# Medical Necessity and Prior Authorization Timeframes and Member Responsibilities

- “Medical necessity” describes care that is reasonable, necessary and/or appropriate based on evidence-based clinical standards of care.
- Prior Authorization, also known as “Preauthorization,” is a process through which FirstCarolinaCare approves or denies a request to use a covered benefit before the member uses the benefit. FirstCarolinaCare’s decisions are based on medical necessity and plan benefits. FirstCarolinaCare maintains a prior authorization list that states which services require prior authorization. This list is reviewed annually.
- Members may be held responsible if they did not receive prior authorization from FirstCarolinaCare. According to regulatory standards, FirstCarolinaCare has up to 3 business days to make a decision to approve or deny prior authorization. Medically urgent prior authorization requests must have a decision rendered within 72 hours.

Consideration:

1. Medicare Advantage routine requests must be reviewed within 14 calendar days, and urgent requests must be reviewed within 72 hours.