PHYSICIANS' GUIDE TO MINNESOTA'S PRIOR AUTHORIZATION LAW *

A summary of the law, statutory citations, and instructions for filing complaints to regulators.

*This document is provided for informational purposes only and does not constitute legal or billing advice.

Staff Contact: Adrian Uphoff, Manager of Health Policy & Regulatory Affairs, auphoff@mnmed.org
Last Updated: January 2026

When the Law Applies

Overview

Minnesota's prior authorization (PA) law only applies to Minnesota patients with state-regulated health insurance products. Below is a table denoting which products are state-regulated.

Product Type	State-Regulated?	Market Share*
Employer-Sponsored Insurance (Self-Insured)	**No**	35%
Employer-Sponsored Insurance (Fully Insured)	**Yes**	20%
Medical Assistance (i.e., Medicaid) & MinnesotaCare (includes fee-for-service and managed care)	**Yes**	20%
Medicare (Traditional and Advantage)	**No**	19%
MNsure (i.e., Individual Marketplace)	**Yes**	3%
State Employees (SEGIP)	**Yes**	N/A
Federal Employees, Postal Workers, VA, TRICARE	**No**	N/A

*Minnesota Department of Health, 2025 (MN Health Care Markets Chartbook, Sections 2 and 5)

Self-Insured vs Fully Insured

When an employer assumes the financial risk of paying for medical claims, their product is **self-insured** and **is subject to federal ERISA law, not** state law or regulations. When an employer pays an insurance carrier to assume the financial risk of paying medical claims, their product is **fully insured** and **is** subject to state regulations. This distinction may not always be obvious to patients, physicians, or billing staff.

How to Identify Product Type

1) Look for information on the patient's insurance card,
2) Ask the patient about their source of insurance, and/or
3) Contact the insurance company.

What If It's Not State-Regulated?

A discussion of other PA laws is beyond the scope of this guide.

The Law

Below is a summary of Minnesota's prior authorization law, followed with full descriptions of each provision.

Summary

1	**Prohibitions & Limitations**
1A	Prohibition of PA for Select Services
1B	Limitations of PA for Chronic Conditions
1C	Limitations of PA When There Are No Evidence-Based Standards
1D	Limitations of PA When Switching Health Plans
1E	Coverage When PA Approval Wasn't Obtained but Service Met Criteria
1F	Coverage When PA Approval Wasn't Obtained but PA Requirements Weren't in Effect
2	**Availability of PA Requirements & Criteria**
2A	Public Website Posting of PA Requirements & Criteria
2B	Real Time Benefit Tool (Effective 2027)
2C	Notification of Changes to PA Requirements & Criteria
3	**Initial PA Requests**
3A	Decision Deadlines for Initial PA Requests
3B	Requirements When Plans Approve Initial PA Requests
3C	Requirements When Plans Deny Initial PA Requests
4	**PA Appeals**
4A	Decision Deadlines for PA Appeals
4B	Requirements When Plans Approve PA Appeals
4C	Requirements When Plans Deny PA Appeals
4D	External Review Process (i.e., State Appeal Process)

1) Prohibitions & Limitations

#	Provision	MN Statues Citation
1A	**Prohibition of PA for Select Services** 1) Emergency confinement or emergency services, 2) Outpatient mental health treatment, excluding medications, 3) Outpatient substance use disorder treatment, excluding medications, 4) Antineoplastic cancer treatment consistent with National Comprehensive Cancer Network guidelines, excluding medications, 5) Services that have an A or B rating from the United States Preventive Services Task Force or select preventive services described in federal law, 6) Pediatric hospice services, 7) Treatment delivered through a neonatal abstinence program.	62M.07
1B	**Limitations of PA for Chronic Conditions** A PA approval for treatment of a chronic condition does not expire unless the standard of treatment for the condition changes. “Chronic condition” is defined in statute as “a condition that is expected to last one year or more and: (1) requires ongoing medical attention to effectively manage the condition or prevent an adverse health event; or (2) limits one or more activities of daily living.”	62M.07
1C	**Limitations of PA When There Are No Evidence-Based Standards** The absence of evidence-based standards for a service is not grounds for a health plan to deny coverage for the service on the basis that it "does not meet an evidence-based standard."	62M.072
1D	**Limitations of PA When Switching Health Plans** If a patient obtains coverage from a new health plan company, and the new health plan company uses a different utilization review organization (i.e., PA processing vendor), the new health plan company must comply with the patient's active PA approvals from the previous health plan company for the first 60 days	62M.17

