DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244

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To: Medicare Advantage Preferred Provider Organizations

From: Patricia Smith, Director, Medicare Advantage Group

Subject: Pre-authorization Requirement for Out-of-Network Benefits and Other Rules for Medicare Advantage Preferred Provider Organizations

The Centers for Medicare and Medicaid Services (CMS) has completed its review of the 2005 Adjusted Community Rate Proposals (ACRPs). The review revealed that a number of Medicare Advantage (MA) preferred provider organizations (PPOs) anticipated requiring that their beneficiaries secure Plan authorization prior to receiving certain types of services out-of-network (OON), or in a few cases, before receiving any services OON. This Q and A is intended to clarify CMS policy related to the pre-authorization issue and the responsibility of the PPO.

Note: This question and answer applies to current MA PPOs and will not apply to demonstration PPOs until 2006, when their demonstration status ends and they transition to the regular Medicare Advantage program.

Q AND A ADDRESSING PRE-AUTHORIZATION AND OTHER RULES FOR MA PPO PLANS

Q: What rules may an MA PPO plan apply for enrollees who are accessing out-of-network providers? Specifically, can a PPO plan apply pre-authorization requirements as a condition for payment or for enrollee access to out-of-network providers?

A: MA PPOs may use permitted authorities and established review techniques to conduct pre-authorization activities for the following purposes:

1. To determine medical necessity. These prospective review techniques must be applied consistently on both in- and out-of-network services. We understand that the primary purpose for using prospective review is to ensure that beneficiaries seeking out-of-network care are not financially burdened by retrospective adverse medical necessity determinations. **MA PPOs are not allowed to require their beneficiaries to secure authorization prior to receiving out-of-network services for the purpose of denying services.** Should a member receive medically necessary plan-covered services from a qualified provider, in a non-

network setting, but without following the established review techniques, the PPO must pay for the service. In these instances, the PPO may charge the beneficiary higher cost-sharing for this service. Any health care service that the member receives that is determined not to be medically necessary can be denied by the PPO.

2. To determine if a service is a medical service that is covered by the plan.

3. To determine if a non-network provider is qualified to provide the plan-covered services. A PPO may require that in order to be a covered service the non-network provider must meet the PPO's terms and conditions of participation and payment.

Further, MA PPOs may restrict reimbursement to the provision of such covered services by Medicare qualified providers, that is, providers who are eligible to be paid by original Medicare and meet the requirements at section 422.204(b)(3).

MA PPOs may encourage beneficiaries to use pre-authorization by offering favorable cost sharing on out-of-network services.