# Prior Authorization and Pre-Claim Review Program Stats for Fiscal Year 2023

January 17, 2025 Fiscal Year (FY): October 1, 2022 – September 30, 2023

## Prior Authorization and Pre-Claim Review Overview

CMS regularly assesses vulnerabilities for items and services that are subject to fraud, waste, and abuse. One tool that CMS uses to combat fraud, waste, and abuse is prior authorization and pre-claim review. CMS runs a variety of Medicare Fee-for-Service prior authorization and pre-claim review programs that support efforts to safeguard beneficiaries' access to medically necessary items and services while also reducing improper Medicare billing and payments.

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before an item or service is furnished to a Medicare patient. Pre-claim review is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. Prior authorization and pre-claim review are similar but differ in the timing of the review and when services can begin. Under prior authorization, the provider or supplier submits the prior authorization request and receives the decision before services are provided. Under pre-claim review, the provider or supplier submits the pre-claim review request; however, the provider or supplier can begin or complete services before submitting the request.

Both methods help to ensure that all applicable Medicare coverage, payment, and coding rules are met before an item or service is furnished and a claim is submitted, which helps providers and suppliers address claim issues early and avoid denials and appeals. By utilizing these methods, CMS ensures compliance with Medicare rules and protects the Medicare Trust Fund from improper payments. CMS works closely with providers and associations to share prior authorization and pre-claim review guidelines and procedures.

A provider or supplier submits to their Medicare Administrator Contractor (MAC) either the prior authorization request or pre-claim review request with all supporting medical documentation for provisional verification of coverage for the item or service. The MAC reviews the request and sends the provider or supplier an affirmed or non-affirmed decision. This process ensures that Medicare coverage and documentation requirements likely are met before the item or service is provided and/or a claim is submitted.

In an effort to reduce provider burden, these programs do not change any medical necessity or documentation requirements. They require the same information currently needed to support Medicare payment, just earlier in the process. This helps providers and suppliers address claim issues early and avoid denials and appeals. Prior authorization and pre-claim review also offer providers and suppliers some assurance of payment for items and services that receive provisional affirmation decisions.

### Current Prior Authorization and Pre-Claim Review Programs

- Prior Authorization for Certain Hospital Outpatient Department (OPD) Services
- Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model
- Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items
- Review Choice Demonstration for Home Health Services (HH RCD)
- Review Choice Demonstration for Inpatient Rehabilitation Facility Services (IRF RCD)

# Glossary of Terms

### Prior authorization request
A request for provisional affirmation of coverage through review of the documentation that supports medical necessity before an item or service is furnished.

### Pre-claim review
A provisional affirmation of coverage submitted to the MAC for review before a final claim is submitted for payment. The provider can begin or complete services before submitting the request.

### Prior authorization decision
A preliminary assessment that a future claim for the service submitted to Medicare likely meets (affirmative) or does not meet (non-affirmative) Medicare's coverage, coding, and payment requirements.

### Medicare Administrative Contractor (MAC)
A private health care insurer that has been awarded a geographic jurisdiction to process claims for Medicare Fee-For-Service beneficiaries. CMS relies on a network of MACs to serve as the primary operational contact between Medicare and the health care providers enrolled in the program.

### Accuracy/accuracy rate
CMS's Medical Review Accuracy Contractor (MRAC) reviews a sample of MAC prior authorization and pre-claim review decisions to determine the accuracy rate for each program. To calculate the accuracy rate, divide the number of prior authorization/pre-claim review decisions when the MRAC agreed with the MAC's decision by the total number of prior authorization/pre-claim decisions the MRAC reviewed.

### MAC review timeliness
The average timeframe for a prior authorization or pre-claim review decision.

### Exemption
CMS exempts hospital outpatient department providers that submitted at least 10 prior authorization requests and achieved a provisional affirmation rate of at least 90 percent as they are assumed to understand the requirements for submitting accurate claims.

### Appeals
The process used to request review when a party (for example, a patient, provider, or supplier) disagrees with an initial decision or revised decision on a claim for health care items or services. A first-level appeal is handled by the MAC that processed the original Medicare claim.[1]

- Upheld appeals: When the MAC maintains the denial decision they initially made.
- Overturned appeals: When the MAC reverses the denial decision in favor of the patient, provider, or supplier.

### Total requests received
The total number of requests submitted to the MAC through the prior authorization or pre-claim review process.

### Total requests completed
The total number of requests that were reviewed and processed with a provisional affirmation or non-affirmation decision.

### Total requests provisionally affirmed
The total number of prior authorization or pre-claim review requests that received a provisional affirmation decision. A provisional affirmation decision is a preliminary finding that a future claim submitted to Medicare for the service likely meets Medicare's coverage, coding, and payment requirements.

### Percent of provisionally affirmed requests
The total number of prior authorization or pre-claim review requests with a provisional affirmation decision divided by the total number of requests completed.

### Expedited review
The total number of prior authorization requests, made by the provider, in which a MAC determined that delays in review and response could jeopardize the life or health of the beneficiary.

1. There are subsequent levels of appeal, but this document does not address those levels. For more information on appeals please visit: www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals.

# Prior Authorization for Certain Hospital Outpatient Department (OPD) Services

The prior authorization program for certain hospital OPD services ensures that Medicare beneficiaries continue to receive medically necessary care while protecting the Medicare Trust Funds from unnecessary increases in the volume of covered services and improper payments. The Calendar Year (CY) 2020 Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) Final Rule (CMS -1717-FC) established a nationwide prior authorization process and requirements for certain hospital OPD services. These services are blepharoplasty, botulinum toxin injection, rhinoplasty, panniculectomy, and vein ablation. As part of the CY 2021 OPPS/ASC Final Rule (CMS -1736-FC), CMS added cervical fusion with disc removal and implanted spinal neurostimulators to the prior authorization process. Through CY 2023 OPPS/ASC Final Rule (CMS -1772-FC), CMS added facet joint interventions to the prior authorization process.

