DC Prior Authorization Reform Amendment Act of 2023

What is a Prior Authorization?

A prior authorization, or pre-certification, is a review and assessment of planned services that helps to distinguish the medical necessity and appropriateness to utilize medical costs properly and ethically. Prior authorizations are not a guarantee of payment or benefits.

How do I submit an authorization?

Member Responsibility: If the Member receives Covered Services **outside the CareFirst Service Area**, or care is rendered by an **Out-of-Network Non-Participating Provider**, the Member is responsible for all prior authorization requirements. It is the Member's responsibility to assure that providers associated with the Member's care cooperate with prior authorization requirements. This includes initial notification in a timely manner, responding to CareFirst inquiries and, if requested, allowing CareFirst representatives to review medical records on-site or in CareFirst offices. If CareFirst is unable to conduct prior authorization request reviews, the Member's benefits may be reduced or excluded from coverage. This means that the Member may be financially responsible for rendered services that required an approved prior authorization in the setting where an out-of-network provider did not obtain an approved prior authorization.

To initiate a prior authorization request, the Member may directly contact CareFirst or may arrange to have notification given by a family member or by the provider that is involved in the Member's care. However, these individuals will be deemed to be acting on the Member's behalf. If the Member and/or the Member's representatives fail to contact CareFirst as required or provide inaccurate or incomplete information, benefits may be reduced or excluded.

Members should share the prior authorization request requirements with family members and other responsible persons who could arrange for care on the Member's behalf in accordance with these provisions in case the Member is unable to do so when necessary. CareFirst will provide additional information regarding prior authorization request requirements and procedures, including telephone numbers and hours of operation, at the time of enrollment and at any time upon the Member's request.

Provider Responsibility: When a member seeks services from an **In-Network Provider or Out-of-Network Participating Provider** inside the CareFirst Services Area, the In-Network Provider or Out-of-Network Participating Provider inside the CareFirst BlueChoice Services Area is responsible for obtaining **prior authorization and/or reauthorization**.

What services require a prior authorization?

Refer to the webpages below to determine which services and/or prescriptions require prior authorization.

- In-Network: https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page

- Out-of-Network: https://provider.carefirst.com/providers/medical/out-of-area-precertification-preauthorization.page
- Pharmacy: https://provider.carefirst.com/providers/pharmacy/pharmacy-forms.page
- For more information, you can view additional clinical guidelines on the CareFirst Member portal.

Appealing a Prior Authorization Decision

If the Member or the Member's provider disagrees with a prior authorization request decision, CareFirst will review the decision upon the Member's request. A prior authorization appeal will be reviewed and decided upon by the CareFirst Medical Director or Associate Medical Director not involved in the initial denial decision. If necessary, the Medical Director or Associate Medical Director will discuss the case with the Member's physician and/or request the opinion of a specialist board certified in the same specialty as the treatment under review. Refer to the Benefit Determinations and Appeals for more information on how to appeal a utilization management decision.