American
Clinical Laboratory
Association

Prior Authorization of Laboratory Services

ACLA is a not-for-profit association representing the nation's leading clinical and anatomic pathology laboratories, including national, regional, specialty, hospital, ESRD and nursing home laboratories. The clinical laboratory industry employs nearly 277,000 people directly and generates over 115,000 additional jobs in supplier industries. Clinical laboratories are at the forefront of personalized medicine, driving diagnostic innovation and contributing more than $100 billion to the nation's economy.

While prior authorization is intended to support clinically appropriate care, its use to discourage use of laboratory tests poses a serious risk to patient care. In the interest of maintaining accessibility to the timely provision of laboratory services for health plan members, ACLA has developed basic tenets for prior authorization programs that encompass laboratory services. These tenets seek to 1) improve prior authorization processes that may not be functioning as intended and therefore creating significant barriers to patients and providers, and 2) to minimize delays in laboratory testing and results particularly where components of such processes are not of value to stakeholders including health plans, health plan members, laboratories and ordering physicians. These barriers and delays that arise under prior authorization programs threaten access to critical laboratory services used in the prevention, diagnosis, and monitoring of disease.

By category, ACLA urges adoption of the following items as essential components of a prior authorization program that encompasses laboratory services.

1. Implementation – Prior authorization program implementation includes

- Adequate prior notice to laboratories and ordering physicians of intended implementation
- Adequate time for complete training of affected providers (use of portal and requirements for ordering physicians and laboratories) at least 90 days prior to implementation with training materials made publicly available to end users within the same time frame prior to implementation

2. Provision of Services – To ensure prior authorization programs are not negatively affecting providers' ability to diagnose and treat health plan members, prior authorization programs must not interrupt or delay the provision of necessary medical services, both diagnostic and therapeutic through financial incentive, operations, or otherwise.

3. Transparency – Prior authorization programs need to provide for the following to afford a) members access to medically necessary services and providers the ability to comply with prior authorization programs, and b) the opportunity to streamline and improve the efficacy of requirements as programs mature:

- The ability for laboratory to track prior authorization status from initial request for prior authorization to issuance/denial, not just upon issuance of prior authorization

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- Disclosure of coverage policies/medical necessity and documentation requirements for those services requiring prior authorization that are based on up-to-date generally accepted clinical criteria

- Open collaboration and communication with laboratories including the specific reason for prior authorization when not granted (i.e. identified criterion not met)

- Clarity in written and publicly available form on CPT codes/services subject to prior authorization and rationale for their requiring prior authorization

- Publication by health plan on its website or other publicly available website of prior authorization statistics to include:

    - Number of prior authorization requests received

    - Prior authorizations granted and denied and associated turnaround times

    - Number of denied prior authorization requests appealed and results (overturned or upheld)

    - Denial reasons (administrative, medical necessity, etc.)

    - Ordering provider specialty

    - Summary by CPT code of number of prior authorization requests received and granted or denied

4. Administration - In the interest of not unreasonably increasing administrative burden for both laboratories and ordering providers, the inclusion of the following is needed for prior authorization programs that encompass laboratory services

- The ability to identify which health plan members are subject to the prior authorization requirements by specific identifier on identification card and via other means for providers that do not routinely see a copy of the member identification card such as an extra digit appended to the member identification number or other similar identifier.

- Initiation of prior-authorization request and validation of existence of prior authorization by both the laboratory and ordering physician. Note that where reflex testing is involved (i.e. the initial result is inconclusive), the test is performed automatically without intervention of the ordering physician.

- Appeal of denials by laboratory on behalf of patients

- An avenue for laboratory to secure prior authorization after date of service and before claims submission if not secured prior to the date of service

- Inclusion among program objectives of the following: a) reducing administrative burdens that can result in delays in care including varying criteria across products, b) striving to achieve consistency across payors in information requested, criteria, and c) to the extent possible, format and process and molecular test coverage.

5. Access to Services – To facilitate assessing the impact, if any, of prior authorization on its provider networks, the following need to be provided by health plans

- Demonstration on a quarterly basis post-implementation via public reporting/posting to health plan website that access to care has not been negatively affected by the requirements (# of ordering physician and laboratory terminations from network participation and identification of alternative providers)

6. Turnaround Time – So that care is not delayed due to prior authorization requirements or claims improperly denied, programs should be based on

- Accurate understanding of laboratory date of service (DOS) rules and operations in setting forth turnaround times. The laboratory DOS for services subject to prior authorization is typically the date of collection rather than the date the test was performed.
    - Requiring initiation of prior authorizations within 48 hours of accessioning the sample from the patient is not realistic as it can often take longer for the laboratory to receive the sample. Those performing biopsies, particularly surgeons, because of their surgery schedules may not be able to submit prior authorization requests within the required time frame.

- Issuance of prior authorization in an appropriate and consistent turnaround (i.e. within 24 hours of receipt of information necessary to assess the authorization and grant request)

- An avenue for expedited administrative review prior to claims submission rather than full appeal when denial of authorization was for an administrative/mechanical reason