National Committee on Vital and Heath Statistics (NCVHS) Review Committee Adopted Standards, Code Sets, Identifiers and Operating Rules Hearing

Thank you for the invitation to discuss the Centers for Medicare & Medicaid Services (CMS) Provider Compliance Group's efforts to reduce improper payments through the use of prior authorization programs. The Administration is strongly committed to reducing the rate of improper payments and ensuring that our programs pay claims in an accurate and timely manner.

Background on Prior Authorization

Prior authorization is used by many insurers to decrease utilization and unnecessary services and to make sure proper payment is made prior to services being rendered. Medicare Fee-for-Service prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before a service is furnished to a beneficiary and before a claim is submitted for payment. Prior authorization in Medicare helps ensure that applicable coverage, payment and coding rules are met before services are rendered.

In Medicare Fee-for-Service prior authorization does not create new documentation requirements. It simply is a review of required documentation earlier in the claims payment process. The prior authorization methodologies used today are administered by the Medicare Administrative Contractors (MACs), the same contractors that currently process claims and conduct medical review. Clinicians complete the review of the prior authorization requests. Requests can be submitted by the Medicare provider/supplier or beneficiary through mail, fax, electronic submission of medical documentation (esMD), or submitted through the MAC provider portals, where available.

CMS has tried to implement a prior authorization process that is timely for providers and beneficiaries and allows sufficient time for reviewers to make accurate determinations. CMS has implemented a 10 day response time from the date of receipt of an initial complete prior authorization package. In addition, a prior authorization request can be re-submitted an unlimited number of times. Each non-affirmed decision is accompanied by detailed reasons for the non-affirmation. As these programs are for non-emergent services, CMS expects requests for expedited reviews to be extremely rare.

CMS currently has 3 prior authorization demonstrations or pilot programs. They are:

The Power Mobility Device (PMD) Prior Authorization Program

This program establishes a prior authorization process for scooters and power wheelchairs to help make sure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines.

The program began in September 2012 in 7 states and in October 2014 CMS expanded the program to 12 additional states.

The Repetitive Scheduled Non-Emergent Ambulance Transport Prior Authorization Program:

This program establishes a three year prior authorization process for repetitive scheduled non-emergent ambulance transports to reduce utilization of services that do not comply with Medicare policy while maintaining or improving quality of care. The program impacts the states of New Jersey, Pennsylvania, and South Carolina based on where the ambulance is garaged. The program began on December 1, 2014.

The prior authorization decision, justified by the beneficiary's condition, may affirm up to 40 round trips (which equates to 80 trips) per prior authorization request in a 60-day period. Transports exceeding 40 round trips (or 80 one-way trips) in a 60-day period require an additional prior authorization request.

The Non-Emergent Hyperbaric Oxygen Therapy Prior Authorization Program:

The program establishes a three year prior authorization process for hyperbaric oxygen therapy for certain covered conditions to reduce utilization of services that do not comply with Medicare policy while maintaining or improving quality of care. This prior authorization program impacts the states of Illinois, Michigan, and New Jersey based on where the service is rendered. The program began on April 13, 2015 in the state of Michigan and New Jersey and Illinois will be added in the future.

A provisional affirmative prior authorization decision may affirm up to 40 courses of treatment in a 12 month period. If additional sessions are needed in excess of the 40 treatments, a new prior authorization may be submitted.

Prior authorization affirmations will apply retroactively to the start date listed on the prior authorization request. Prior authorization should be requested as soon as the hyperbaric oxygen therapy is scheduled. Treatment should not be delayed due to a pending prior authorization decision. However, claims should not be submitted until the prior authorization decision has been received.

Lessons Learned from the Prior Authorization Program

CMS has learned that there tends to be a steep learning curve for providers/suppliers when they first begin submitting prior authorization requests. This has led to CMS allowing additional time prior to the official start date of the programs for submitters to correct and resubmit incomplete requests. CMS has learned that in addition to those provider types directly affected by the prior authorization program, education should also be provided to related provider/supplier types such as ordering/referring providers.

Conclusion

CMS aims to continue reducing improper payments. Prior authorization is proving to be effective in lowering expenditures and improper payments. The programs are helping to make sure coverage and documentation requirements are met before services are rendered and before the claims are submitted for payment. These programs are also helping to make sure the beneficiaries are receiving reasonable and necessary services.

Standards and requirements put into place for prior authorization need to be flexible and allow for Medicare FFS's definition and process. Strict guidelines regarding timeliness or decision timeframes could impede the Medicare progress and make it difficult for providers to respond to requests from all payers electronically. In addition, Medicare providers come in all sizes and have varying degrees of sophistication as it pertains to electronic submission. In order to be able to use prior authorization to its fullest extent, Medicare needs to be able to offer different solutions to providers. This may mean submission through a portal, submission through the electronic submission of medical documentation (esMD) in a pdf format, submission in x12 format and submission through secure email as well as paper and fax submissions. The future needs to allow for the inevitable change of technology but not forget about also servicing the providers who have not upgraded.