**Fiscal Year 2023**

**MAC Accuracy Rate:**

**99.1%**[2]

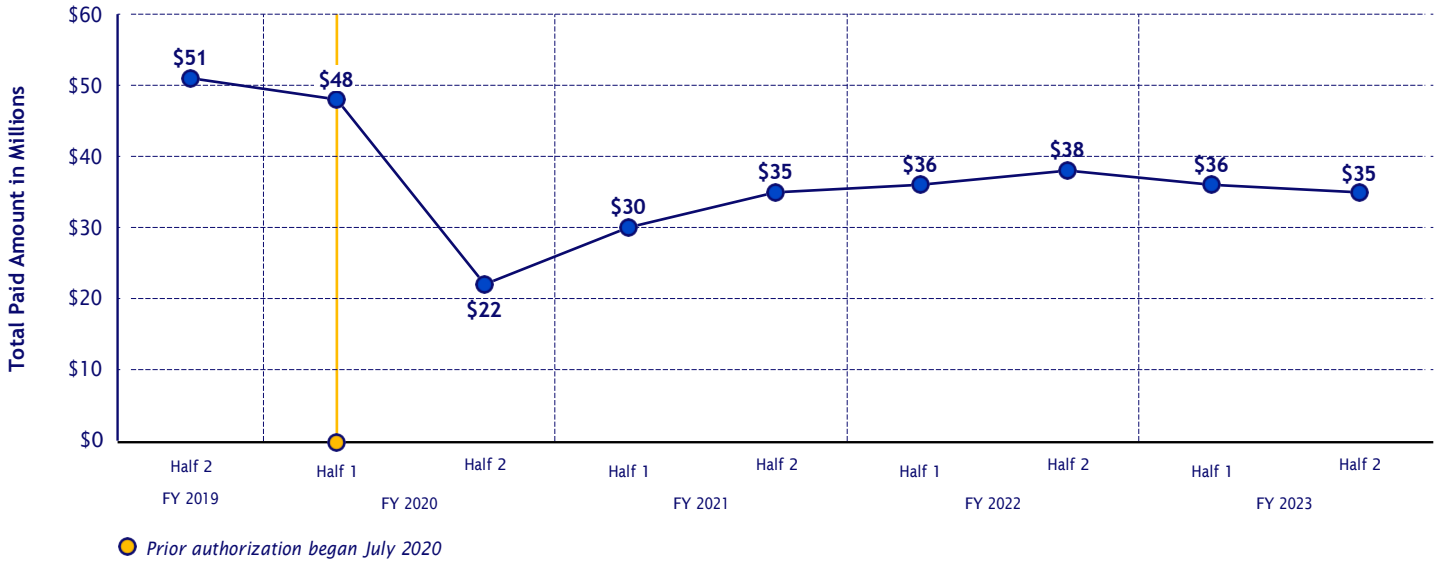
**MAC Timeliness (Average Number of Days):**

**6.2**

| Prior Authorization Requests | | | | | | | |
|---|---|---|---|---|---|---|---|
| Total Requests Received | Total Requests Completed | Total Requests Provisionally Affirmed | Percent of Provisionally Affirmed Requests | OPD Providers Exempt from Prior Authorization | Total Expedited Requests Received | Percent of Expedited Requests Substantiated | Percent of Expedited Requests Unsubstantiated |
| 214,660 | 206,986 | 152,993 | 73.9% | 321 | 9,695 | 29.5% | 70.5% |

| Claims and Appeals | | | | |
|---|---|---|---|---|
| Claims Reviewed | Claims Paid | Claims Denied | Claims Appealed | Percentage of Claims Overturned on Level 1 Appeal[3] |
| 118,588 | 91,115 | 27,473 | 2,256 | 24.7% |

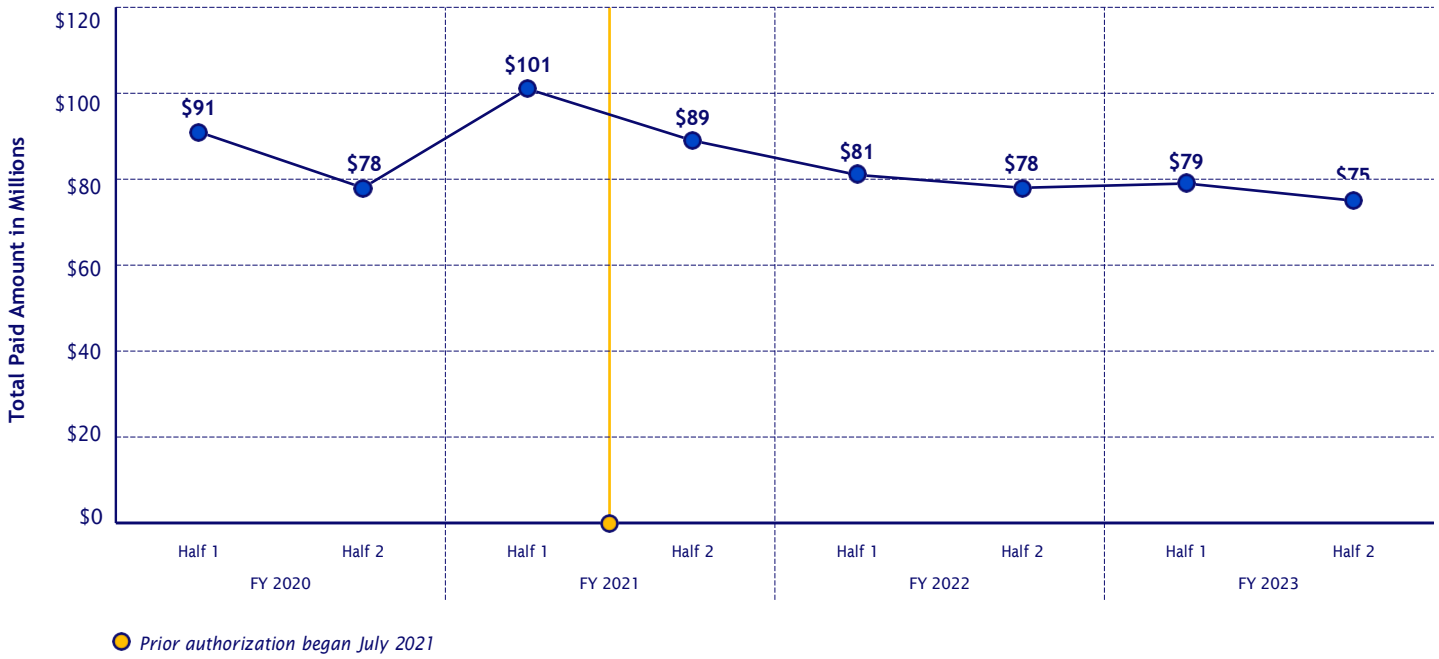
**Blepharoplasty, Botulinum Toxin Injection, Panniculectomy, Rhinoplasty, and Vein Ablation**
**By Date of Service**




2. MAC Accuracy Rate: 2,044 (MRAC Agreed) / 2,063 (MRAC Claims Reviewed) x 100 = 99.1%
3. Percentage of All Claims Overturned on Level 1 Appeal: The most common reason for appeal overturns is due to the submission of additional documentation that was not provided during the initial review.

## Cervical Fusion with Disc Removal and Implanted Spinal Neurostimulators

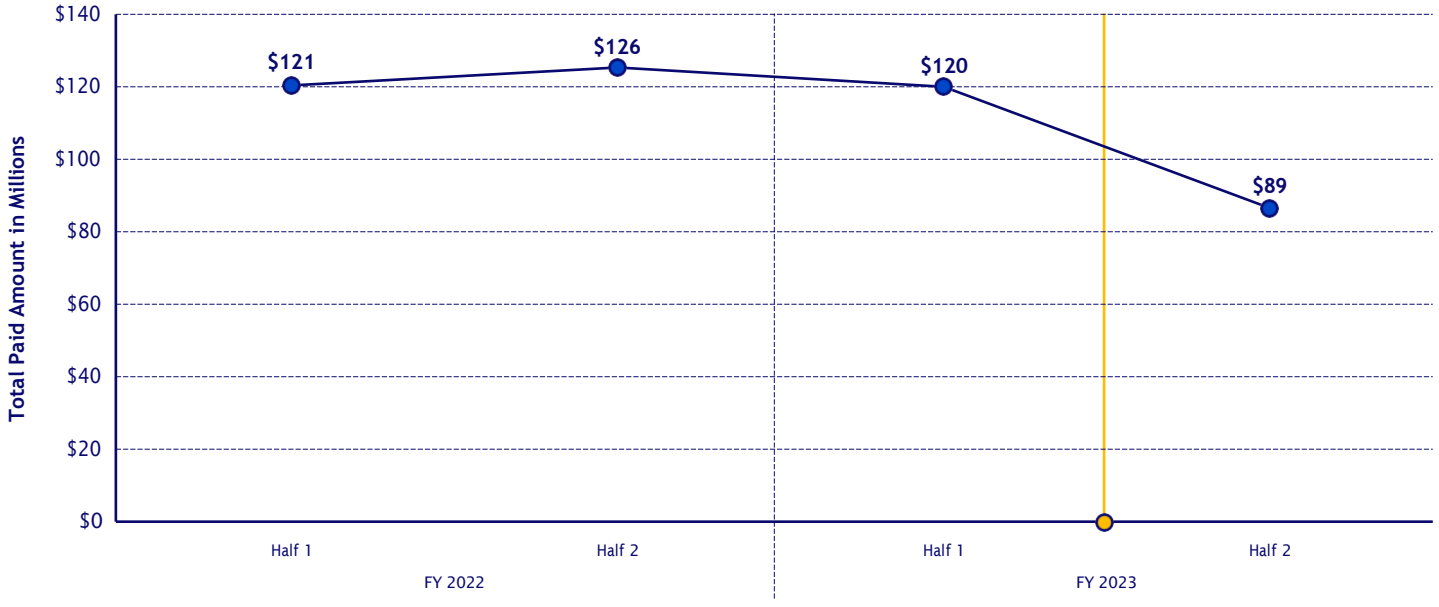
**By Date of Service**




*Prior authorization began July 2021*

## Facet Joint Interventions

**By Date of Service**




*Prior authorization began July 2023*

# Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model

The RSNAT Prior Authorization Model is a nationwide model that applies to independent ambulance suppliers that are not based at an institution and provide non-emergent ambulance services covered by Part B Medicare. The model is testing whether prior authorization helps reduce expenditures, while maintaining or improving quality of care by using the prior authorization process. The model establishes a process through which a request for provisional affirmation of coverage is submitted for review to the MAC before the beneficiary receives the service and before the claim is submitted for payment. The prior authorization process allows ambulance suppliers to address issues with claims prior to claim submission with unlimited opportunities to correct issues. Prior authorization is voluntary; however, if the ambulance supplier does not participate, applicable RSNAT claims will go through a prepayment medical record review.

