Medicare Prior Authorization

Prior Authorization is….

- …a requirement wherein a proposed service must be reviewed and approved prior to the delivery of patient care. A failure to gain approval where required results in claim denials without the ability to bill the patient for denied charges.
- …only a conditional approval of payment. Changes in the patient's condition or benefits eligibility, or a provider's failure to meet post-delivery requirements may still result in payment denials.
- …a cost-cutting/cost-savings measure that CMS contends will "protect" Medicare beneficiaries, and the Medicare Trust Funds.

Prior Authorization is not….

- …a guarantee of payment. Changes in the patient's condition or benefits eligibility, or a provider's failure to meet post-delivery requirements may still result in payment denials.
- …effective in eliminating post-payment audit activity at the CERT, RAC or Z-PIC level. Those programs will still exist for the purposes of measuring contractor and provider performance.
- …in the best interest of the expedient delivery of patient care.
- …in the best interests of patients or the Medicare program, when a patient is under a per diem payment structure (e.g. SNF)

What would Medicare Prior Authorization look like?

- 100% prepayment/RAC review
- The supplier is required to submit a request for prior authorization *after* the patient has been examined and assessed by a clinician, but *before* a device or service can be delivered.
- We would expect that CMS will require much of the same documentation as it does with RAC audits (e.g., "evidence that the item complies with all coverage, coding, and payment rules"):
    - Clinician's notes, functional assessment, other documentation
    - Detailed prescription from the referring physician/entity
    - Contemporaneous clinical notes supporting medical necessity and the functional assessment from the referring physician, therapist(s) and others involved in the patient's rehabilitation. (Contemporaneous notes usually requires a recent physician visit)
- CMS proposes a 10 day turnaround time for first-time prior authorization requests.
    - In situations where CMS agrees that delaying a prior authorization decision might put the patient's life at risk, it will make "reasonable attempts" to communicate its decision to the supplier within 2 business days.
- Non-affirmed (denied) prior authorization requests are not appealable, but can be resubmitted until finally approved (or until the patient and supplier agree to stop pursuing authorization.)

    - Resubmitted requests are subject to a proposed 20 day turnaround time.
- It can be assumed that resubmitting a prior authorization request without additional documentation will result in another non-affirmed (denied) prior authorization request. Before resubmitting, the supplier may consider:
    - Referring the patient back to the physician or therapist for further assessment and (presumably) more robust clinical documentation.
    - Further assess the patient and better document the clinical need for the proposed services.
- When a prior authorization request is non-affirmed (denied), an Advance Beneficiary Notice (ABN) may be used to shift financial liability to the patient should they choose to proceed with obtaining services.
    - ***Note:*** if a claim is denied because the supplier failed to request prior authorization, the patient may not be billed.
- If the supplier/provider believes that sufficient information exists for an affirmed (approved) prior authorization, yet the CMS contractor continues to deny, there is no appeal rights. The only choice is to resubmit again and have the patient wait.
- There is no reason to believe that the non-affirmed (denied) prior authorization will be detailed enough to troubleshoot and/or correct.
- Current RAC and Prepayment denials are many times generic in nature (i.e. 'lacks sufficient justification').