Prior Authorization and Pre-Claim Review Program Stats for Fiscal Year 2024

September 16, 2025 | Fiscal Year (FY): October 1, 2023 – September 30, 2024

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 2024 OPPS/ASC Final Rule (CMS -1772-FC), CMS added facet joint interventions to the prior authorization process.

Fiscal Year 2024

MAC Accuracy Rate:

99.5%[2]

MAC Timeliness (Average Number of Days):

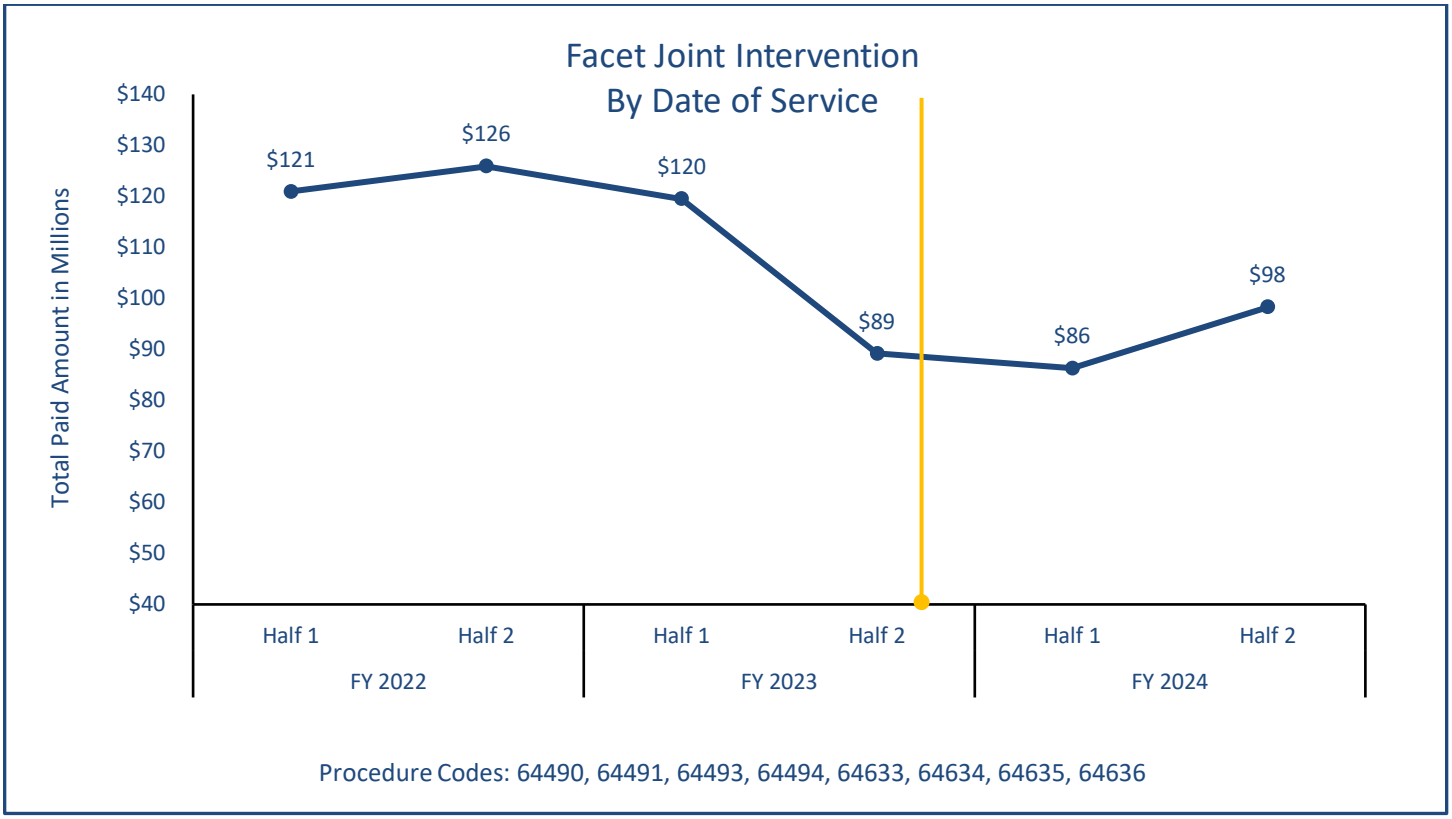
5.5

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
422,435	423,830	335,656	79.2%	257	10,658	22.8%	77.2%

