Prior Authorization and Pre-Claim Review Program Stats

September 15, 2023

Prior Authorization and Pre-Claim Review Overview

CMS regularly assesses vulnerabilities for items and services that are subject to fraud, waste, and abuse. One tool that CMS uses to combat fraud, waste, and abuse is prior authorization and pre-claim review. CMS runs a variety of Medicare Fee-for-Service prior authorization and pre-claim review programs that support efforts to safeguard beneficiaries' access to medically necessary items and services while also reducing improper Medicare billing and payments.

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before an item or service is furnished to a Medicare patient. Pre-claim is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. Prior authorization and pre-claim review are similar but differ in the timing of the review and when services can begin. Under prior authorization, the provider or supplier submits the prior authorization request and receives the decision before services are provided. Under pre-claim review, the provider or supplier submits the pre-claim review request; however, the provider or supplier can begin or complete services before submitting the request.

Both methods help to ensure that all applicable Medicare coverage, payment, and coding rules are met before an item/service is furnished and a claim is submitted, which helps providers and suppliers address claim issues early and avoid denials and appeals. By utilizing these methods, CMS ensures compliance with Medicare rules and protects the Medicare Trust Fund from improper payments. CMS works closely with providers and associations to share prior authorization and pre-claim review guidelines and procedures.

A provider or supplier submits to their Medicare Administrator Contractor (MAC) either the prior authorization request or pre-claim review request with all supporting medical documentation for provisional verification of coverage for the item or service. The MAC reviews the request and sends the provider or supplier an affirmed or non-affirmed decision. This process ensures that Medicare coverage and documentation requirements likely are met before the item or service is provided and a claim is submitted.

In an effort to reduce provider burden, these programs do not change any medical necessity or documentation requirements. They require the same information currently needed to support Medicare payment, just earlier in the process. This helps providers and suppliers address claim issues early and avoid denials and appeals. Prior authorization and pre-claim review also offer providers and suppliers some assurance of payment for items and services that receive provisional affirmation decisions.

Current Prior Authorization and Pre-Claim Review Programs

- Prior Authorization for Certain Hospital Outpatient Department (OPD) Services
- Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model
- Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items
- Review Choice Demonstration for Home Health Services (HH RCD)

Glossary of Terms

Prior authorization request
A request for provisional affirmation of coverage through review of the documentation that supports medical necessity.

Prior authorization decision
A preliminary assessment that a future claim for the service submitted to Medicare likely meets (affirmative) or does not meet (non-affirmative) Medicare's coverage, coding, and payment requirements.

Medicare Administrative Contractor (MAC)
A private health care insurer that has been awarded a geographic jurisdiction to process claims for Medicare Fee-For-Service beneficiaries. CMS relies on a network of MACs to serve as the primary operational contact between Medicare and the health care providers enrolled in the program.

Accuracy/accuracy rate
CMS's Medical Review Accuracy Contractor (MRAC) reviews a sample of MAC prior authorization and pre-claim review decisions to determine the accuracy rate for each program. To calculate the accuracy rate, divide the number of prior authorization/pre-claim review decisions when the MRAC agreed with the MAC's decision by the total number of prior authorization/ pre-claim decisions the MRAC reviewed.

MAC review timeliness
The average timeframe for a prior authorization or pre-claim review decision

Appeals
The process used to request review when a party (for example, a patient, provider, or supplier) disagrees with an initial decision or revised decision on a claim for health care items or services. A first level appeal is handled by the MAC that processed the original Medicare claim.[1]

- Upheld appeals: When the MAC maintains the denial decision they initially made.
- Overturned appeals: When the MAC reverses the denial decision in favor of the patient, provider, or supplier.

Exemption
CMS exempts hospital outpatient department providers that submitted at least 10 prior authorization requests and achieved a provisional affirmation rate of at least 90 percent as they are assumed to understand the requirements for submitting accurate claims.

Total requests received
The total number of requests submitted to the MAC through the prior authorization or pre-claim review process.

Total requests completed
The total number of requests that were reviewed and processed with a provisional affirmation or non-affirmation decision.

Total requests provisionally affirmed
The total number of prior authorization or pre-claim review requests that received a provisional affirmation decision. A provisional affirmation decision is a preliminary finding that a future claim submitted to Medicare for the service likely meets Medicare's coverage, coding, and payment requirements.

