



**ASSOCIATION FOR MOLECULAR PATHOLOGY**  
*Providing global expertise in molecular testing that drives patient care*  
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## **Association for Molecular Pathology Position Statement: Addressing Challenges with Prior Authorization in Medicare Advantage**

The Association for Molecular Pathology (AMP) is an international medical and professional association representing approximately 3,100 physicians, doctoral scientists, and medical technologists who perform or are involved with laboratory testing based on knowledge derived from molecular biology, genetics, and genomics. Membership includes professionals from the government, academic medicine, private and hospital-based clinical laboratories, and the in vitro diagnostic industry. Through the work of our subject matter experts, AMP continues to develop and update our evidence-based guidelines to foster and support innovation while establishing clinical best practice recommendations.

### **Background**

Prior authorization is a health care utilization management technique used by payers that requires a provider to obtain approval from the payer usually before providing a medical service to a patient so that the service can qualify for payment. Federal policy limits the use of prior authorization to a few select items and services under Traditional Medicare (Parts A & B). Comparatively, prior authorization is commonly used by Medicare Advantage Organizations (MAOs) for many items and services, despite them being deemed medically necessary by the Centers for Medicare and Medicaid Services (CMS) or Medicare Administrative Contractors (MACs). The prior authorization processes used by MAOs are burdensome, requests are often inappropriately denied, and the practice negatively impacts patient care and access to reasonable and necessary testing, including molecular testing.

According to the Kaiser Family Foundation, nearly 50 million prior authorization requests were sent to Medicare Advantage organizations in 2023.<sup>1</sup> Evidence suggests that MAOs are denying prior authorization requests inappropriately. For instance, the Department of Health and Human Services Office of Inspector General (OIG) noted that MAOs fully or partially overturned 82 percent of appealed prior authorization denials in favor of enrollees in 2019<sup>2</sup>, suggesting that MAOs recognize during their own review of their decisions that they had initially wrongfully denied care to patients. Another report analyzing data from 2015 indicates that CMS determined that 56 percent of the 140 MAO contracts audited were inappropriately denying care in 2015.<sup>3</sup> These findings are concerning in part because they indicate that Medicare Advantage patients do not readily have access to the same care that is available to patients covered by Traditional Medicare. Indeed, another OIG report from 2022 confirmed that 13

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<sup>1</sup> <https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/#:~:text=The%20vast%20majority%20of%20denied,of%20the%20prior%20authorization%20process.>

<sup>2</sup> <https://oig.hhs.gov/oei/reports/OEI-09-19-00350.asp>

<sup>3</sup> <https://oig.hhs.gov/reports/all/2018/medicare-advantage-appeal-outcomes-and-audit-findings-raise-concerns-about-service-and-payment-denials/>

percent of prior authorization requests would have otherwise been approved had the patients been covered under Traditional Medicare.<sup>4</sup>

The prior authorization and appeal process is also slow and cumbersome. A 2024 survey of providers by the American Medical Association demonstrates that providers and their staff spend an average of 13 hours per week completing prior authorization requests, and this increased workload significantly contributes to burnout.<sup>5</sup> Further, 93 percent of those providers report that prior authorization delays access to necessary care, and that 82 percent of the time, the process can lead to a patient abandoning recommended services. These burdens are compounded when the coverage requests are denied, which requires the provider or beneficiary to appeal the decision. OIG has noted that these appeals processes can be confusing and overwhelming, and as a result, beneficiaries and providers initiated the appeals process for only one percent of denials during 2014–2016.<sup>6</sup>

CMS is working to resolve some of these burdens. For example, CMS issued the Interoperability and Prior Authorization Final Rule in 2024 to reform aspects of the prior authorization process.<sup>7</sup> Set to go into effect in 2026, the rule requires an array of payers, including MAOs, to use a standardized electronic exchange of information to allow providers, payers, and consumers to know what medical items and services require prior authorization, what documentation is required for the plan to make a prior authorization decision, and the current status of a prior authorization decision. It will also facilitate the transmission of documentation needed for prior authorization requests. The rule also requires certain payers, including MAOs, to respond to prior authorization expedited requests no later than 72 hours after receiving a request and no later than seven calendar days after receiving a standard request. Additionally, the rule seeks to improve data transparency by requiring the impacted payers to publicly report metrics annually related to prior authorization.

