Missouri Department of Commerce & Insurance

Prior Authorization: Consumer FAQs

1. What is Prior Authorization & WHY is it needed?

- Without prior authorization, your health plan may not pay for your treatment or medication. Prior authorization means your health plan must approve certain health care services or prescriptions before they're provided. It's a way for your health plan to check whether it covers the proposed care and if the care is medically necessary and safe.

2. Is prior authorization needed for emergencies?

- No. Prior authorization is never required for emergencies.
- An emergency is when you suddenly get very sick, are hurt, or have a condition with severe symptoms, like serious pain. It's an emergency if a reasonable person would think you need immediate care to avoid serious harm to your health, loss of body function, or danger to life (including the life of an unborn child).

3. Whose responsibility is it to ask for prior authorization?

- Who is responsible for requesting prior authorization depends on whether your doctor or other health care provider is in your health plan's network (an "in-network" provider) or outside of your health plan's network (an "out-of-network" provider).
- If the provider is in-network, then they should ask for prior authorization for you.
- If the provider is out-of-network, it may be your responsibility to ask for prior authorization.

4. What's involved in requesting prior authorization?

- ***If your provider submits the request,*** they'll send the required information to the health plan. In some cases, your provider will ask you to start the process by filling out some of the forms. A prior authorization form includes 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 must submit the prior authorization request,*** ask your health plan how to do that. Most likely, completing the request is your responsibility only if your provider is out-of-network. Make sure you meet the deadlines your health plan gives you. Keep copies of all documents and communications sent and received, including 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.

5. How much time does my health plan have to make a decision?

- Most health plans doing business in Missouri must decide within 36 hours, including one business day, after receiving all the information they need. If "Fully Insured" or "Fully Funded" is printed on the front of your insurance ID card, then your health plan must follow Missouri law and respond within the specified timeframe. However, health plans that aren't regulated by state law may have more time to decide.

6. What rules must health plans follow about prior authorization?

- Health plans must follow their written procedures when they make prior authorization decisions. They must disclose a clear description of those procedures to health plan members in their member handbook. Health plans must also give their members information about their appeal process.
- Health plans are required to put a toll-free telephone number on your insurance ID card to call for prior authorization decisions. They must meet the timeframes in the law for appeals.

7. What if my health plan has concerns about the 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 best care plan. Your health plan might suggest other tests based on clinical guidelines before deciding whether to authorize the treatment or medication.

8. What can I do if my health plan doesn't approve my prior authorization request?

- You can appeal a health plan's prior authorization decision. Your health plan is required to give you, in writing, the primary reason for the denial, including the clinical reason, and instructions to appeal the decision. Call your health plan if you have questions about the denial or the appeal process.
- Make sure your health plan received all the requested information when you asked for prior authorization, and that the information was correct. If a simple error, such as missing information, caused the problem, correcting it might be a quick fix.
- If all the information was correct and complete, 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 process to submit an appeal.

8. Who can I go to for help with prior authorization denials?

- For more information about how to appeal a prior authorization decision, contact the Missouri Department of Commerce & Insurance (DCI). They can help guide you through the process or help you file a complaint, if appropriate.
- DCI can be contacted by calling our Insurance Consumer Hotline at 800-726-7390.

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