#	Provision	MN Statues Citation
	of enrollment in the new health plan, provided that the patient or provider submits documentation of the past PA approval.	
1E	**Coverage When PA Approval Wasn't Obtained but Service Met Criteria** Health plans may not deny or limit coverage for a completed service solely for the lack of PA approval if the service would have been approved had a PA request been submitted.	62A.59
1F	**Coverage When PA Approval Wasn't Obtained but PA Requirements Weren't in Effect** If a health plan did not have an active PA requirement in effect for a service up to the date of service, the health plan cannot deny coverage for the service on the basis that PA was not obtained.	62A.59

2) Availability of PA Requirements & Criteria

#	Provision	MN Statues Citation
2A	**Public Website Posting of PA Requirements & Criteria** Health plans must publicly post their PA requirements, restrictions, and clinical criteria on their websites in a manner that is "detailed and written in language that is easily understandable to providers."	62M.10
2B	**Real Time Benefit Tool (Effective 2027)** Effective January 1, 2027, health plans must offer and maintain a PA application programming interface (API) that automates the PA process for services, excluding medications. The API must allow providers to determine whether a PA is required for health care services, identify PA information and documentation requirements, and facilitate the exchange of PA requests and determinations from provider electronic health records or practice management systems.	62M.07
2C	**Notification of Changes to PA Requirements & Criteria** Health plans must give in-network providers at least a 45-day notice (written or electronic) of changes to PA requirements before the requirements can be implemented. Proposed changes must be posted on the health plan's website.	62M.10

3) Initial PA Requests

<table>
<tr><th>#</th><th>Provision</th><th>MN Statues Citation</th></tr>
<tr><td>3A</td><td>Decision Deadlines for Initial PA Requests
<table>
<tr><th>Review Type</th><th>Circumstance</th><th>Deadline</th></tr>
<tr><td>Standard</td><td>Default</td><td>3 business days (5 days max).</td></tr>
<tr><td>Expedited</td><td>(A) The attending physician feels that an expedited review is warranted and requests it,
OR
(B) The request is for a medication used for outpatient mental health treatment, outpatient substance use disorder treatment, or antineoplastic cancer treatment.</td><td>"As expeditiously as the enrollee's medical condition requires, but no later than 48 hours and must include at least one business day after the initial request.” (3 days max).</td></tr>
</table></td><td>62M.07</td></tr>
<tr><td>3B</td><td>Requirements When Plans Approve Initial PA Requests

When a health plan approves an initial PA request, the health plan is required to promptly notify the physician by telephone. Health plans are then required to maintain an audit trail of that phone call OR send a written follow-up notification to the provider.</td><td>62M.05</td></tr>
<tr><td>3C</td><td>Requirements When Plans Deny Initial PA Requests

To deny an initial PA request for clinical reasons, the health plan must:

1) Have a licensed physician* with the same or similar specialty review and issue the denial,
2) Ensure that said physician is “reasonably available by telephone to discuss the determination,” and
3) Send a written notification to the patient’s physician via email, fax, or US mail that includes reasons for the denial and instructions on how to appeal the denial, including appeal deadlines and how to make an expedited appeal, if applicable.</td><td>62M.09
62M.09

62M.05</td></tr>
</table>

#	Provision	MN Statues Citation
	*Pharmacists may review and issue a PA denial for medications if they are “competent to evaluate the specific clinical issues presented in the review.”	62M.09

4) PA Appeals

<table>
<tr><th>#</th><th>Provision</th><th>MN Statues Citation</th></tr>
<tr><td>4A</td><td>Decision Deadlines for PA Appeals
<table>
<tr><th>Review Type</th><th>Circumstance</th><th>Deadline</th></tr>
<tr><td>Standard</td><td>Default</td><td>15 days, unless the health plan claims a 4-day extension for circumstances outside the control of the health plan (must specify circumstance).</td></tr>
<tr><td>Expedited</td><td>(A) Appeal is made prior to or during an ongoing service requiring PA and the attending physician believes it’s warranted and requests it, or
OR
(B) The appeal is for a medication used for outpatient mental health treatment, outpatient substance use disorder treatment, or antineoplastic cancer treatment.</td><td>"As expeditiously as the enrollee's medical condition requires, but no later than 72 hours.”

During this process, the patient’s physician has an opportunity to appeal the determination over the telephone on an expedited basis, and the health plan must “ensure reasonable access to its consulting physician or healthcare provider.”</td></tr>
</table></td><td>62M.06</td></tr>
<tr><td>4B</td><td>Requirements When Plans Approve PA Appeals

When a health plan approves a standard PA appeal, the health plan is required to notify the patient and their physician in writing.