However, significant process issues for seeking prior authorization for laboratory testing will continue to exist even after the new requirements take effect if no additional action is taken. For instance, certain MAOs are preventing laboratories from initiating prior authorization requests which is in conflict with existing regulation<sup>8</sup> and adds significant complexity to the process.

The documentation requests associated with prior authorization are often unreasonable and duplicative of information that has already been submitted. Laboratories often lack clarity on whether a test requisition form is part of the patient's medical record and, therefore, whether it is appropriate and/or adequate to support documentation for a prior authorization request. Providers are also encountering situations where rendered services are denied payment after prior authorization has already been obtained.<sup>9</sup> Further, insurance plans often do not give detailed explanations for a denial, which delays care and creates additional challenges to successfully appeal the denial. One survey found that 29

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<sup>4</sup> <https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/>

<sup>5</sup> <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>

<sup>6</sup> <https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp>

<sup>7</sup> <https://www.cms.gov/priorities/burden-reduction/overview/interoperability/policies-and-regulations/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f/cms-interoperability-and-prior-authorization-final-rule-cms-0057f#:~:text=The%20Centers%20for%20Medicare%20&%20Medicaid,requirements%20in%20this%20final%20rule>

<sup>8</sup> 42 CFR 422.566(c)(1)

<sup>9</sup> <https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims>

percent of providers reported that the prior authorization process had led to a serious adverse event for a patient in their care.<sup>10</sup>

Although the Interoperability and Prior Authorization Final Rule established criteria for prior authorization turnaround time, this timeline is often not feasible for laboratory tests in time-sensitive clinical circumstances, where delaying patient care is detrimental to their health, such as when initiating treatment for late-stage cancer or infectious disease. In other situations, some specimen types lose viability in an even shorter period of time, including certain blood and tissue samples which are often used in tests that need prior authorization. As such, laboratories will often begin processing the sample while they await prior authorization to avoid delays in patient care. In doing so, laboratories shoulder the risk of prior authorization not being granted and thus, the lack of payment for their services.

Finally, while the Interoperability and Prior Authorization Final Rule creates a pathway for patients to report potential misuse for denial of prior authorization starting in 2026, the rule did not create a similar pathway for healthcare providers to report concerns to CMS if they observe trends in inappropriate use of this utilization management technique. Despite laboratory professionals working in good faith to submit all the requested paperwork and overcome process hurdles, prior authorization is still wrongfully denied, and CMS must be made aware of these circumstances to inform their audits and investigations and further deter the use of prior authorization when it needlessly disrupts access to patient care.

### **AMP Position**

Policymakers must make several regulatory and statutory changes to ease the burden on providers, streamline the prior authorization and appeals process, and align Medicare Advantage with Traditional Medicare to ensure the coverage and payment of medically necessary care for all Medicare beneficiaries.

First, AMP supports the Improving Seniors' Timely Access to Care Act [S. 3018, 117th Congress], which would codify a number of changes to the prior authorization system for Medicare Advantage. Similar to CMS' final rule, the legislation would establish an electronic prior authorization (ePA) program, requiring Medicare Advantage plans to adopt ePA capabilities. It would also require MAOs to meet other standards set by CMS for the quality and timeliness of prior authorization determinations and require MA plans to report on their use of prior authorization, as well as the rate of approvals and denials. These changes will further improve the prior authorization process for laboratories and other providers, ensure consistency of prior authorization policies across administrations, and most importantly, improve patient care.

To further address the challenges that clinical laboratories encounter with prior authorization, AMP also recommends the following regulatory changes.

1. **CMS should affirm, at least through guidance, that laboratory professionals are allowed to initiate the prior authorization process.** Several MAOs do not permit laboratories to file prior authorization for the testing services they perform and provide for beneficiaries. This is inefficient as it requires the laboratory professional to re-engage with the ordering provider despite the laboratory most often being directly reimbursed for these ancillary services. Further, MAOs prohibiting laboratory professionals from initiating prior authorization requests conflicts

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<sup>10</sup> <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>

with regulation that states that any provider that furnishes, or intends to furnish, services to the enrollee can request a determination.<sup>11</sup> Laboratory professionals should be able to assist their patients with navigating the cumbersome prior authorization process.

