outpatient;
25. Tertiary Care Services, Admissions, Procedures, Testing or Surgery, inpatient Or outpatient; and
26. Varicose Vein Treatment.

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframes:

- For MA plans and applicable integrated plans, 72 hours for **expedited requests** (urgent)and 14 calendar days for **standard requests** (non-urgent)
- For state CHIP FFS programs, 14 days for **standard requests** (non-urgent)
- For Medicaid managed care plans and CHIP managed care entities, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For QHP issuers on the FFEs, 72 hours for **expedited requests** (urgent) and 15 days for **standard requests** (non-urgent)

There are no Medicaid FFS program required timeframes for either type of prior authorization request prior to January 1, 2026, and there are no CHIP FFS program required decision timeframes for expedited prior authorization requests prior to January 1, 2026.

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires [MA plans, state Medicaid agencies, Medicaid managed care plans, state CHIP agencies, CHIP managed care entities] to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent)
- 7 calendar days for **standard requests** (non-urgent)

For FHCP Medicare Advantage Plans, please visit the Florida Blue Medicare website.

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Standard (non-urgent) Prior Authorization Requests

On Exchange Federally Facilitated Plans	How many times this happened	Out of total requests	Percentage
Request approved	10,538	12,914	81.6%
Request denied	2,376	12,914	18.4%

On Exchange Federally Facilitated Plans	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended	0	0	0%

On Exchange Federally Facilitated Plans	How many times this happened	Out of total requests	Percentage
Request approved	81	163	49.7%
Request denied	82	163	50.3%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

On Exchange Federally Facilitated Plans	How many times this happened	Out of total requests	Percentage
Request approved	79	86	91.9%
Request denied	7	86	8.1%

On Exchange Federally Facilitated Plans	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended	0	0	0%

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Time Between Receiving a Prior Authorization Request and Sending a Decision

On Exchange Federally Facilitated Plans	Mean (Average) Time In Days	Median (Middle) Time In Days
Standard (non-urgent) Prior Authorization Requests	6	6
Expedited (urgent) Prior Authorization Requests	1	0

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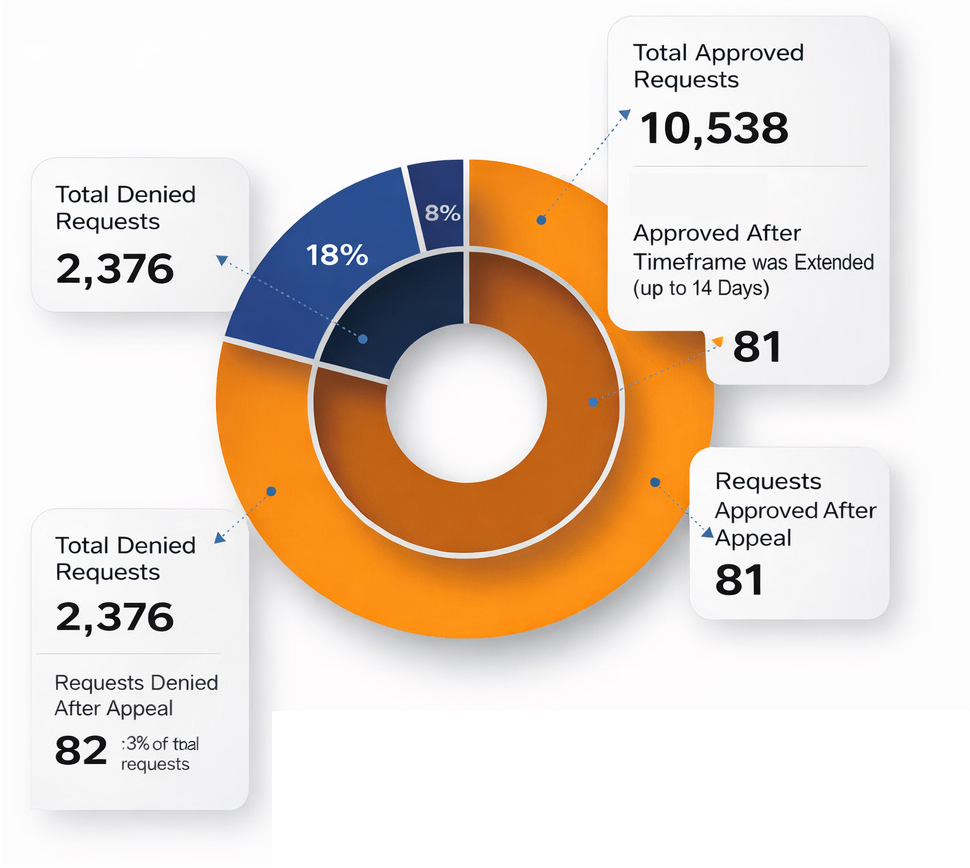
In 2025, we received a total of 12,914 standard (non-urgent) prior authorization requests for our patients enrolled in an On-Exchange Federally Facilitated Plans.