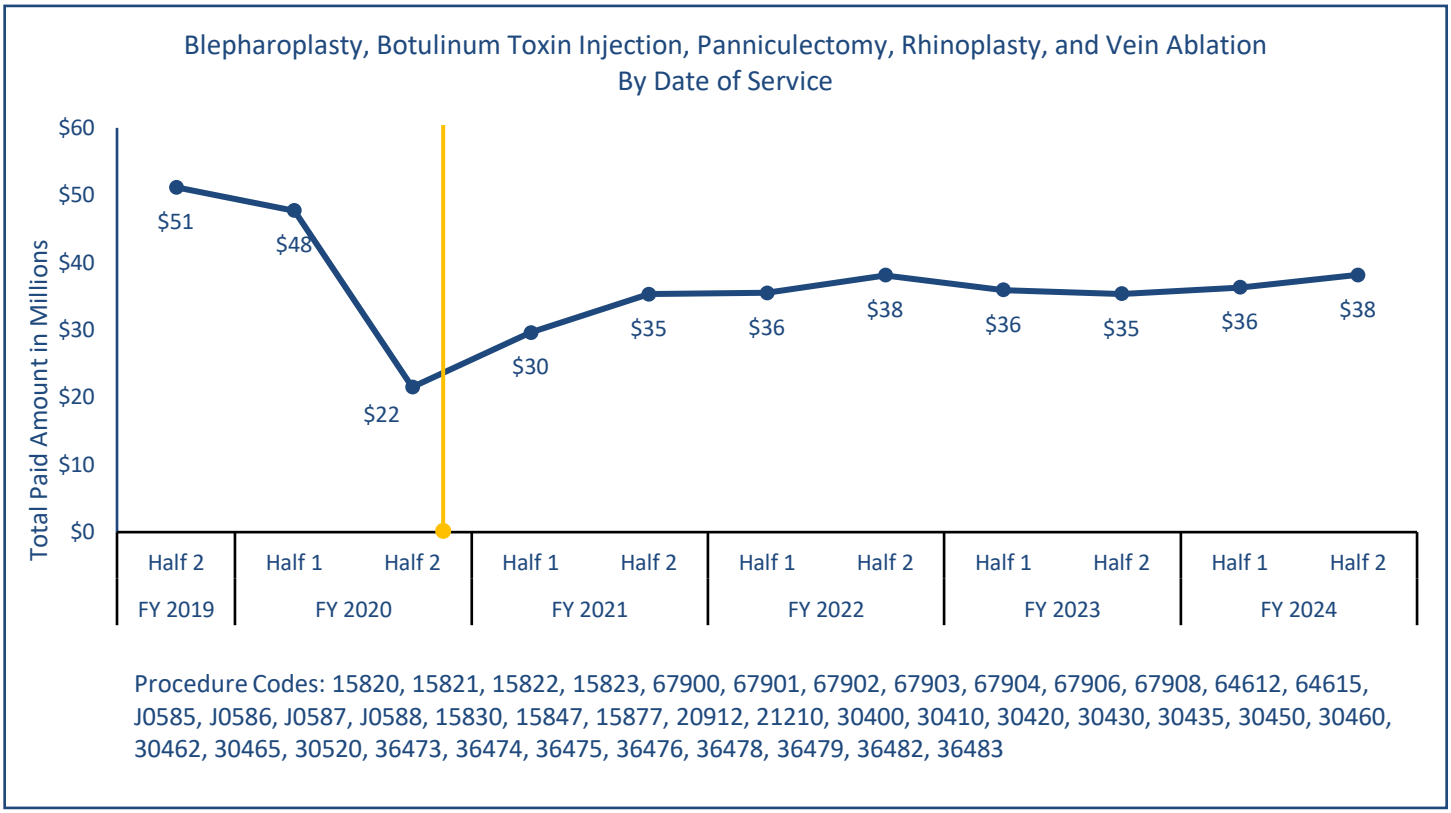
Claims and Appeals				
Claims Reviewed	Claims Paid	Claims Denied	Claims Appealed	Percentage of Claims Overturned on Level 1 Appeal
275,390	237,524	37,866	4,393	18.4%[3]

[2] 2,293 (MRAC Agreed) / 2,304 (MRAC total claims reviewed) x 100 = 99.5%

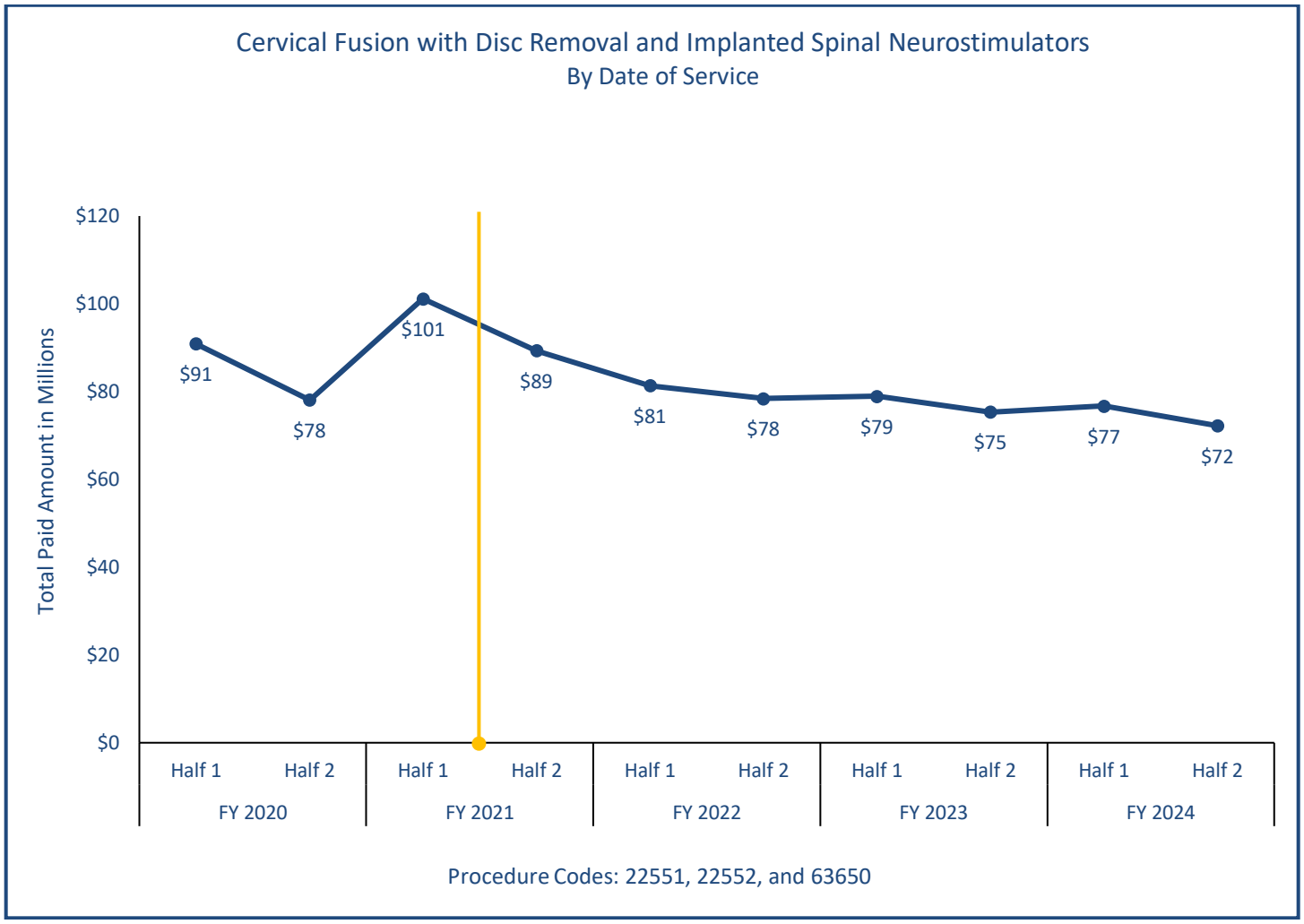
[3] Percentage of All Claims Overturned on Level 1 Appeal: The most common reason for appeal overturns is due to the submission of additional documentation that was not provided during the initial review.