2. **CMS should continue to require that MAOs implement and maintain an application programming interface (API)** that is populated with information about covered items and services, can identify documentation requirements for prior authorization approval, and can support a prior authorization request and response. It is important that all the information needed to support a provider or patient seeking to initiate a prior authorization request is easily accessible in a single location to ease the burden associated with the process. AMP applauds CMS' decisions to require MAOs to establish prior authorization APIs and believes that this requirement should be maintained and strengthened over time.
3. **CMS should implement additional policy changes to ensure that patients receive timely access to care, especially in urgent clinical situations.** Patients suffering from cancers or those with suspected infectious diseases need results quickly to begin treatment. Early intervention is critical in these areas. Additionally, sample quality quickly degrades if testing is not immediately performed. Despite CMS requiring that MAOs issue a decision within 72 hours after receiving an expedited request starting in 2026, this is often not fast enough to support optimal patient care. Thus, AMP supports establishing quicker response times given the advancements in electronic information transmission that will take place due to the CMS' Interoperability and Prior Authorization Final Rule. Specifically, AMP supports requiring decisions within 24 hours for urgent care and [48 or 72] hours for nonurgent situations. Further, CMS should issue guidance describing instances in which prior authorization will be allowed to occur concurrently for laboratory tests that need to be run immediately due to clinical circumstances.
4. **CMS should clarify that the test requisition form is part of the patient's medical record and may be sufficient documentation for a prior authorization request.** Laboratories often use test requisition forms to establish medical necessity as well as collect relevant information to demonstrate the appropriateness of the test for a patient. However, MAOs often ask for information already collected in the test requisition form but indicate that the form is not part of the medical record. The practice of asking for duplicative information is widespread, as OIG similarly found that MAOs have asked for additional documentation, delaying the prior authorization process despite the sufficient information to demonstrate medical necessity already being provided to the MAO.<sup>12</sup> One MAC Local Coverage Article (LCA) clarified that the test requisition form is part of the medical record.<sup>13</sup> The LCA states, "When requisition forms include complete information validating medical necessity, such as qualifying clinical information that demonstrate test coverage criteria are met, the requisition form may be sufficient to determine if the service is reasonable and necessary without other medical information from the ordering provider." This was an important step forward, but MAOs are still not complying with this clarification, and further action is needed to ensure these rules are clear in all MAC jurisdictions. CMS should set policy that clarifies that test requisition forms are a valid

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<sup>11</sup> 42 CFR 422.566(c)(1)

<sup>12</sup> <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp>

<sup>13</sup> <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=59744>

part of the medical record to prevent MAOs from inappropriately using medical documentation requests to further delay access to care.

5. **CMS should amend guidance to allow laboratory professionals to require MAOs to accept submission of prior authorization requests for testing services any time after the date of service.** The date of service for molecular laboratory tests used as part of inpatient hospital care is the date of specimen collection as required by CMS regulation.<sup>14</sup> As a result, the documented date of service is earlier than the date of performance. This discrepancy leads to numerous issues with processing prior authorization requests for laboratory tests.
6. **CMS should ensure that MAOs provide detailed information about the specific rationale for the denial.** CMS requires that a written notice be sent to the beneficiary and the physician involved, as appropriate, whenever a determination is partially or fully denied, which should state the specific reasons for the denial.<sup>15</sup> However, these explanations often do not have adequate information to expeditiously resolve any issues. For example, CMS should require that MAOs provide specific details about whether coding contributed to the denial. This would aid streamlining the process to ensure that patients have access to medically necessary care.
7. **CMS should amend regulation to further prevent MAOs from denying payment for laboratory services for services performed after prior authorization is granted and investigate instances in which payment is withheld.** AMP members have encountered situations when a provided laboratory service is denied payment even after a prior authorization request has been approved. These denied payments are detrimental to laboratories, which are often already operating with thin profit margins. Retrospective denial of payment or payment recoupment for care which has been preauthorized should be prohibited, except when materially false or fraudulent information has knowingly been given to the MAO.
8. **CMS should create an electronic reporting mechanism for providers to submit concerns, including suspected policy violations related to prior authorization, appeals, and denials within Medicare Advantage.** Currently, there is not a mechanism for healthcare providers, including laboratory professionals, to report concerns to CMS. Given that providers are best positioned to report errors such as improper denials, pre-emptive denials, overly burdensome and unnecessary documentation requirements and/or requests for previously submitted documentation, it would greatly benefit CMS to create a mechanism or pathway for providers to report misuse to CMS and support CMS' efforts to investigate suspected regulatory and coverage policy violations.

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<sup>14</sup> 42 CFR § 414.510

<sup>15</sup> <https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf>