Medical Necessity and Prior Authorization Timeframes and Enrollee Responsibilities

Medical necessity is used to describe care that is reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. Prior authorization is a process through which an issuer approves a request to access a covered benefit before the insured accesses the benefit.

Some Covered Services require Community Health Options' Prior Approval before we will pay Benefits. The Prior Approval program helps us ensure that:
a. The services you receive are Medically Necessary
b. You receive the appropriate level of care in the appropriate setting
c. Information is shared with your Providers so that your care can be coordinated and
d. We pay the correct amount of Benefits

If Prior Approval is granted for a service, Benefits will be paid as described in the Schedule of Benefits (unless there is a reason to deny Benefits). Prior Approval must be requested prior to the medical service being performed.

For services requiring Prior Approval, Community Health Options makes the initial coverage determinations within two business days after obtaining all necessary information. If Community Health Options does not receive enough information to make a Prior Approval decision, Community Health Options will notify the Provider within two business days after receiving the Prior Approval request that more information is needed. Community Health Options will inform you and your Provider within two business days after the Prior Approval request is made if Community Health Options needs to consult someone outside of Community Health Options to make a decision.

For Medical Necessity determinations involving ongoing care, Community Health Options will provide notice of the coverage determination within one business day after obtaining all necessary information. Ongoing care will be continued without liability to you until you are notified of the coverage determination. We will notify you and your Provider of our Prior Approval decisions. Our Prior Approval decisions will discuss whether the requested service is Medically Necessary and is a Covered Service. All denial of coverage determinations based on Medical Necessity are initially communicated verbally to the Provider(s), then followed up in writing to the Member and Provider(s). The written notification cites the reason(s) why the decision was made and includes information about the Appeals process and the right to request in writing copies of any clinical criteria applied in a denial of coverage decision. Additionally, Members will receive written notification of any denial of coverage that is based on non-covered Benefits or Benefit limits that have been reached.

Medical Necessity and Prior Authorization Timeframes and Enrollee Responsibilities

Some services require Prior Approval before Benefits will be provided by the Plan. Some services require that we be notified that you have received services. If you have any questions or need assistance to determine which services require Prior Approval or notification, please visit www.healthoptions.org or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

If you fail to obtain Prior Approval for a service needing Prior Approval, or if you fail to submit prior notification for a service that requires notification, you may not receive Benefits for that service and you may be responsible for the full cost of the service.