- *Prior authorization began July 2023*



- *Prior authorization began July 2020*



● *Prior authorization began July 2021*

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 2024

MAC Accuracy Rate:

96.3%[4]

MAC Timeliness (Average Number of Days):

4.3

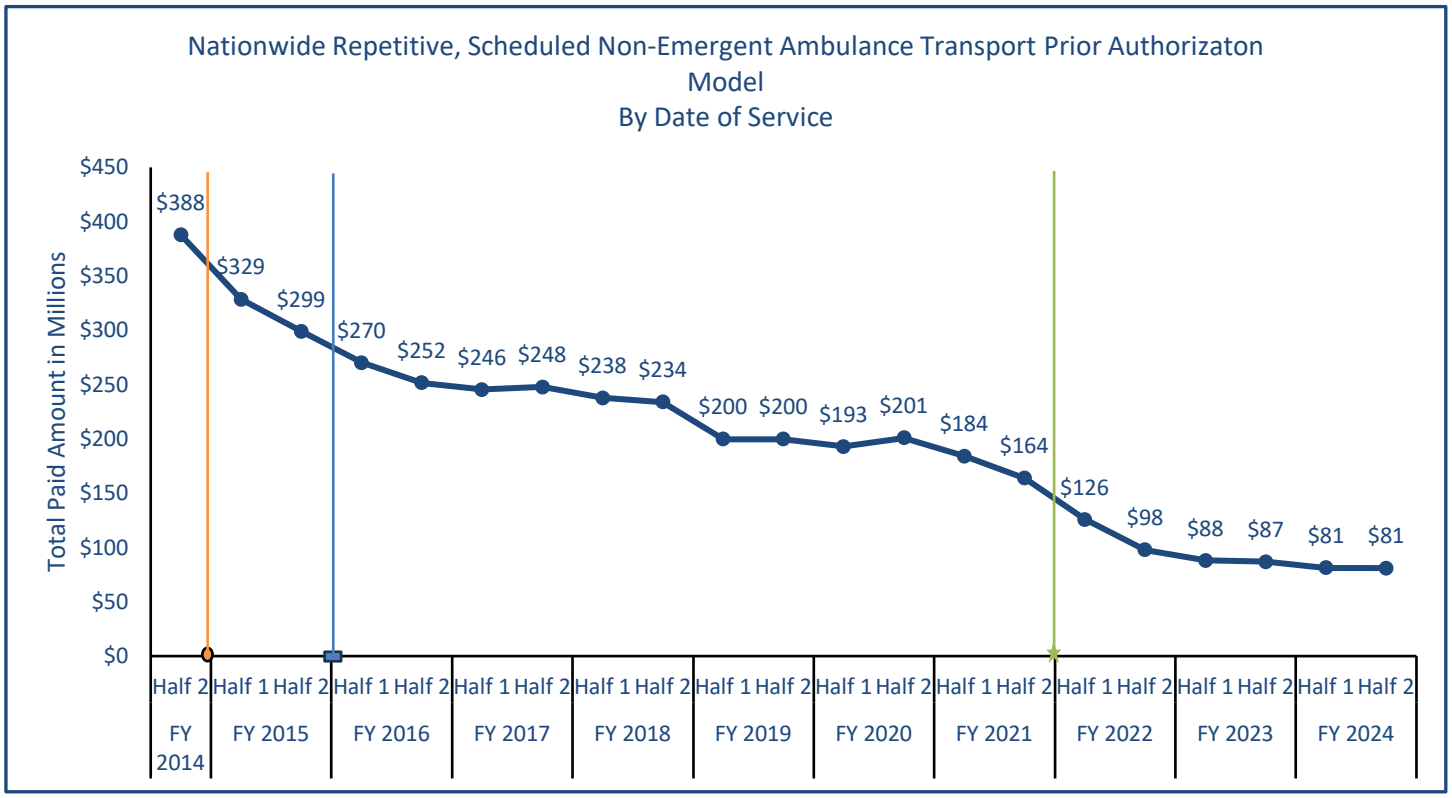
Prior Authorization Requests						
Total Requests Received	Total Requests Completed	Total Requests Provisionally Affirmed	Percent of Provisionally Affirmed Requests	Percent of Eligible Requests Expedited	Percent of Expedited Requests Approved	Percent of Expedited Requests Denied
29,901	28,836	20,888	72.4%	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
23,622	9,354	14,268	11,953