**Fiscal Year 2023**

**MAC Accuracy Rate:**

**98.5%**[4]

**MAC Timeliness (Average Number of Days):**

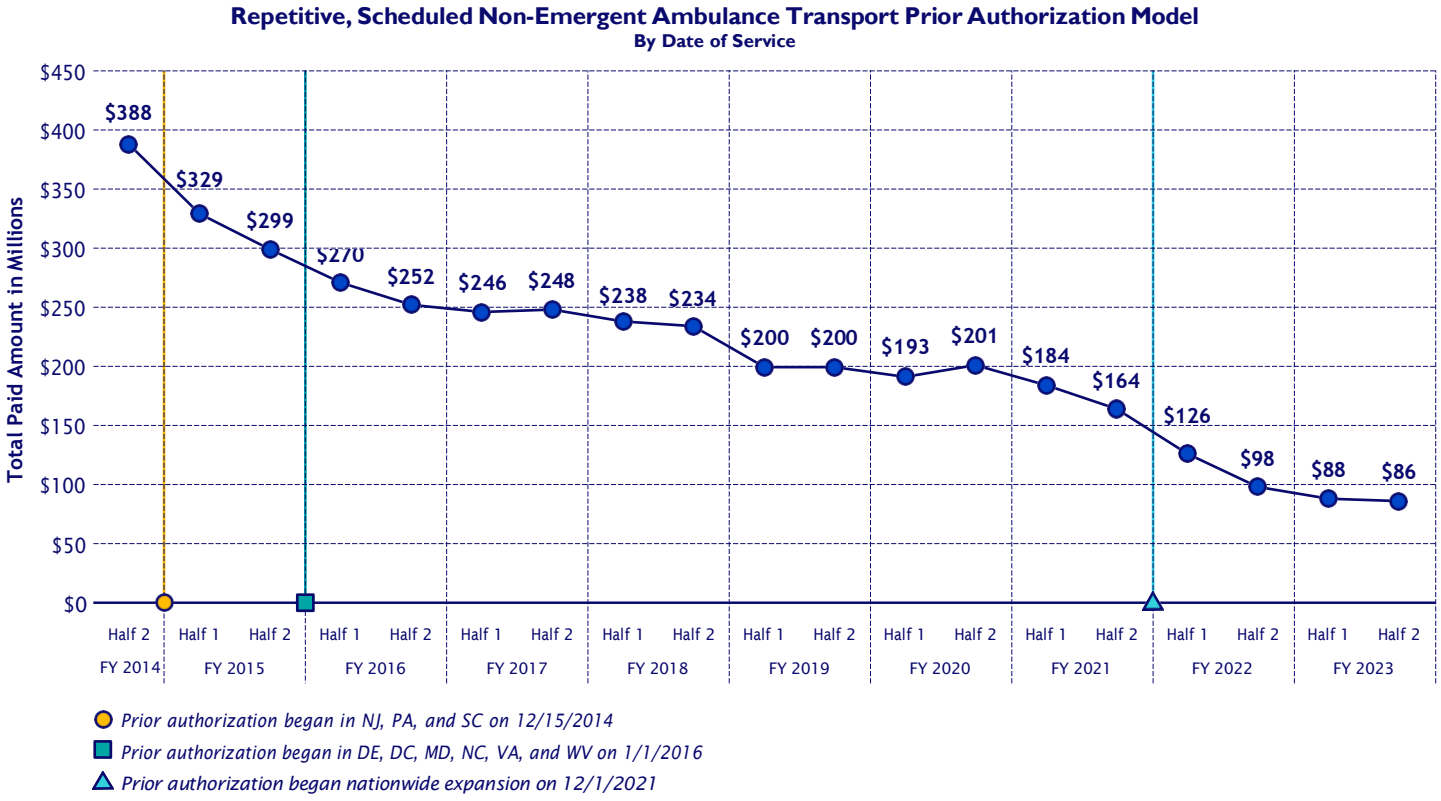
**3.8**

| Prior Authorization Requests | | | | | | |
|---|---|---|---|---|---|---|
| Total Requests Received | Total Requests Completed | Total Requests Provisionally Affirmed | Percent of Provisionally Affirmed Requests | Percent of Eligible Requests Expedited | Percent of Expedited Requests Approved | Percent of Expedited Requests Denied |
| 33,048 | 32,174 | 22,760 | 70.7% | N/A | N/A | N/A |

| Prepayment Medical Record Reviews | | | |
|---|---|---|---|
| Number of Claim Lines Reviewed | Number of Claim Lines Approved | Number of Claim Lines Denied | Number of Claim Lines Denied Due to Provider Not Submitting Documentation for Review |
| 34,363 | 12,286 | 22,077 | 13,938 |

| Claims and Appeals | | | | |
|---|---|---|---|---|
| Claims Reviewed | Claim Lines Paid | Claim Lines Denied | Claim Lines Appealed | Percentage of Claim Lines Overturned on Level 1 Appeal[5] |
| 857,456 | 808,032 | 49,424 | 8,768 | 38.7% |

4. MAC Accuracy Rate: 920 (MRAC Agreed) / 934 (MRAC Claims Reviewed) x 100 = 98.5%
5. Percentage of All Claims Overturned on Level 1 Appeal: The most common reason for appeal overturns is due to the submission of additional documentation that was not provided during the initial review.


Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model
By Date of Service
Total Paid Amount in Millions
$450
$400
$350
$300
$250
$200
$150
$100
$50
$0
$388
$329
$299
$270
$252
$246
$248
$238
$234
$200
$200
$193
$201
$184
$164
$126
$98
$88
$86
Half 2
Half 1
Half 2
Half 1
Half 2
Half 1
Half 2
Half 1
Half 2
Half 1
Half 2
Half 1
Half 2
Half 1
Half 2
Half 1
Half 2
FY 2014
FY 2015
FY 2016
FY 2017
FY 2018
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
Prior authorization began in NJ, PA, and SC on 12/15/2014
Prior authorization began in DE, DC, MD, NC, VA, and WV on 1/1/2016
Prior authorization began nationwide expansion on 12/1/2021

# Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items

CMS issued a final rule establishing a national prior authorization process as a condition of payment for certain DMEPOS items that are often overused. The CMS Required Prior Authorization List currently contains 62 Healthcare Common Procedure Coding System (HCPCS) items including 46 power mobility devices (PMDs), five pressure reducing support surfaces (PRSSs), six lower limb prosthetics (LLPs), and five orthoses. Prior authorization of these HCPCS is required as a condition of payment nationwide.

**Fiscal Year 2023**

**MAC Accuracy Rate:**

**99.5%**[6]

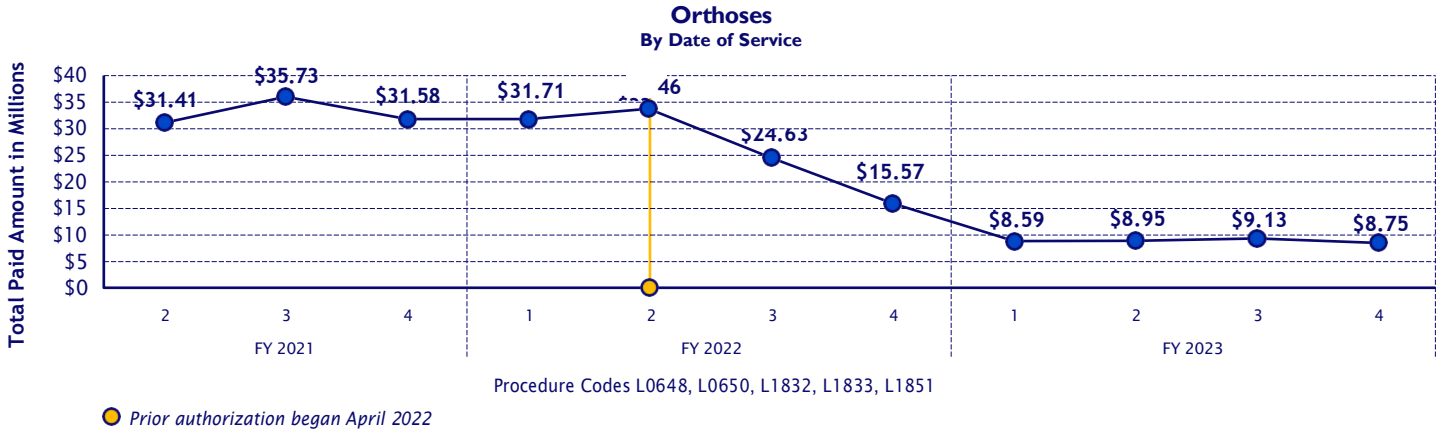
**MAC Timeliness (Average Number of Days):**

