In the best case scenario, health plans would provide authorization and perform medical necessity reviews in the pre-service environment. This methodology significantly minimizes provider abrasion related to the ‘retrospective’ review of delivered services. Applying utilization management/authorization processes pre-service prevent hospitals and providers from expending resources providing services as well as reviewing and defending retrospectively denied services.

For a variety of reasons pre-service review is not always necessary or achievable. Program design, contractual requirements, government audits, quality reviews, research and investigation surrounding policy non-compliance, and other initiatives impact the placement/timing of authorization and medical necessity reviews. Even when prior authorization is provided, it does not guarantee that a post-payment review surrounding the medical necessity of a procedure or service will not be undertaken.

Medical necessity and authorization requirements are primarily driven by payer policy including: administrative, payment, and medical policies. The sheer number of medical and payment policies in force at a given health plan (sometimes measuring between 500-1,000 or more) make comprehensive pre-payment prior authorization enforcement challenging if not impractical. The degree to which these policies are enforced and the mechanism for enforcement is left to the health plan to determine.

There is a segment of the industry (Medicare FFS, some Medicaid FFS plans, excluding MA and Medicaid Managed Care) that have few if any front-end authorization processes in place mandating that UM/medical necessity be performed ‘after the fact’. In general, group health plans do not have this limitation and have more flexibility to define what requires medical necessity review on the front end of the process.
Examples of medical necessity reviews and requirements for authorization may include (but are not limited to):

- Admissions (right setting, e.g., inpatient versus outpatient)
- Elective services and procedures (bariatric surgery, total hip/knee replacements, implantable neurostimulators, sleep studies, etc.)
- Genetic testing (cancer risks, other)
- Radiology procedures (MRI/MRA, PET Scans, CT Scans, etc.)
- Durable medical equipment (power mobility devices)
- New technologies

**Challenges: Provider Network Sensitivity**

In no small part providers feel burdened by complex, ever-changing, and payer-specific administrative requirements that are deeply embedded within the process of health care approval and delivery. Medicare Recovery Audit Contractor activities (RAC) and other similar activities have sensitized the provider community who are often critical and skeptical of these activities. Incorporating language in provider contracts that enforce UM/Medical Necessity on the front-end can make the contracting process particularly complex and contentious.

**Risks**

There are some in the industry that believe if a service is pre-authorized by a health plan that the service cannot be denied for payment. Equian has been involved in a number of conversations with clients regarding this aspect of medical necessity audits and prior authorizations. Our position, one that is supported throughout the payer community including BCBS plans, Cigna, Aetna, United, and others is that prior authorization of services is not a guarantee of payment. Payment of covered services may be subject to additional requirements including benefit plan exclusions and limitations, patient eligibility, payment of premiums, and other factors. Additionally, if the medical record and the pre-authorization are not aligned, the health plan should have a right to deny or re-coup payment (either partial or full based on the audit).
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