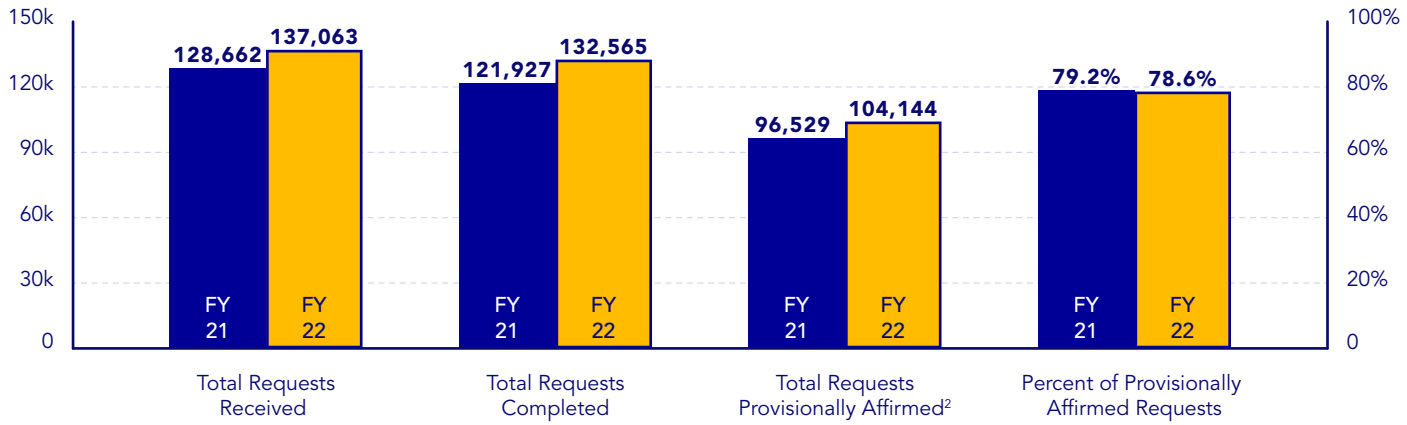
Percent of provisionally affirmed requests
The total number of prior authorization or pre-claim review requests with a provisional affirmation decision divided by the total number of requests completed.

1. There are subsequent levels of appeal, but this document does not address those levels. For more information on appeals please visit: www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals

Prior Authorization for Certain Hospital Outpatient Department (OPD) Services

The prior authorization program for certain hospital OPD services ensures that Medicare beneficiaries continue to receive medically necessary care while protecting the Medicare Trust Funds from unnecessary increases in the volume of covered services and improper payments. The Calendar Year (CY) 2020 Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) Final Rule (CMS -1717-FC) established a nationwide prior authorization process and requirements for certain hospital OPD services. These services are blepharoplasty, botulinum toxin injection, rhinoplasty, panniculectomy, and vein ablation. As part of the CY 2021 OPPS/ASC Final Rule (CMS -1736-FC), CMS added cervical fusion with disc removal and implanted spinal neurostimulators to the prior authorization process.

Prior Authorization Requests



MAC Review Timeliness	
	Average Number of Days
FY 21	4.3
FY 22	4.5

Appeals							
	Total Reviews Completed	Total Reviews Affirmed	Total Reviews Non-Affirmed	Claims Appealed to Level 1	Level 1 Appeals: Overturned	Level 1 Appeals: Upheld	% Of Claims Overturned Out of Total Reviews Completed
FY 21	121,927	96,529	25,398	2,454	511	1,943	0.4%
FY 22	132,565	104,144	28,421	1,886	419	1,467	0.3%

OPD Providers Exempt from Prior Authorization[3]	
FY 21	165
FY 22	302

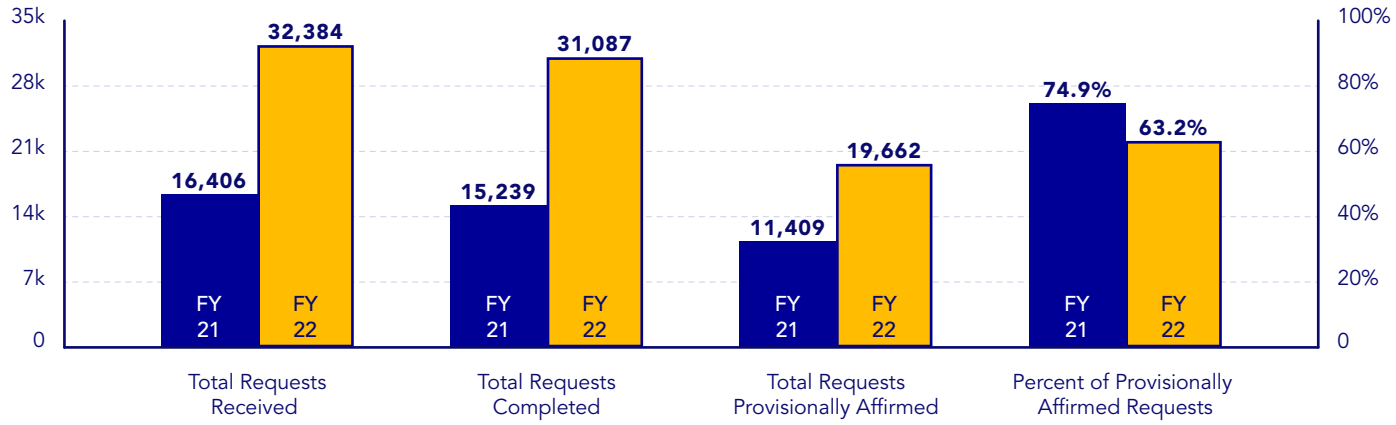
MAC Accuracy Rate	98.1% FY 21	98.5% ↑ FY 22