Claims and Appeals				
Claims Reviewed	Claim Lines Paid	Claim Lines Denied	Claim Lines Appealed	Percentage of Claim Lines Overturned on Level 1 Appeal[5]
752,798	721,767	31,031	6,216	45.1%

[4] 681 (MRAC Agreed) / 707 (MRAC total claims reviewed) x 100 = 96.3%

[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.



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 67 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 ten orthoses. Prior authorization of these HCPCS is required as a condition of payment nationwide.

Fiscal Year 2024

MAC Accuracy Rate:

100%[6]

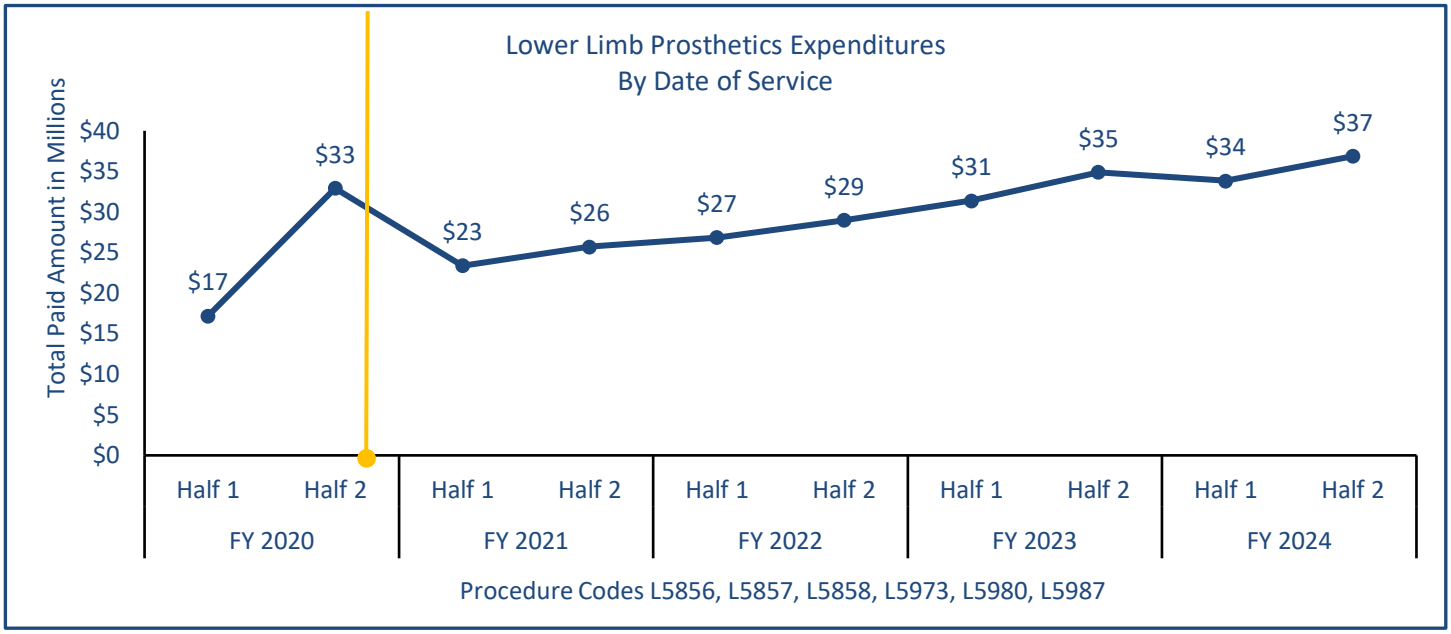
MAC Timeliness (Average Number of Days):

4.5

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
193,140	175,577	127,994	72.9%	2.9%	7.4%	93%

