AAOE
American Alliance of Orthopaedic Executives

Supporting the Business of Orthopaedics

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Prior Authorization in the Medicare Program

Prior authorizations, sometimes called pre-authorizations or pre-claim review, are used by healthcare payers to regulate the clinical care provided to their beneficiaries. Many payers use prior authorization as a tool to control costs. Physicians are often the parties responsible for submitting prior authorization requests. When the request does not meet the payers guidelines, criteria, or policies for treatment, the request is generally denied and the patient is responsible for the costs of treatment.

Traditional Medicare (Parts A and B) currently only allows prior authorization for a limited set of services including durable medical equipment and some physicians' services. Medicare Advantage (Part C) and Medicare Prescription Drug Plans (Part D) typically require prior authorization to see specialists, receive care outside the insurers network, and receive non-emergent hospital care.

In February 2016, the Centers for Medicare and Medicaid Services (CMS), which administers the Medicare program, published notice in the Federal Register that it would implement a Pre-Claim Review Demonstration for Home Health Services. CMS suspended this demonstration model in March 2017 and released the Review Choice Demonstration for Home Health Services on May 29, 2018.

The Effect of Prior Authorization on Medicare Providers

Prior authorization represents a significant monetary and administrative burden on physician offices. A study in the Journal of the American Board of Family Medicine conducted in 2013 found that a primary care practice sees financial costs of prior authorization between $2,161 and $3,430 per physician.

Physician practices also face opportunity costs with prior authorization reviews. Many payers continue to utilize older methods of obtaining prior authorization including paper, phone, and fax. These methods take substantial time (some estimates for phone prior authorizations indicate they can take up to two hours per patient/service) of physician, physician assistant, and/or nurse practitioner time, time that could be spent providing care to patients.

AAOE Recommends

AAOE recommends that Congress prohibit future attempts at implementing prior authorization in traditional Medicare. We also encourage Congress to require that contracting Medicare Advantage organizations utilize electronic prior authorization as a requirement for participation in the Medicare Advantage program.

We encourage passage of HR 3107, *Improving Seniors' Timely Access to Care Act of 2019* in the 116th Congress to streamline Medicare Advantage prior authorization process and require MA plans to accept electronic prior authorization transmissions, prohibit MA plans from requiring prior authorization during the peroperative period, and establish a "real-time decisions" process for the approval of routine, non-complex items and services.

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