Your Guide to Prior Approval for Medical, Behavioral Health, and Prescription Services

We regard our relationship with you as a vital partnership and want to play a role in improving your health and wellbeing. Understanding how insurance processes work and your Member rights and responsibilities will help you get the most out of your plan and be your healthiest self. This document provides helpful information on Prior Approval and Notification requirements and your Appeal rights.

Understanding the Prior Approval and Notification Process

Prior Approval and Notification Requirements:

Some types of health services, treatments, prescription drugs/infusions, and medical equipment require Prior Approval and/or Notification to ensure the service or procedure will be covered by the Health Plan.

Emergency Services:

Emergency ambulance transports (911 response) and hospital-based emergency department services do not require Prior Approval. However, once your medical condition has been stabilized, Notification and Prior Approval requirements apply.

Urgent Care Services:

Prior Approval and Notification are not required to use an Urgent Care Center; however, any service that the Urgent Care Center provides during the visit is subject to Prior Approval and Notification requirements.

In-Network Services

If your provider is in-network, they are responsible for submitting Prior Approval and Notification to Health Options prior to the scheduled procedure.

If you believe a Prior Approval or Notification request has been delayed, please contact your provider's office.

Out-Of-Network Services

If you receive care from an out-of-network provider, **you are responsible** for Prior Approval and Notification requirements.

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If you plan to receive care from an out-of-network provider, please call Member Services at (855) 624-6463 (TTY/TDD: 711) with questions about authorization requirements.

If you are receiving services from an out-of-network provider and you are unsure if the service or procedure requires Prior Approval or Notification, please call Member Services. Your timely phone call to Member Services satisfies your notification responsibility. If we have not received required clinical information from your out-of-network provider, Health Options will attempt to contact your provider to obtain the necessary information.

Services Requiring Notification:

Some types of health services and treatments require Notification. When your provider is unable to obtain Prior Approval before the service, procedure, or admission, Notification is still required.

Notification is required within 48 hours of any admission or overnight observation stay, within three visit days (home health), and within 10 business days for any outpatient service or procedure that requires Prior Approval.

Failure to provide timely notification results in an administrative denial, meaning Health Options does not approve coverage for the service.

- If an in-network provider fails to provide timely notification to Health Options and the service is denied, they generally should not bill you for the service (unless you signed an authorization waiver prior to the service or procedure being performed).
    - Call Member Services if you have questions about services provided by your in-network provider.
- **If you fail to notify us of an out-of-network service, the out-of-network provider can bill you for the service, even if Health Options denies payment to the provider.**

Notification requirements apply to the following services:

- All admissions (hospital, rehabilitation, skilled nursing, hospice, home health services)
- Clinical trial and/or study and associated services
- Crisis evaluation (notification only)
- Inpatient medical withdrawal management (inpatient detox services)
- Outpatient services when Prior Approval was not submitted before the service date
- Overnight observation stays
- Transfer of care from one facility to another facility, or to hospice or home health

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Medical service categories requiring Prior Approval include, but are not limited to:

- Advanced imaging (CT, MRI, PET, etc.)
- Allergy testing
- Cardiac (heart) tests and procedures
- Chemotherapy
- Colonoscopies
- Dialysis
- Durable medical equipment
- Elective inpatient admissions
- Gender confirming surgery
- Genetic labs and diagnostics
- Experimental/Investigational services (generally non-covered)
- Home health services
- Hospice/Hospice respite care
- Nuclear radiology studies
- Nutritional therapy/products/services
- Out-of-network services (please call us)
- Pain management devices
- Potentially cosmetic procedures
- Prosthesis (an artificial body part)
- Radiation treatment
- Reconstructive procedures
- Sleep Studies
- Surgical procedures
- Transplants and related services
- Ultrasounds
- Wound care services

Non-covered medical services include, but are not limited to:

- Artificial hearts
- Cosmetic procedures
- Custodial care
- Dental (preventive/routine services)
- Dental Implants
- Erectile dysfunction treatment
- Infertility/surrogacy services
- Over-the-counter drugs/supplies
- Reversing gender confirming surgery
- Reversing sterility
- Routine circumcisions
- Routine foot care
- Temporomandibular joint syndrome (TMJ) treatment services

Behavioral Health (Mental Health and Substance Use Disorder) service categories requiring Prior Approval include, but are not limited to:

- Alcohol biomarker tests
- Applied behavioral analysis (ABA)
- Assertive community treatment (ACT)
- Crisis stabilization (notification only)
- Electroconvulsive therapy (ECT)
- Experimental/Investigational (generally non-covered)
- Intensive outpatient procedures (IOP)
- Neuropsychological testing
- Partial hospitalization (PHP)
- Psychological testing
- Residential treatment admissions
- Transcranial magnetic stimulation (TMS)
- Urine drug tests performed by out-of-network labs

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Drug categories covered under the Medical Benefit (Not dispensed by a pharmacy) that generally require Prior Approval include, but are not limited to:

- Alpha-1 proteinase inhibitor (human)
- Botulinum toxins
- Blood clotting factors
- Enzyme replacement drugs
- Erythropoiesis (blood cell)-stimulating agents
- Granulocyte-colony stimulating factors
- Growth Hormones
- Hepatitis C drugs
- Hereditary angioedema agents
- HeR2 Receptor drugs
- Immunoglobulins
- Immunologic agents
- Inflammatory Conditions ((i.e., Crohn's, Rheumatoid Arthritis, Ulcerative Colitis)
- Lyme Disease (IV/Injectable antibiotics)
- Metabolic Disorders
- High-Cost Infusions/Injections
- Multiple sclerosis drugs
- Cancer agents (infusions, injections)
- Ophthalmic (eye) injections
- Osteoporosis (bone loss) agents
- Pegylated interferons
- Pulmonary (lung) arterial hypertension drugs

Non-covered medications dispensed by a pharmacy under the pharmacy benefit include, but are not limited to:

- Drugs used for cosmetic purposes
- Drugs related to Infertility services
- Drugs used for weight control
- Erectile dysfunction (based on benefit plan coverage)
- Experimental or Investigational drugs
- Herbal remedies
- Over-the-counter drugs/supplies (except Insulin, Insulin supplies or recommended by the USPSTF)

Prior Approval requirements for drugs covered under the pharmacy benefit must be submitted by your provider. Medications that require Prior Approval are noted as "PA" on the formulary. Medications with a quantity limit ("QL") or a step therapy requirement ("ST") may also require Prior Approval.

PA (Prior Approval): Health Options requires you or your Provider to get Prior Approval for certain drugs. This means that you will need to get approval before you fill your prescriptions. If you do not get approval, we may not cover the drug. We may require that you try certain drugs to treat your medical condition before you are provided coverage.

For more detailed information about your pharmacy benefits, please visit our website at HealthOptions.org. If you have specific questions, please contact Member Services at (855) 624-6463, Monday through Friday, 8 a.m. to 6 p.m.

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Your Appeal Rights

As a Health Options Member, you have the right to request an appeal if you disagree with a denial of service(s). For more information on appeals: click **here**. You may call our Member Services team at (855)-624-6463 for information and assistance with filing an appeal or requesting an external review of a denied service.

For more detailed information about our health plans or to review your Member Benefit Agreement and Schedule of Benefits, the Provider Directory, Prescription Formulary, or Privacy Notice, please visit our website at HealthOptions.org. If you have specific questions, please contact Member Services at (855) 624-6463, Monday through Friday, 8 a.m. to 6 p.m.

Note: These are general guidelines and are subject to change. If you have any questions, please call Member Services.