Medicare Prior Authorization

What is Prior Authorization?

Prior authorization is a process that requires a health care provider to submit a request for advanced approval of coverage to a health insurance plan or claims processor before providing certain items or services to a plan enrollee. Prior Authorization is often required in Medicare Advantage (MA), and less frequently in Traditional Medicare. Theoretically, the purpose of prior authorization is to ensure that the proposed health care item or service is medically necessary and meets the requirements for coverage in a given MA or other insurance plan. In reality, prior authorization denials can prohibit medically reasonable and necessary care, and the prior authorization process itself can create interruptions and barriers to care.

Prior Authorization in Medicare Advantage

Prior authorization is frequently required before Medicare Advantage plans cover a wide array of services, particularly higher cost services, including inpatient hospital stays, skilled nursing facility care, inpatient and outpatient psychiatric services, Part B drugs, and chemotherapy. Medicare Advantage plans often require Prior Authorization for specialist visits, as well. Prior authorization is rarely required for preventive services. Almost all Medicare Advantage plans require prior authorization for at least some services.

According to a recent study by the Kaiser Family Foundation (KFF), Prior Authorization requests are on the rise, with over 46 million Medicare Advantage Prior Authorization requests submitted in 2022, up from 37 million in 2019. KFF reports that the number and proportion of Prior Authorization denials are also on the rise, and few beneficiaries – about one in ten - appeal Prior Authorization denials. Those who do appeal are generally successful, however: 83 percent of Prior Authorization denials that were appealed in 2022 were overturned [KFF, 2024].

The fact that the overwhelming majority of Prior Authorization denials are appealed successfully points to the use of Prior Authorization as a cost-saving measure, rather than a tool to ensure proper care.

Prior Authorization in Traditional Medicare

Historically, Traditional Medicare has rarely required Prior Authorization. Originally, the Social Security Act did not authorize **any** form of Prior Authorization for Medicare services, but the law was subsequently changed to allow Prior Authorization for limited items of Durable Medical Equipment and, more recently, certain hospital outpatient department services.

In 2019, CMS issued a final rule that subjected certain hospital outpatient department services to Prior Authorization under Traditional Medicare. From 2020 through 2023, the following services have been gradually added to the list of hospital outpatient department (OPD) services that require prior authorization under Traditional Medicare:

- Blepharoplasty
- Botulinum toxin injections
- Panniculectomy
- Rhinoplasty
- Vein ablation
- Implanted Spinal Neurostimulators
- Cervical Fusion with Disc Removal
- Facet Joint Interventions

There is also a demonstration project currently running to test the use of prior authorization on Repetitive Scheduled Non-Emergent Ambulance Transport.

Despite these changes, there are currently still far fewer services requiring Prior Authorization in Traditional Medicare than in Medicare Advantage. For example, Traditional Medicare beneficiaries can generally see specialists, visit hospitals, and get care out-of-state, without having to ask Medicare's permission.

What To Do if Prior Authorization is Denied by a Medicare Advantage Plan

A Prior Authorization denial in Medicare Advantage can be appealed. It is considered a pre-service initial determination and, as such, is subject to the same expedited and standard appeal rights and processes as comparable initial determinations made after a claim has been filed. To appeal a Prior Authorization denial in Medicare Advantage, follow the appeal instructions on the notice issued by the Medicare Advantage plan. The Center for Medicare Advocacy has toolkits and self-help packets to help with appeals of certain care, including home health, outpatient therapy, and skilled nursing facility coverage.

What to Do if Prior Authorization is Denied by Traditional Medicare

In Traditional Medicare, a Prior Authorization is not considered an initial determination, and as such, cannot be appealed. However, a provider can re-submit the Prior Authorization request and "include all documentation necessary to show that the proposed care meets applicable Medicare coverage, coding, and payment rules" (42 CFR 419.82(e)).