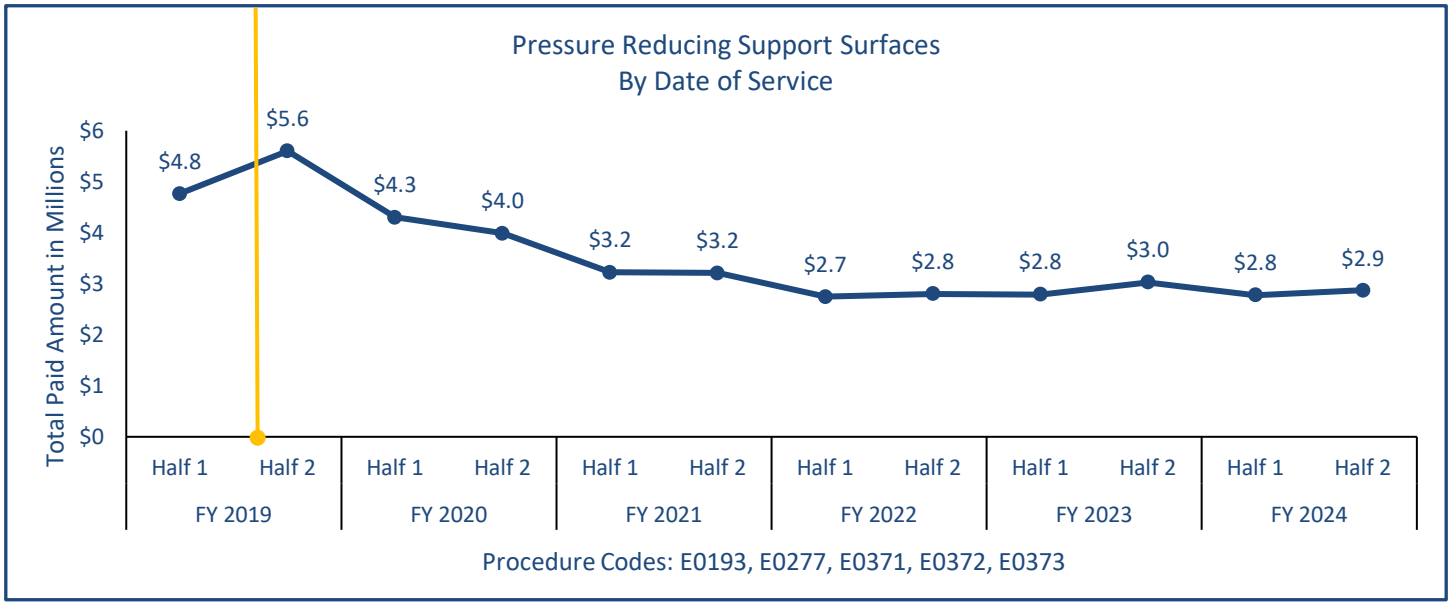
Claims and Appeals				
Claims Reviewed	Claims Paid	Claims Denied	Claims Appealed	Percentage of Claims Overturned on Level 1 Appeal[7]
283,298	188,897	94,401	1165	38.4%

[6] 960 (MRAC Agreed) / 960 (MRAC total claims reviewed) x 100 = 100%
[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.

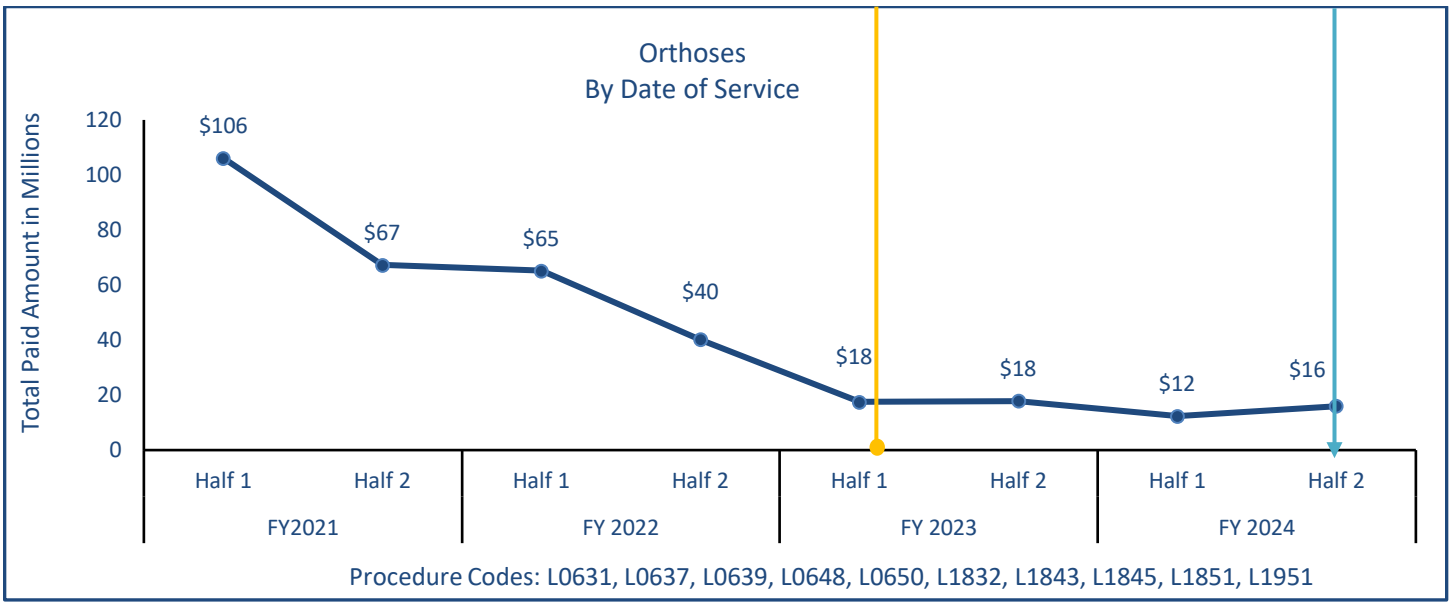


- *Prior Authorization began first in CA, MI and PA in September 2020 and then nationwide in December 2020.*

