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 Medicare Fee-for-Service 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.

Prior authorization is relatively new to Medicare but 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. In 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 created a 278 receipt process using the x12 standard through the esMD system. While it has been in place for over 6 months and CMS has advertised it to providers, no 278 transactions have been received or even attempted. This was not unexpected. CMS did not expect that Medicare providers were ready to submit prior authorization requests in 278 format. For Medicare, the prior authorization request has to be received along with documentation supporting the request. Although medical documentation in pdf format can be submitted along with the 278 via esMD, providers typically use MAC portals, when available, or fax to submit the prior authorization request. The 278 format does not cover all scenarios in the paperwork (PWK) field. Currently only mail, fax and electronic is available and this leaves no clear option for CMS's esMD system.

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. CMS has been able to use a 10 day response time because all of the services/items requiring prior authorization are non-emergent. In addition, providers can re-submit a prior authorization request an unlimited number of times. Each non-affirmed decision is accompanied by detailed reasons for the non-affirmation. These denial decisions are mailed but are also available to providers through the MAC portals and the esMD system.

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, process and response time. Strict guidelines regarding timeliness or decision timeframes could impede the Medicare progress and make it more burdensome 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.