**4.4**

| Prior Authorization Requests | | | | | | |
|---|---|---|---|---|---|---|
| Total Requests Received | Total Requests Completed | Total Requests Provisionally Affirmed | Percent of Provisionally Affirmed Requests | Percent of Eligible Requests Expedited | Percent of Expedited Requests Approved | Percent of Expedited Requests Denied |
| 181,951 | 154,589 | 104,548 | 67.6% | 2.5% | 6.2% | 91.7% |

| Claims and Appeals | | | | |
|---|---|---|---|---|
| Claims Reviewed | Claims Paid | Claims Denied | Claims Appealed | Percentage of Claims Overturned on Level 1 Appeal[7] |
| 261,886 | 158,540 | 103,346 | 763 | 37.4% |

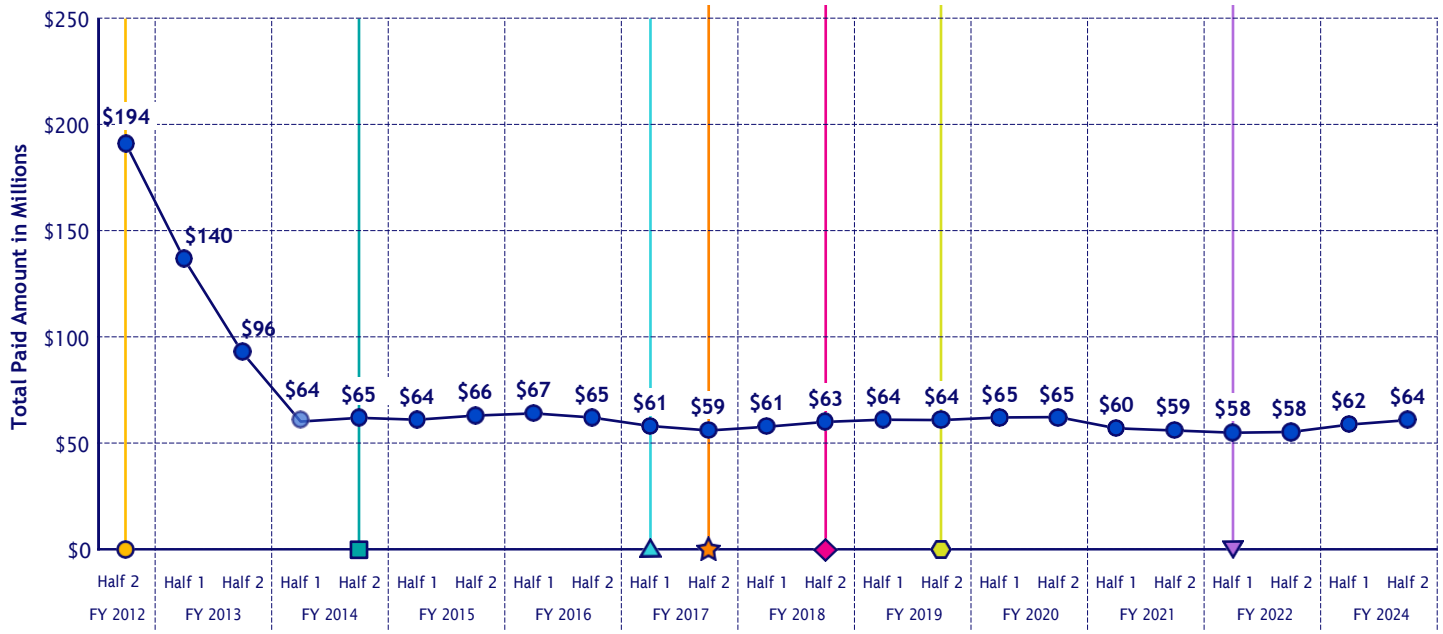
The four charts below show the total amount paid for the pressure reducing support service, lower limb prosthetic, power mobility devices and orthoses items that are eligible for prior authorization both before and after they were added to the required prior authorization list.




6. MAC Accuracy Rate: 956 (MRAC Agreed) / 960 (MRAC Claims Reviewed) x 100 = 99.5%

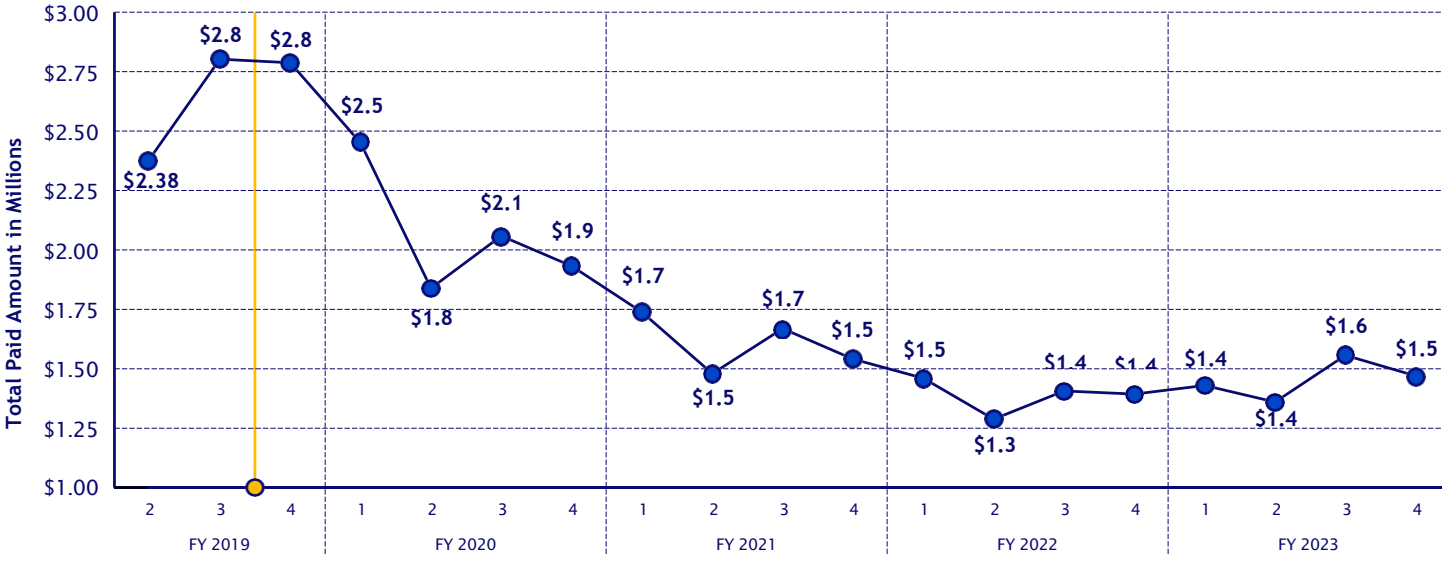
7. Percentage of All Claims Overturned on Level 1 Appeal: The most common reason for appeal overturns is due to the submission of additional documentation that was not provided during the initial review.