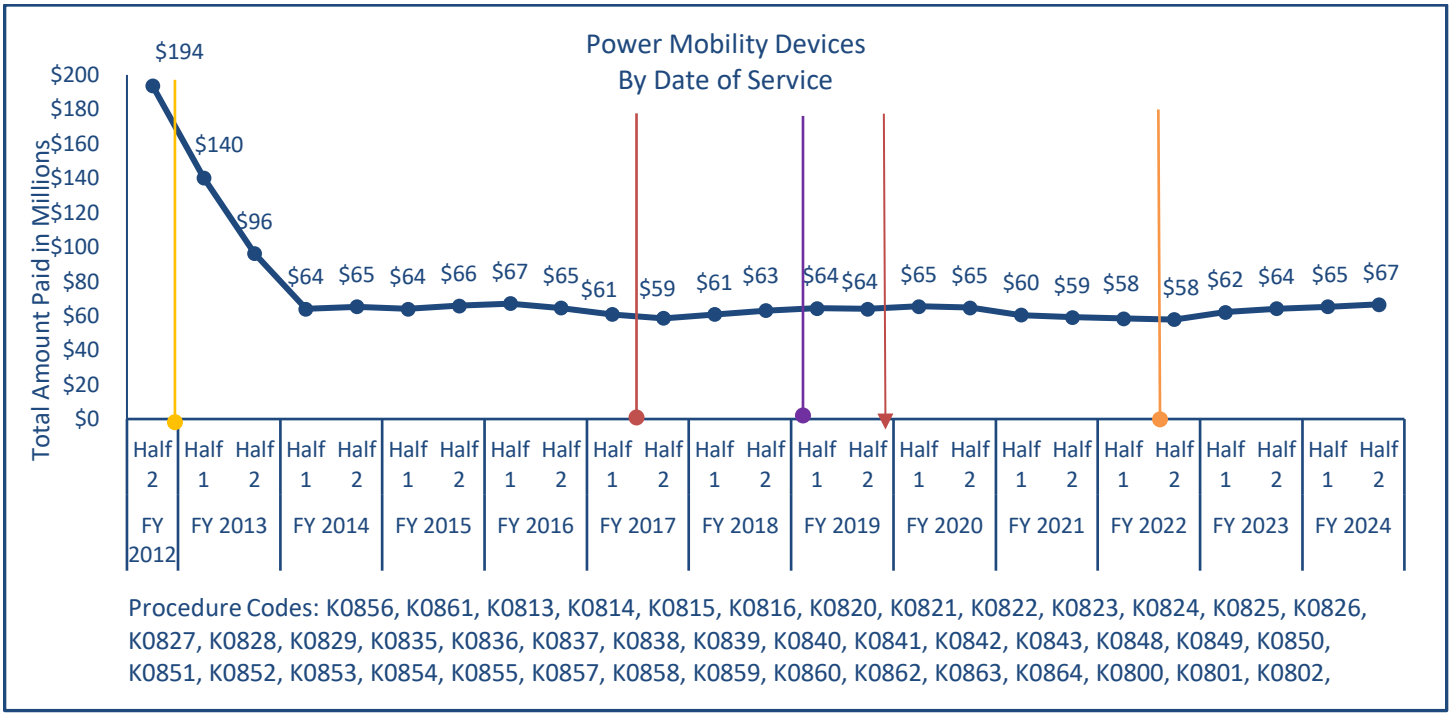
Spending for LLPs has gradually increased due to the growth in the DME Fee Schedule prices for these items. Additionally, recent local coverage determination (LCD) changes have expanded the coverage of these items to a broader patient population, resulting in increased utilization and expenditure.



- *Prior Authorization began in CA, IN, NJ, and NC in July 2019 and then nationwide in October 2019.*



- *Prior authorization for codes L0648, L0650, L1832, L1833, and L1851 began in NY, Il, FL, and CA in April 2022; MD, PA, NJ, MI, OH, KY, TX, NC, GA, MO, AZ, and WA in July 2022; and then nationwide in October 2022.*
- *Prior authorization began nationwide in August 2024 for codes L0631, L0637, L0639, L1843, L1845, L1951; Code L1833 removed from prior authorization nationwide.*



- *Demonstration began in CA, IL, MI, NY, NC, FL, and TX in September 2012; expanded to PA, OH, LA, MO, MD, NJ, IN, KY, GA, TN, WA and AZ in October 2014*
- *Prior authorization began for codes K0856 and K0861 in IL, MO, NY, and WV in March 2017 and then nationwide in July 2017*
- *Prior authorization 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*

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 2024

MAC Accuracy Rate:

97.7%[8]

MAC Timeliness (Average Number of Days):

