Patient Quick Guide: Electronic Prior Authorization

- **What this means for you:** This is a new, behind-the-scenes electronic process designed to support more timely processing of prior authorization requests submitted by your providers.
- **The Benefit:** This is intended to support more timely decisions and reduce administrative work for your provider. Applicable decision timeframes are described below.
- **Your Action:** In most cases, no direct action is required from you. Your provider may use this electronic process to submit requests and check requirements on your behalf.

Electronic Prior Authorization

Prior Authorization API

Covered Health Plan is required to support electronic prior authorization capabilities through a standardized process known as the Prior Authorization API (Application Programming Interface) - a secure electronic connection for sharing data.

Beginning in 2027, this capability enables health care providers to use secure electronic tools to request and receive information related to prior authorization to the extent maintained for certain medical items and services. These capabilities are intended to improve efficiency, reduce administrative burden, and support more timely access to care.

How Prior Authorization Works

Through the Prior Authorization API, participating providers may:

- Determine whether prior authorization is required for a specific service
- Review documentation requirements for a prior authorization request
- Submit prior authorization requests electronically
- Receive status updates and decisions on prior authorization requests

These capabilities support an end-to-end electronic workflow designed to improve the prior authorization process.

Information That May Be Shared

As part of the prior authorization process, Covered Health Plan may exchange information with your provider, including:

- Information necessary to determine whether prior authorization is required
- Clinical and other supporting documentation submitted by your provider
- Prior authorization status and decisions, including any additional information requests

This information is used to evaluate requests for coverage of certain services.

Processing Timeframes

Covered Health Plan follows applicable requirements for processing prior authorization requests:

- For applicable impacted plans, expedited or urgent requests are processed as expeditiously as the patient's condition requires and generally no later than 72 hours
- For applicable impacted plans, standard requests are processed as expeditiously as the patient's condition requires and generally no later than seven calendar days

These timeframes are intended to support timely decision-making.

Important Information

- The Prior Authorization API is intended to improve efficiency and reduce reliance on manual processes, such as phone, fax, and payer portals, but does not eliminate those processes
- Only services that require prior authorization under your benefit plan are subject to this process
- These requirements apply to medical items and services and do not currently include outpatient prescription drugs
- If a prior authorization request is denied, Covered Health Plan will provide an explanation consistent with applicable requirements

Your Rights and Protections

- Your provider will generally submit prior authorization requests on your behalf
- You have the right to receive information about prior authorization decisions affecting your care
- You may have the right to appeal certain prior authorization decisions, as described in your plan materials

Covered Entities and HIPAA Enforcement

The U.S. Department of Health and Human Services' Office for Civil Rights (OCR) enforces the HIPAA Privacy, Security, and Breach Notification Rules. Covered Health Plan and participating providers are subject to HIPAA.

You can find more information about your rights under HIPAA here: https://www.hhs.gov/hipaa/for-individuals/index.html

To file a complaint with Covered Health Plan about its compliance with HIPAA requirements, please call the customer service number located on the back of your member ID card.

Relationship to Other Interoperability Tools

The Prior Authorization API is part of a broader set of interoperability capabilities required by CMS. Additional tools are available to support:

- Member access to health information (Patient Access API)
- Data sharing between health plans when coverage changes (Payer-to-Payer API)
- Provider access to patient information for care coordination (Provider Access API)

These capabilities are designed to improve access to information, enhance coordination of care, and reduce administrative burden across the health care system.