2. For FY 21, there was a formula error resulting in a slightly higher number of requests affirmed. The formula was corrected after the release of the Department of Health and Human Services' annual agency financial report.
3. The exemption cycle from prior authorization runs from January 1 through December 31.

Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model

The RSNAT Prior Authorization Model is a nationwide[4] model that applies to independent ambulance suppliers that are not based at an institution and provide ambulance services covered by Part B Medicare. The model is testing whether prior authorization helps reduce expenditures, while maintaining or improving quality of care by using the prior authorization process. The model establishes a process through which a request for provisional affirmation of coverage is submitted for review to the MAC before the beneficiary receives the service and before the claim is submitted for payment. The prior authorization process allows ambulance suppliers to address issues with claims prior to claim submission with unlimited opportunities to correct issues. Prior authorization is voluntary; however, if the ambulance supplier does not participate, applicable RSNAT claims will go through a prepayment medical record review.

Prior Authorization Requests



MAC Timeliness	
	Average Number of Days
FY 21	3.3
FY 22	4.1

Appeals							
	Total Reviews Completed	Total Reviews Affirmed	Total Reviews Non-Affirmed	Claims Appealed to Level 1	Level 1 Appeals: Overturned	Level 1 Appeals: Upheld	% Of Claims Overturned Out of Total Reviews Completed
FY 21	15,239	11,409	3,830	1,605	433	1,172	4.3%
FY 22	31,087	19,662	11,425	2,234	587	1,647	3.9%

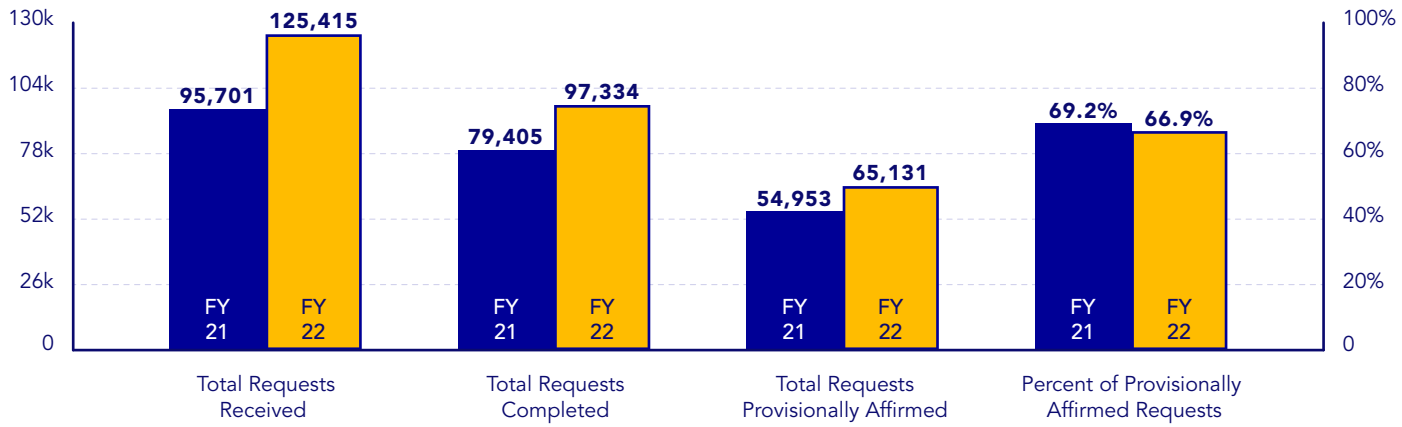
MAC Accuracy Rate	94% FY 21	98.9% ↑ FY 22

4. The model expanded to MAC Jurisdiction H (JH) on 12/1/2021; to JJ and JE on 2/1/2022; to JN, J5, and J6 on 4/1/2022; to J8 and JK on 6/1/2022; and to JF, J15, and the Railroad Retirement Board on 8/1/2022.

Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items

CMS issued a final rule establishing a national prior authorization process as a condition of payment for certain DMEPOS items that are often overused. The CMS Required Prior Authorization List currently contains 62 Healthcare Common Procedure Coding System (HCPCS) items including 46 power mobility devices (PMDs), 5 pressure reducing support surfaces (PRSSs), 6 lower limb prosthetics (LLPs), and 5 orthoses. Prior authorization of these HCPCS is required as a condition of payment nationwide.

