Medical Necessity and Preauthorization Timeframes and Member Responsibilities

- "Medical necessity" describes care that is reasonable, necessary and/or appropriate based on evidence-based clinical standards of care.

  Preauthorization, also known as "prior authorization," is a process through which Health Alliance approves or denies a request to use a covered benefit before the member uses the benefit. Health Alliance's decisions are based on medical necessity and plan benefits. Health Alliance maintains a preauthorization list that states which services require preauthorization. This list is reviewed annually.

- Members may be held responsible if they did not receive preauthorization from Health Alliance. According to regulatory standards, Health Alliance has up to 15 calendar days to make a decision to approve or deny preauthorization. Medically urgent preauthorization requests must have a decision rendered within 72 hours.

Considerations:

1) WA small group and individual plans have different turnaround times. Routine requests must be reviewed within 5 calendar days, and urgent requests must be reviewed within 48 hours.
2) Medicare Advantage routine requests must be reviewed within 14 calendar days, and urgent requests must be reviewed within 72 hours.