May 13, 2022: Advocacy Update spotlight on prior auth & Medicare Advantage plans

How Medicare Advantage plans wrongly deny prior auth requests

Momentum to fix prior authorization is building in the wake of a Department of Health and Human Services Office of Inspector General (OIG) report showing that Medicare Advantage plans delayed and denied patients' access to medically necessary treatment. They also denied payments to physicians and other health professionals for services that met both coverage and billing rules.

OIG found that 13% of the prior authorization requests that were denied by Medicare Advantage plans met the clinical coverage rules of traditional Medicare. And of the claim-payment denials in the study sample, 18% met Medicare coverage rules and Medicare Advantage plan billing rules.

The OIG recommended that the Centers for Medicare & Medicaid Services (CMS):

- Issue new guidance on the appropriate use of Medicare Advantage clinical criteria in medical necessity reviews
- Update its audit protocols to address the issues identified in this report, such as Medicare Advantage plans' use of clinical criteria
- Direct Medicare Advantage plans to take steps to identify and address vulnerabilities that can lead to manual review errors and system errors

According to the OIG report (PDF), "CMS concurred with all three recommendations."

AMA President-elect Jack Resneck Jr., MD, told The New York Times that Medicare Advantage plans' denials have become commonplace, and that prior authorization has "spread way beyond its original purpose."

In a statement, AMA President Gerald E. Harmon, MD, added that the OIG report "uncovered information that mirrors physician experiences." He noted that the AMA's prior authorization physician surveys (PDF) "have consistently found that excessive authorization controls required by health insurers are persistently responsible for serious harm when necessary medical care is delayed, denied

or disrupted."

"The time is now," Dr. Harmon said, "for federal lawmakers to act to improve and streamline the prior authorization process so that patients are ensured timely access to the evidence-based, quality health care they need."

Read the full story by Kevin B. O'Reilly, AMA news editor, for more information.

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