

## FIX PRIOR AUTHORIZATION AND PROTECT PATIENTS

Heart disease is the leading cause of death for men and women in the United States. There are many tests that can be used to diagnose cardiovascular diseases and conditions. Which test is ordered by a physician should be based on a variety of factors, including symptoms, medical history, and an individual's physical characteristics. **Too often, however, decisions are taken out of the hands of physicians and made by insurance companies solely on the basis of cost.**

Prior authorization policies that deviate from Medicare coverage criteria ignore current evidence, disregard the value of shared decision-making, and are disruptive to patient care. **According to a KFF analysis published on Jan. 28, 2026, a majority of appeals following a denial are approved.** Denials eventually approved on appeal represent care that was likely delayed and significant administrative burden on physician practices fighting with Medicare Advantage (MA) organizations to gain approval of medically necessary care.

The American Society of Nuclear Cardiology has partnered with other cardiovascular societies to develop clinical guidelines, appropriate use criteria, and quality measures to guide clinicians toward the appropriate use of diagnostic imaging tests. Too often payers use restrictive algorithms that uniformly guide patients to the same diagnostic test regardless of individual characteristics. This is not good patient care, and reform is needed to end such harmful practices.

The Centers for Medicare & Medicaid Services (CMS) has regulations that address prior authorization, including limiting MA plans from using their own internal coverage criteria to deny care. CMS also requires more transparency from health plans about their use of prior authorization. However, gaps remain. Action by Congress is needed to expand and enhance these regulations.

### Fast Facts

52.8 million Medicare Advantage prior authorization determinations in 2024

4.1 million (7.8%) fully or partially denied

A small share (11.7%) of denied prior authorization requests appealed

Most appeals (80.7%) partially or fully overturned

Source: [KFF.org](https://www.kff.org)

## HOW MEMBERS OF CONGRESS CAN HELP

Pass the ***Improving Seniors' Timely Access to Care Act (S. 1816, H.R. 3514)*** to codify CMS prior authorization regulations for MA plans and require greater transparency of prior authorization processes, which will help patients and healthcare providers understand whether particular services are likely to be approved. MA plans should be required to report prior authorization metrics at a more granular level, including approvals and denials by service and item category, as well as the number of requests denied and appealed using AI or similar technology. These requirements will make transparency data more useful and actionable.