When a health plan approves an expedited appeal, the health plan is required to notify the patient’s physician via telephone.</td><td>62M.06</td></tr>
</table>

#	Provision	MN Statues Citation
4C	**Requirements When Plans Deny PA Appeals** To deny a standard PA appeal, the health plan must: 1) Have a licensed physician with the same or similar specialty review and issue the denial –this physician must be different than the one who issues the original denial, 2) Ensure that a reviewing physician is "reasonably available to review the case," **and** 3) Send a written notification to the patient's physician via email, fax, or US mail that includes reasons for the denial and instructions on how to appeal the denial, including how to initiate an appeal under the external process. To deny an expedited PA appeal, the health plan must: 1) Ensure that the enrollee and the attending physician can appeal the determination over the telephone on an expedited basis, during which the health plan must ensure reasonable access to its consulting physician or healthcare provider, 2) Notify the attending physician of the denial of the appeal via a telephone call, during which the health plan must give instructions on how to initiate an appeal under the external process.	62M.06 62M.06 62M.06 62M.09
4D	**External Review Process (i.e., State Appeal Process)** Any patient – or physician acting on behalf of a patient – who has received a denial for a PA request **and** a denial for a PA appeal may request an external review of the appeal facilitated by the appropriate state agency (i.e., Commerce or Health) at no cost to the patient or physician. External reviews involving medical determinations must be performed by a healthcare professional with expertise in the medical issue being reviewed. Standard Review = as soon as practical, but no more than 45 days. Expedited Review (per statutory criteria) = decision as quickly as possible, no more than 72 hours. Please see the "How to Request an External Review" section of this guide for more information.	62Q.73

How to Request an External Review (i.e., State Appeal)

If you have received a denial for a PA request **and** a denial for a PA appeal, you may request an external review of the appeal facilitated by an appropriate state agency. Instructions for external reviews should be included in the health plan's letter issuing the denial for the internal PA appeal. The table below provides supplemental instructions for requesting an external review.

Product Type	Regulator for External Reviews
Non-HMO Employer-Sponsored Insurance (Fully Insured) MNsure (i.e., Individual Marketplace) Small Employer Group Health Plans State Employees (SEGIP)	**Minnesota Department of Commerce** ***Consumer Services Center*** External Review Form: https://mn.gov/commerce-stat/pdfs/external-review-appeal.pdf Phone Assistance: 651-539-1600 // 800-657-3602 Email Assistance: consumer.protection@state.mn.us
Medical Assistance (i.e., Medicaid) Managed Care and Fee-For-Service, MinnesotaCare, and County-Based Purchasers	**Minnesota Department of Human Services** ***Appeals Division*** External Review Form: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG Phone Assistance: 651-431-3600 Email Assistance: dhs.appealsupport@state.mn.us
Health Maintenance Organizations (HMOs)	**Minnesota Department of Health** ***Managed Care Systems*** External Review Form: https://www.health.state.mn.us/facilities/insurance/managedcare/complaint/external.html Phone Assistance: 651-201-5100 // 800-657-3916 Email Assistance: health.mcs@state.mn.us

*****IF YOU ARE UNSURE, CALL THE MINNESOTA DEPARTMENT OF COMMERCE, AND THEY WILL DIRECT YOU TO THE APPROPRIATE REGULATOR*****

How to Submit a Complaint

Minnesota's prior authorization law is only as effective as it is enforced. Regulators can impose significant penalties on health plans found to be noncompliant with the law, but their ability to identify noncompliance is limited to the extent that patients and physicians submit formal complaints. The table below describes the appropriate regulator for different types of health insurance products.

Product Type	Regulator for Complaints
Non-HMO Employer-Sponsored Insurance (Fully Insured) MNsure (i.e., Individual Marketplace) Small Employer Group Health Plans State Employees (SEGIP)	**Minnesota Department of Commerce** ***Consumer Services Center*** Complaint Form: https://mn.gov/commerce/consumer/file-a-complaint/ Phone Assistance: 651-539-1600 // (800) 657-3602 Email Assistance: consumer.protection@state.mn.us
Medical Assistance (i.e., Medicaid) Managed Care and Fee-For-Service, MinnesotaCare, and County-Based Purchasers	**Minnesota Department of Human Services** ***Minnesota Healthcare Programs Provider Relations*** Complaint Form: Not Available, Call Number Below Phone Assistance: 651-431-2700 Email Assistance: dhs.healthcare-providers@state.mn.us
Health Maintenance Organizations (HMOs)	**Minnesota Department of Health** ***Managed Care Systems*** Complaint Form: https://www.health.state.mn.us/facilities/insurance/managedcare/complaint/investigate.html Phone Assistance: 651-201-5100 // 800-657-3916 Email Assistance: health.mcs@state.mn.us

*****IF YOU ARE UNSURE, CALL THE MINNESOTA DEPARTMENT OF COMMERCE, AND THEY WILL DIRECT YOU TO THE APPROPRIATE REGULATOR*****