## Power Mobility Devices
**By Date of Service**



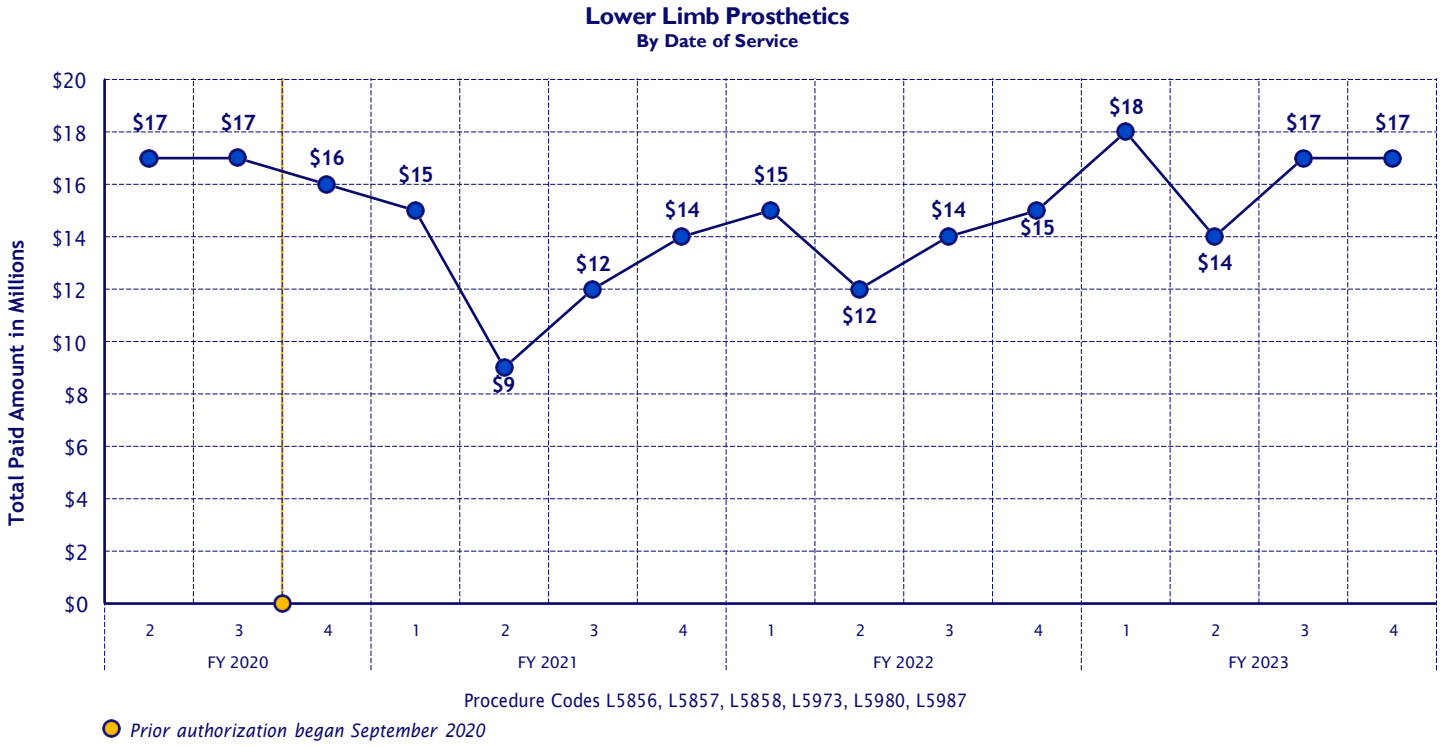

- *Demonstrations began September 2012 for PDM*
- *Demonstrations expanded October 2014 for PDM*
- *Prior authorization began in IL, MO, NY, and WV in March 2017 for codes K0856 and K0861*
- *Prior authorization began nationwide in July 2017 for codes K0856 and K0861*
- *Prior authorizations began nationwide in September 2018 for codes K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, and K0855*
- *Prior authorization began nationwide in July 2019 for codes K0857, K0858, K0859, K0860, K0862, K0863, and K0864*
- *Prior authorization began nationwide in April 2022 for codes K0800, K0801, K0802, K0806, K0807, and K0808*

## Pressure Reducing Support Surfaces
**By Date of Service**




Procedure Codes E0193, E0277, E0371, E0372, E0373

- *Prior authorization began 7/22/2019*


Lower Limb Prosthetics
By Date of Service
Total Paid Amount in Millions
$20
$18
$16
$14
$12
$10
$8
$6
$4
$2
$0
$17
$17
$16
$15
$9
$12
$14
$15
$12
$14
$15
$18
$14
$17
$17
2
3
4
1
2
3
4
1
2
3
4
1
2
3
4
FY 2020
FY 2021
FY 2022
FY 2023
Procedure Codes L5856, L5857, L5858, L5973, L5980, L5987
Prior authorization began September 2020

# Review Choice Demonstration for Home Health Services (HH RCD)

The HH RCD improves procedures for identifying, investigating, and prosecuting potential Medicare fraud. The program—which is currently implemented in Illinois, Ohio, Texas, North Carolina, Florida, and Oklahoma—helps ensure through either pre-claim review or postpayment review that payments for home health services are appropriate. Under this program, home health agencies choose how they demonstrate their compliance with CMS home health policies. They may participate in either 100 percent pre-claim review or 100 percent postpayment review, and these agencies will continue to be subject to review until they reach the 90 percent target affirmation or claim approval rate. Home Health Agencies that reach that target may choose to be relieved from claim reviews, except for spot checks of claims to ensure continued compliance.