4.7

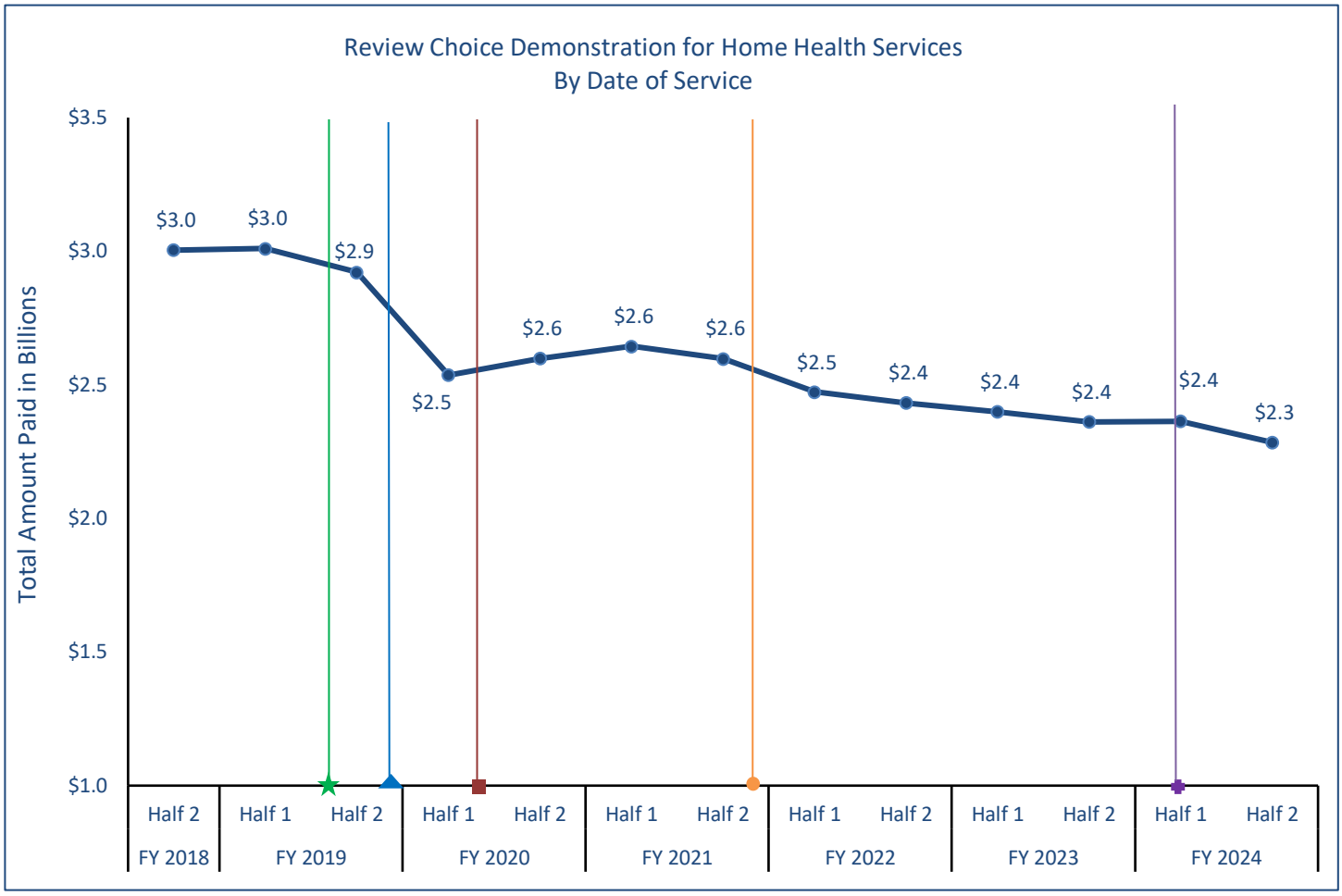
Providers in Each Choice

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
1,791,226	1,849,354	1,790,902	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
49,168	41,524	84.4%

Claims and Appeals				
Claims Reviewed	Claims Paid	Claims Denied	Claims Appealed	Percentage of Claims Overturned on Level 1 Appeal[9]
1,898,522	1,832,426	66,096	4,695	51.6%

[8] 681 (MRAC Agreed) / 697 (MRAC total claims reviewed) x 100= 97.7%
[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.



★ *Demonstration began in IL in June 2019*
▲ *Demonstration began in OH in September 2019*
■ *Demonstration began in TX in March 2020*
● *Demonstration began in FL and NC in September 2021*
✚ *Demonstration began in OK in December 2023*

Review Choice Demonstration for Inpatient Rehabilitation Facility (IRF) Services

Fiscal Year 2024

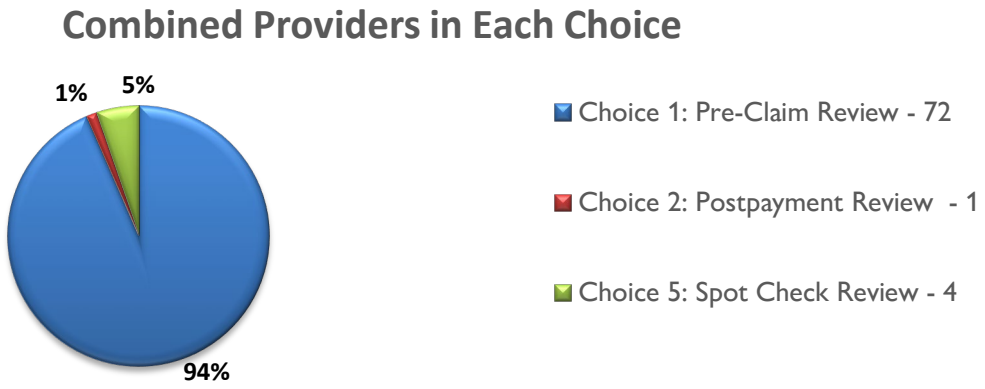
MAC Accuracy Rate:

100%[10,11]

MAC Timeliness (Average Number of Days):

1.6

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 reduces 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. In Fiscal Year 2024, Alabama continued the demonstration and entered Cycle 2 on May 1. For Cycle 2, 14 out of the 16 eligible providers selected the pre-claim review choice, of which 7 selected pre-claim review choice forever, and 2 selected spot check choice. On March 1, 2024, CMS announced its expansion into Pennsylvania, beginning June 17, 2024. For Cycle 1, in Pennsylvania, 52 out of 53 eligible providers selected the pre-claim review choice and 1 selected the post-payment review.



