What to know about prior authorization

If you're a participant of a self-funded benefit plan, you may have questions about the prior authorization process for certain services. Here are some answers.

What is Prior Authorization?

Prior Authorization programs are a medical necessity process built to help improve health care quality and cost outcomes for certain procedures. The process is designed to help reduce variation in care, prevent avoidable and duplicative procedures and improve the employee experience.

How does the prior authorization process work?

If prior authorization is required, a clinical coverage review will be conducted before the service is performed to determine whether it's medically necessary based on evidence-based clinical guidelines. Prior authorization must be completed before the service is performed.

Here's a closer look

Identify
Patient visits a physician who then recommends a test, procedure or service that requires prior authorization

Inquire
For network services, the physician contacts UnitedHealthcare, but for out-of-network services the patient must contact UnitedHealthcare

Verify
UnitedHealthcare reviews the request to verify the service is covered and medically necessary—and a determination is made

Inform
Physician and patient review the decision and plan a course of action

Claim
Claim is submitted for service rendered

continued

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What procedures are included in the Prior Authorization programs?

Services included but are not limited to the following:[1]

- Injectable medications
- MSK surgeries
- Sleep testing
- Radiology procedures

How can you determine if prior authorization is required for a procedure?

Call the toll-free member number on your health plan ID card to confirm prior authorization requirements.

How can you confirm if you are responsible for obtaining a prior authorization?

Your benefit coverage documents will summarize the prior authorization requirements. Generally, your network provider—a physician, facility or other health care professional who contracts to participate in the UnitedHealthcare network—will facilitate this process for you. When seeking services from an out-of-network provider, you will be responsible for obtaining prior authorization.

If you are in a UnitedHealthcare Options PPO plan, you will be responsible for obtaining prior authorization, regardless of whether the service is provided by a network or an out-of-network provider. Although your provider may not be required to call, he or she may call, as a courtesy to you, to obtain prior authorization on your behalf.

How will you be notified of the outcome of your prior authorization request?

You will receive a determination letter by mail and a copy will be sent to your provider.

How long is a prior authorization number valid?

A prior authorization number is valid for 45 calendar days. An authorization is specific to the procedure requested and can only be used once within the 45-day period.

Are you responsible for the cost of the service if it's determined that it's not medically necessary?

If it is determined that the service is not medically necessary, the claim for the service will be denied. You can be billed by a network provider for claims that are denied for services that did not meet medical necessity, if the provider obtained adequate written consent from you before performing the service.

How do you appeal a request that did not meet medical necessity?

If the request does not meet medical necessity, the determination letter will include an explanation for the decision, the criteria used and available appeal rights.

Questions? Call the toll-free number on your health plan ID card

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[1] Individuals should check their specific coverage documents for details.

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