Prior authorization

Frequently asked questions

What does prior authorization mean?

Some types of care require your provider to get an approval from us before you receive care. This is called prior authorization.

Why is prior authorization needed?

Prior authorization helps make sure you get the right care in the right setting and that the service is covered by Medicare and your health plan. It helps us work with your doctor to confirm plan coverage and medical necessity before treatment or services. It also ensures you have the proper follow-up care afterwards.

What is medical necessity?

Medical necessity means that the services, supplies, or drugs are needed to prevent, diagnose, or treat your medical condition and meet accepted standards of medical practice. We use medical records and Medicare coverage determinations to establish medical necessity.

Your Medicare Advantage plan will generally cover care as long as it is medically necessary and the service is included in your Evidence of Coverage and benefits charts.

Do Medicare and Medicare supplements require prior authorizations?

Please note that this answer does not apply to a Medicare Advantage plan where authorization is done before a service.

If you have Medicare as primary coverage and a Medicare supplement as secondary coverage, Medicare authorizes procedures after a service instead of before a service like a Medicare Advantage plan does. It is possible for Medicare to deny paying a claim due to not being a Medicare-approved procedure or meeting medical necessity. In this unfortunate scenario, the beneficiary would be responsible for the entire cost of the claim.

Anthem

Do Medicare Advantage plans cover everything that Medicare covers?

Medicare Advantage plans are required to cover everything that Medicare covers. Medicare Advantage plans use Medicare Local and National coverage determinations as standards to decide medical necessity.

How do I know if I need prior authorization before I receive care?

It is the provider's responsibility to ask for prior authorization from Anthem. **You aren't responsible for asking for it when you see a provider that accepts Medicare Advantage**. The list of common services on the pages that follow should help you know when to ask.

How long does it take for my prior authorization request to be approved?

Urgent preservice authorizations are approved within 24–48 hours, and nonurgent authorizations are approved within 2–10 days depending on how clear and accurate the information from the provider is.

How does prior authorization work?

Providers who accept Medicare Advantage are required to ask for prior authorization before giving certain types of care. Once approved by Anthem, the provider will only bill you for your applicable copay or coinsurance. If your provider doesn't ask for prior authorization when required, the claim will be denied. The provider CANNOT bill you for the treatment if they did not get prior authorization.

Out-of-network providers aren't required to seek prior authorization. Ask your provider to request it for you before you get care to ensure the service is covered by Medicare and your plan.

Whether you see an in-network or out-of-network provider, if your provider does ask for prior authorization and it is denied:

- You will be notified. If you choose to continue with the treatment without authorization, you will be responsible for the cost.
- You have the right to appeal the decision. We will provide direction on how to do so.

The important thing to remember is that you are not responsible for asking for prior authorization when you see an in-network provider. If you see an out-of-network provider, you can ask them to request it for you.

Services requiring prior authorization

The list of services below will help you know when prior authorization is **required** or when to ask your provider to request it. Please note, this is not a complete list and is given as a guide to help you get the most out of your plan. Detailed prior authorization information is available for your providers.

Inpatient admissions

- Elective inpatient admissions
- Rehabilitation facility admissions
- Skilled nursing facility admissions
- Long-term acute care (LTAC) care

Select outpatient services

- Orthotics (performed primarily on ankle, back, foot, and knee)
- Elective inpatient surgery
- All potentially cosmetic surgeries
- Arthroscopies/arthroplasties
- Bariatric/gastric bypass surgery
- Breast reconstruction
- Cervical fusions
- Continuous glucose monitoring (CGM)
- Coronary artery bypass graft (CABG)
- Defibrillator/pacemaker insertion or replacement
- Genetic testing
- Endoscopies
- Epidermal growth factor receptor testing
- Home health
- Hyperbaric oxygen therapy
- Intracardiac electrophysiological studies (EPS) catheter ablation
- Knee and hip replacements
- Laminectomies/laminotomies
- Laparoscopies
- Nerve destructions
- Nonemergency ground, air, and water transportation
- Occupational therapy
- Oncology (breast), mRNA, gene expression profiling
- Pain management
- Physical therapy
- Sleep studies and sleep-study-related equipment and supplies
- Spinal procedures
- Tonsillectomy/adenoidectomy
- UPPP surgery (Uvulopalatopharyngoplasty – removal of excessive soft tissue in the back of the throat to relieve obstruction)
- Vascular angioplasty and stents
- Vascular embolization and occlusion services
- Vascular ultrasound

Durable medical equipment (DME) and prosthetics

- Automated external defibrillators
- Bone stimulators
- Cochlear implants
- Cough assist (insufflator/exsufflator)
- High-frequency chest wall oscillator
- Insulin and infusion pumps
- Knee orthoses (braces)
- Left ventricular assist device
- Nonstandard wheelchairs
- Nonstandard beds
- Oral appliances for obstructive sleep apnea
- Patient transfer systems
- Pneumatic compression devices
- Power wheelchair repairs
- Power wheelchairs, accessories, and power-operated vehicles (POVs)
- Prosthetics, orthotics
- Sleep-study-related equipment and supplies
- Speech-generating devices and accessories
- Spinal cord stimulators
- Spinal orthoses
- Tumor treatment field therapy
- Ventilators
- Wound pump

Radiology services

- CT scan (including CT angiography)
- Echocardiograms
- MRA scan
- MRI scan
- MRS scan
- Nuclear cardiac scan
- PET scan
- Radiation (oncology)
- Radiation therapy

Behavioral health services

- Day hospital/partial hospital admissions
- Inpatient admissions
- Intensive outpatient therapy
- Psychological and neuropsychological testing
- Rehabilitation facility admissions
- Transcranial magnetic stimulation (TMS) for depression

Transplants: human organ and bone marrow/stem cell transplants

Prior authorization is required for Medicare-covered transplant admissions.

Inpatient services

- Heart transplant
- Islet cell transplant
- Kidney transplant
- Liver transplant
- Lung or double lung transplant
- Multivisceral transplant
- Pancreas transplant
- Simultaneous pancreas/kidney transplant
- Small bowel transplant
- Stem cell/bone marrow transplant (with or without myeloablative therapy)

Outpatient services

- Donor leukocyte infusion
- Stem cell/bone marrow transplant (with or without myeloablative therapy)

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