Drafting Note: State laws or rules are referenced in three answers (What is Medically Necessary?, How Long Do Prior Authorization Decisions Take?, and What Rules Must Plans Follow About Prior Authorization?). States may wish to provide specific information on state laws or link to additional information. The final answer on appeals includes a reference to the state department of insurance, where it may be helpful to add contact information.

Prior Authorization: What It Is, When It's Used, and Your Options

What Is Prior Authorization?

Prior authorization means your health plan requires your doctor or other healthcare provider to get approval *before* they provide health care services or prescribe prescription drugs. Without prior authorization, your health plan may not pay for your treatment or medication.

NOTE: Emergency services don't require prior authorization.

Why Do Health Plans Require Prior Authorization?

Prior authorization serves two purposes. First, it's a check that your plan covers the proposed care. It's also a way the health plan can decide if the care is medically necessary, safe, and cost effective.

What Is Medically Necessary?

A medically necessary service or prescription drug is one that's needed to diagnose or treat an illness, injury, condition, disease, or its symptoms. It must meet accepted standards of medicine. To decide what's medically necessary, your health plan must follow any state and federal laws that apply.

How Do Health Plans Decide What's Safe?

To be safe, procedures, treatments, and prescription drugs must meet the latest clinical standards and guidelines. They must avoid negative interactions between drugs you're already taking or treatments you're receiving.

What If My Health Plan Has Concerns with a Proposed Treatment or Medication?

The health plan may deny the request, ask for more information, recommend another approach, or talk with your provider to agree on the most appropriate care plan. Your health plan might suggest other tests based on clinical guidelines before it makes a decision.

Could My Health Plan Deny Prior Authorization Because of Cost?

Yes. Health plans may deny prior authorization when similar drugs or services are equally safe and effective but cost less. For example, a health plan may approve a drug only if you

try a less expensive drug first and that drug isn't effective or causes side effects. This may be called step therapy.

Do I Need Prior Authorization to Continue a Treatment I'm Currently Receiving?

You may. Your health plan may require your provider to confirm that ongoing services or medications would continue to help you.

What Medications and Services Require Prior Authorization?

Your health plan has a list of medications and services that typically require prior authorization. You can find the list in printed plan documents and/or online.

Does Medicare Require Prior Authorization?

Original Medicare (Medicare Part A and Part B) generally does not require prior authorization.

Medicare Advantage and Medicare prescription drug plans (Part D) may require prior authorization.

How Long Do Prior Authorization Decisions Take?

How long it takes to get a prior authorization decision depends on how urgently you need the care. If your need is urgent, you or your provider can ask for an expedited (or quick) review. State or federal rules may limit the time a health plan can take to make decisions.

What Rules Must Plans Follow About Prior Authorization?

Health plans' prior authorization policies must follow federal and state laws. Depending on your state, these laws may address:

- How quickly health plans must respond to requests for prior authorization and appeals,
- What types of professionals may review and approve or deny a prior authorization request,
- What information a health plan must share with you and your provider when it denies a prior authorization request, and
- How long a prior authorization approval may last before you must ask for a new authorization.

How Do I Ask for Prior Authorization?

Your health care provider can make the prior authorization request. In some cases, your provider will request that you start the prior authorization process.

If your provider submits the request, they will send the required information to the health plan. You may need to fill out forms for your provider's office to use. A prior authorization form will include information about you, your medical conditions, and your health care needs. It's important to fill out the form completely and accurately. Missing or wrong information could delay your request or result in a denial.

If you submit the prior authorization request, ask your health plan how to do that. Make sure you meet the deadlines your health plan gives you. Keep copies of all documents and communications sent and received. Note dates and the names and titles of people you speak with. You may need this information if the request is denied. Keep a record of approved prior authorizations in case you need to ask for another one in the future.

Can I Appeal If I Think My Prior Authorization Was Incorrectly Denied?

You may appeal a health plan's prior authorization decision. Before starting the appeal process, call your health plan to learn why the prior authorization was denied. Check that all the requested information was received and was correct. If a simple error was the problem, such as missing information, correcting the error might be a quick fix.

If all information is correct and nothing is missing, you'll need to partner with your provider's office to start an appeal. Give the office the reason for the denial. Ask if there's other information that could support the prior authorization request. If so, you or your provider can follow your health plan's instructions to submit an appeal. For more information about how to appeal a prior authorization decision, contact [your state Insurance Department] to help guide you through the process or help you file a complaint if appropriate.