Pre-Claim Review Requests						
Total Requests Received	Total Requests Completed	Total Requests Provisionally Affirmed	Percent of Provisionally Affirmed Requests[12]	Percent of Requests Expedited	Percent of Expedited Requests Approved	Percent of Expedited Requests Denied
13,752	13,578	10,618	78%	N/A	N/A	N/A

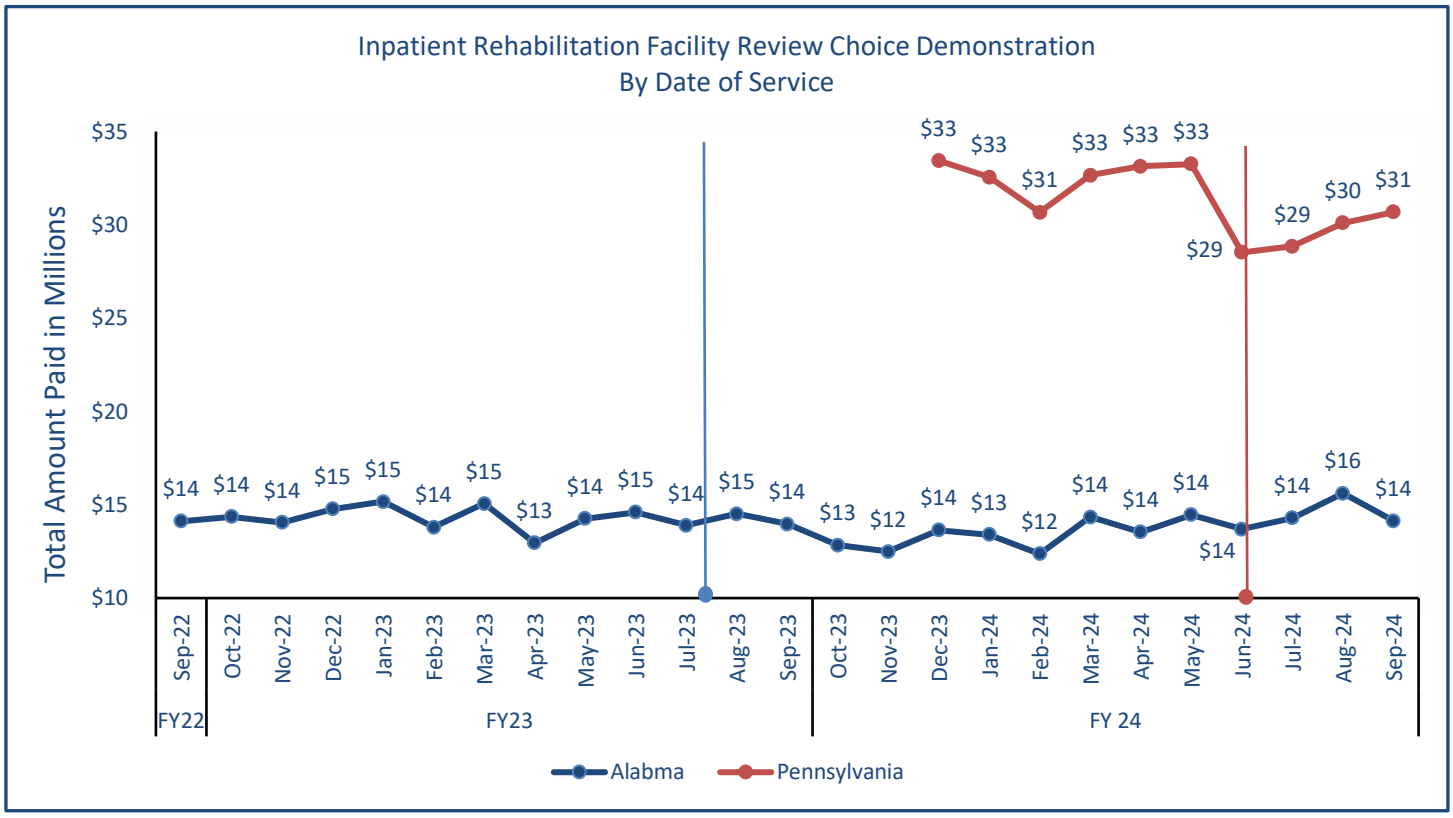
Claims and Appeals				
Claims Reviewed	Claims Paid	Claims Denied	Claims Appealed	Percentage of All Eligible Claims Overturned on Level 1 Appeal[13]
13,578	10,618	2,960	427	0.003%

[10] 40 (MRAC Agreed) / 40 (MRAC total claims reviewed) x 100= 100%. (Alabama only)

[11] The MAC Accuracy Review began in Alabama in June 2024. The Pennsylvania MAC accuracy review will begin in FY 2025

[12] 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.

[13] 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.



Demonstration began in AL August 2023

Demonstration began in PA June 2024