**Fiscal Year 2023**

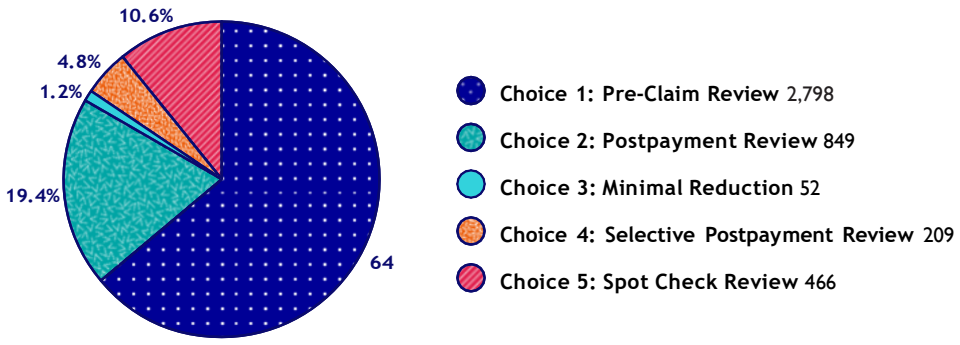
**MAC Accuracy Rate:**

**100%**[8]

**MAC Timeliness (Average Number of Days):**

**4**

**Providers in Each Choice**



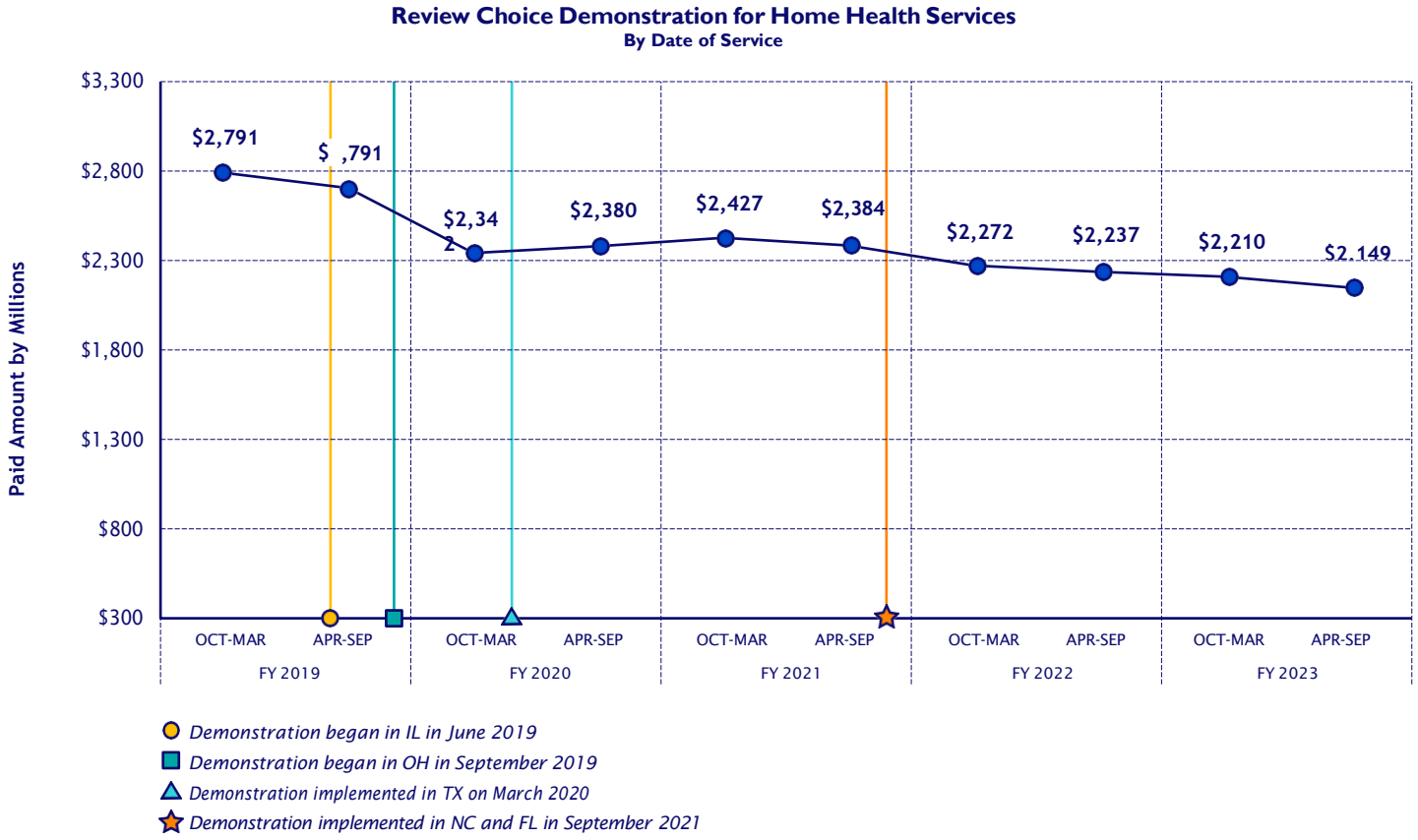

| Pre-Claim Review Requests | | | | | | |
|---|---|---|---|---|---|---|
| Total Number of Requests Received | Total Number of Requests Completed | Total Number of Requests Affirmed | Percent of Affirmed Requests | Percent of Requests Expedited | Percent of Expedited Requests Approved | Percent of Expedited Requests Denied |
| 1,842,316 | 1,841,542 | 1,785,429 | 97% | N/A | N/A | N/A |

| Prepayment and Postpayment Reviews | | |
|---|---|---|
| Total Number of Completed Claim Reviews | Total Number of Approvals | Percent of Approved Requests |
| 46,749 | 39,962 | 85.5% |

| Claims and Appeals | | | | |
|---|---|---|---|---|
| Claims Reviewed | Claims Paid | Claims Denied | Claims Appealed | Percentage of Claims Overturned on Level 1 Appeal[9] |
| 1,888,291 | 1,825,391 | 62,900 | 3,703 | 35.4% |

8. MAC Accuracy Rate: 600 (MRAC Agreed) / 600 (MRAC Claims Reviewed) x 100 = 100%

9. Percentage of All Claims Overturned on Level 1 Appeal: The most common reason for appeal overturns is due to the submission of additional documentation that was not provided during the initial review.