Prior Authorization Requests



MAC Timeliness	
	Average Number of Days
FY 21	4.7
FY 22	4.7

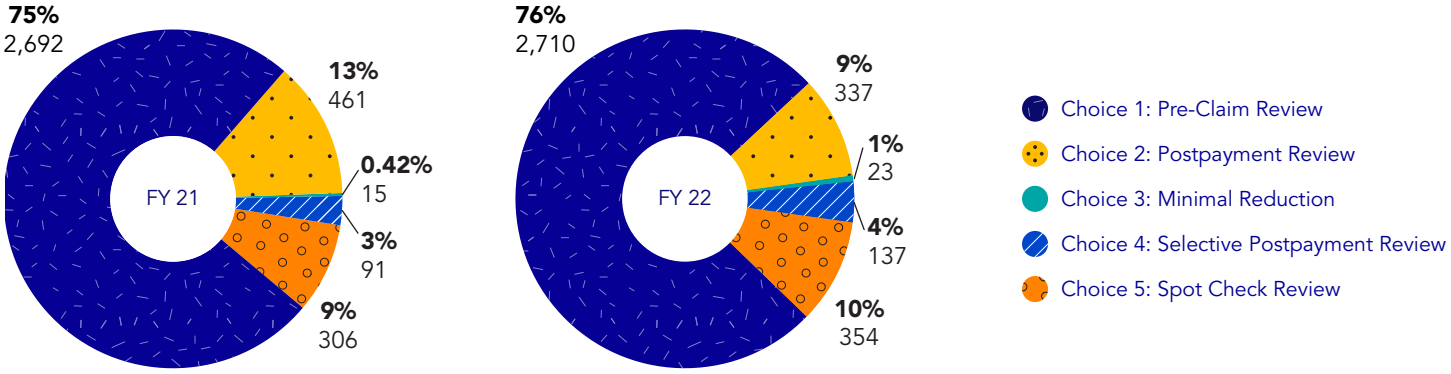
Appeals							
	Total Reviews Completed	Total Reviews Affirmed	Total Reviews Non-Affirmed	Claims Appealed to Level 1	Level 1 Appeals: Overturned	Level 1 Appeals: Upheld	% Of Claims Overturned Out of Total Reviews Completed
FY 21	79,405	54,953	24,452	614	421	193	0.5%
FY 22	97,334	65,151	32,183	496	317	179	0.3%

MAC Accuracy Rate	97.9% FY 21	98.8% ↑ FY 22

Review Choice Demonstration for Home Health Services (HH RCD)

The HH RCD improves procedures for identifying, investigating, and prosecuting potential Medicare fraud. The program—which is currently implemented in Illinois, Ohio, Texas, North Carolina, and Florida—helps ensure through either pre-claim review (PCR) or postpayment review that payments for home health services are appropriate. Under this program, home health agencies choose how they demonstrate their compliance with CMS home health policies. They may participate in either 100 percent PCR or 100 percent postpayment review, and these agencies will continue to be subject to review until they reach the 90 percent target affirmation or claim approval rate. At this point, agencies may choose to be relieved from claim reviews, except for spot checks of claims to ensure continued compliance.

Providers in Each Choice



Pre-Claim Review Requests[5]

	Total Number of Requests Received	Total Number of Requests Completed	Total Number of Requests Provisionally Affirmed	Percent of Affirmed Requests
FY 21	1,680,189	1,670,173	1,603,801	96%
FY 22	1,757,609	1,896,938	1,824,526	96.2%

Prepayment and Postpayment Reviews[6]

	Total Number of Reviews Completed	Total Number of Approvals	% of Approved Requests
FY 21	28,274	21,403	76%
FY 22	48,165	39,365	82%

MAC Timeliness for Pre-Claim Review Requests

	Average Number of Days
FY 21	3.1
FY 22	6.3

Appeals

	Total Reviews Completed	Total Reviews Affirmed	Total Reviews Non-Affirmed	Claims Appealed to Level 1	Level 1 Appeals: Overturned	Level 1 Appeals: Upheld	% Of Claims Overturned Out of Total Reviews Completed
FY 21	1,698,447	1,625,204	73,243	1,671	649	1,022	0.03%
FY 22	1,936,303	1,863,891	72,412	2,821	1,204	1,617	0.06%

MAC Accuracy Rate

99.2% FY 21

99.5% ↑ FY 22

5. The total number of PCRs completed may be higher or lower than the number of PCR requests received because some requests are received at the end of a fiscal year and completed in the next. For example, a request received on September 29, 2021 and reviewed on October 3, 2022, would be included in FY 21 Requests Received and in FY 22 Requests Completed.

6. This includes all prepayment and postpayment claim reviews for all review choice options.