The mean (average) time that it took to make standard prior authorization decisions was | **6 days**

The median (middle) time that it took to make standard prior authorization decisions was | **6 days**

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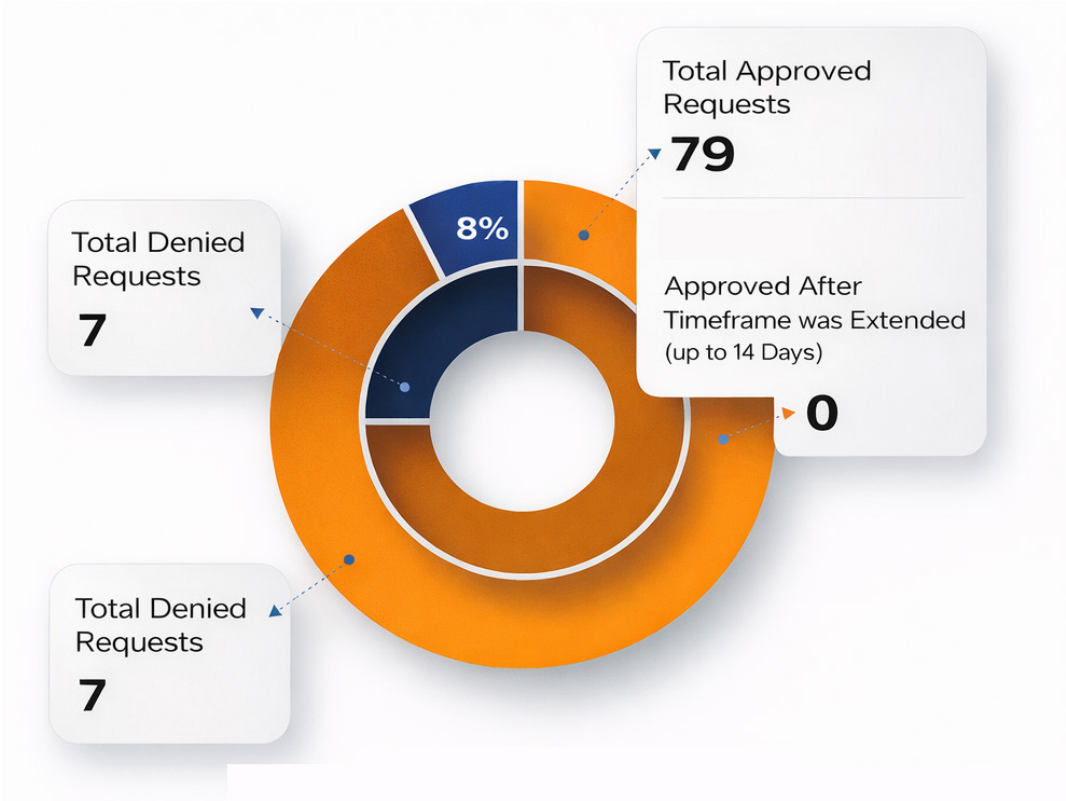
In 2025, we received a total of 86 expedited (urgent) prior authorization requests for our covered patients enrolled in On-Exchange Federally Facilitated Plans.



The mean (average) time that it took to make standard prior authorization decisions was	**1 day**
The median (middle) time that it took to make standard prior authorization decisions was	**< 1 day**