Review Choice Demonstration for Home Health Services
By Date of Service
Paid Amount by Millions
$3,300
$2,800
$2,300
$1,800
$1,300
$800
$300
$2,791
$ ,791
$2,34
2
$2,380
$2,427
$2,384
$2,272
$2,237
$2,210
$2,149
OCT-MAR
APR-SEP
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
Demonstration began in IL in June 2019
Demonstration began in OH in September 2019
Demonstration implemented in TX on March 2020
Demonstration implemented in NC and FL in September 2021

# Review Choice Demonstration for Inpatient Rehabilitation Facility (IRF) Services

**Fiscal Year 2023**

**MAC Accuracy Rate:**

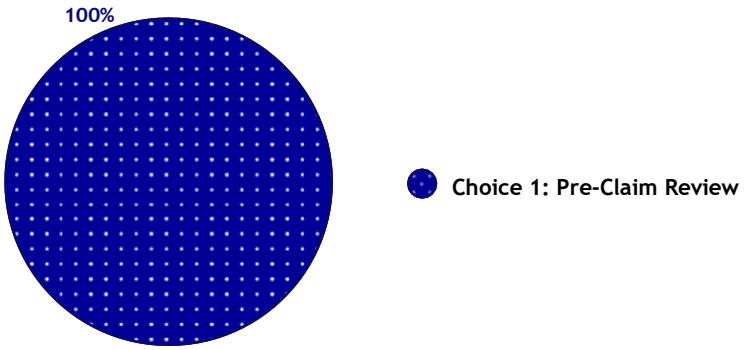
**N/A**[10]

**MAC Timeliness (Average Number of Days):**

**1.4**

The Review Choice Demonstration for IRF Services establishes a review choice process for IRF services to test improved methods for the identification, investigation, and prosecution of potential Medicare fraud. Additionally, this demonstration improves compliance with Medicare program requirements and reduce the number of Medicare appeals, to ensure that the right payments are made at the right time for IRF services. The Review Choice Demonstration protects our programs' sustainability for future generations by serving as a responsible steward of public funds. Under this demonstration, IRF providers choose how to demonstrate their compliance with Medicare IRF requirements. After a 6-month period, IRFs demonstrating compliance with Medicare rules through their pre-claim review affirmation rate or postpayment review approval rate have additional review choices to select from. On May 15, 2023, CMS announced the implementation of the IRF RCD in Alabama, starting August 21, 2023. In Fiscal Year 2023, every eligible provider in the IRF RCD selected the pre-claim review choice.

**Providers in Each Choice**



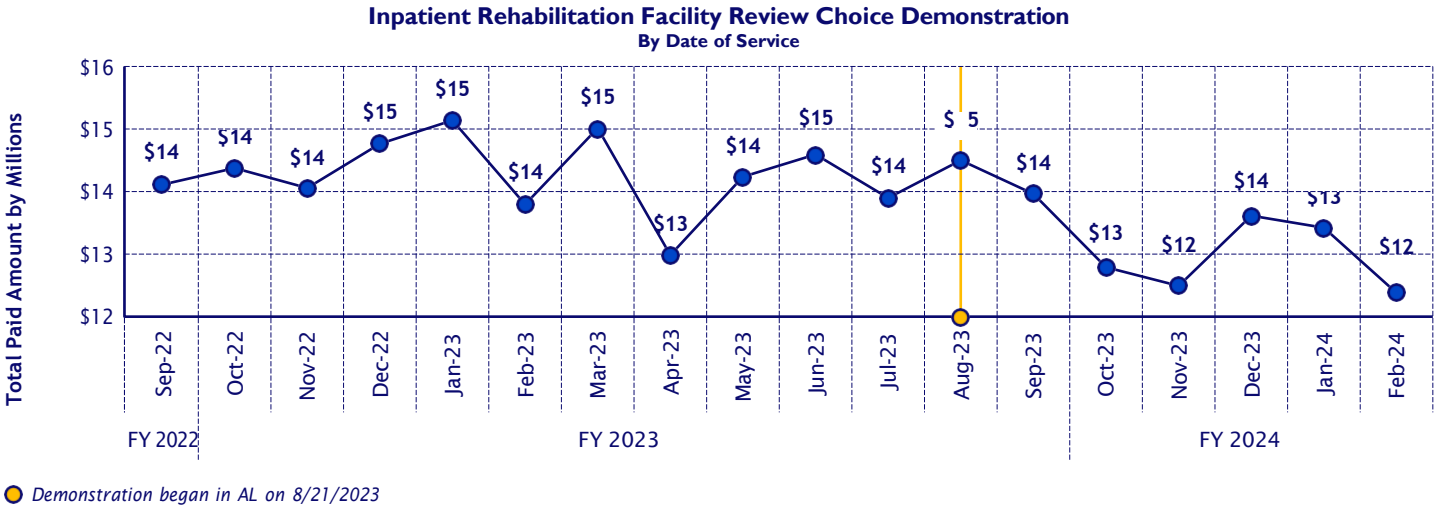

| Pre-Claim Review Requests | | | | | | |
|---|---|---|---|---|---|---|
| Total Requests Received | Total Requests Completed | Total Requests Provisionally Affirmed | Percent of Provisionally Affirmed Requests[11] | Percent of Requests Expedited | Percent of Expedited Requests Approved | Percent of Expedited Requests Denied |
| 932 | 926 | 884 | 95.5% | N/A | N/A | N/A |

| Claims and Appeals | | | | |
|---|---|---|---|---|
| Claims Reviewed | Claims Paid | Claims Denied | Claims Appealed | Percentage of All Eligible Claims Overturned on Level 1 Appeal[12] |
| 926 | 884 | 42 | 0 | 0% |

10. The MAC accuracy rate reviews began in FY 2024.

11. This percentage reflects an aggregate, fiscal-year rate across all providers and operational states and includes all pre-claim review submissions regardless of outcome. It represents a fiscal-year snapshot of MAC review activity and provisional affirmation rates and is not a cycle-level performance measure. In contrast, provisional affirmation rates in the CMS IRF RCD Cycle Reports are calculated at the individual provider level to determine whether applicable affirmation thresholds are met. To ensure there is no disadvantage to the provider, multiple submissions are not included (i.e., each pre-claim review submission for the beneficiary/time period is only counted once, no matter how many times a resubmission occurs to achieve an affirmation). Because these measures use different methodologies and serve different purposes, they are not comparable. The IRF RCD Cycle Reports are available on the IRF RCD webpage in the Downloads section.

12. Percentage of All Claims Overturned on Level 1 Appeal: The most common reason for appeal overturns is due to the submission of additional documentation that was not provided during the initial review.


Inpatient Rehabilitation Facility Review Choice Demonstration
By Date of Service
Total Paid Amount by Millions
$16
$15
$14
$13
$12
$14
$14
$14
$15
$15
$14
$15
$13
$14
$15
$14
$ 5
$14
$13
$12
$14
$13
$12
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
FY 2022
FY 2023
FY 2024
Demonstration began in AL on 8/21/2023