



Issue Brief: Prior Authorizations for Imaging Services

Advocacy

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Purpose

The purpose of this AAFP Advocacy Issue Brief on Prior Authorizations is to provide background information and calls to action to private payers and their vendors that support prior authorization/notification programs for imaging services. Our goal is to facilitate administrative simplification and ensure quality healthcare.

Background

The increase in healthcare expenditures has led to cost containment strategies to reduce inappropriate use of health services. These strategies include requiring prior authorizations or notifications for certain health benefits. The purpose of pre-service review/prior authorization is multi-faceted: (a) to establish that the provider has met the health insurer's medical necessity guidelines for the service based upon the patient's diagnosis and history; and (b) to confirm that the services are being provided in the most cost-effective manner. The health insurer or one of its contracted vendors usually reviews the treatment plan and service requested to determine the patient's eligibility for the requested service, the date, place, and type of service, as well as the *Current Procedural Terminology* (CPT) code to be used. Physicians ordering specific imaging tests are obligated to perform the prior authorization request, which includes providing the vendor with patient-specific demographic and clinical information.

There are multiple areas where cost containment programs have increased administrative activities for physicians as well as those operating the program. However, one main area of consternation for family physicians has been cost containment programs for imaging services. Prior authorization for these services has consumed a considerable portion of healthcare dollars in the form of administrative costs for both the payer and physician practices and is the focus of this brief. There is recognition that ordering medically appropriate advanced imaging is the goal.

Messages

- Imaging management programs should strive for transparency, minimal administrative burden, and standardization and should promote learning and improvements in quality of care.
- A movement towards the use of evidence-based clinical decision-support systems at the physician level is necessary.
- Payer Patient Health Records should be accessible and in compliance with the Continuity of Care Record (CCR) to ensure all pertinent information is available at the point of care.
- Patient-specific health benefits subject to prior authorization should be included in the information received via an electronic eligibility benefits response.
- Physicians following the evidence-based guidelines should be rewarded by easing their administrative burden involved with authorization/notification programs, e.g. exemption/"gold-carding", automatic authorization, etc.

- The post-service work included in the relative value units for Evaluation and Management (E/M) services is insufficient to account for the practice resources expended to comply with prior authorization programs.

Calls to Action for Health Plans and Their Vendors

- Support the principle that prior authorization processes should be simplified, transparent and standardized as much as possible.
- Use evidence-based clinical guidelines when developing “appropriateness criteria” for advanced imaging tests.
- Promote industry collaboration to implement evidence-based decision support tools at the point of care.
- Ensure access to Payers’ Patient Health Record data in compliance with the Continuity of Care Record (CCR) to ensure all pertinent information could be uploaded to physicians’ electronic health record (EHR) system and available at the point of care.
- Enable the use of WEDI standard machine-readable patient health identification cards to auto populate patient demographic data necessary for prior authorizations.
- Support physician education and quality improvement activities by sharing imaging ordering performance data, e.g. Continuing Medical Education modules, ordering pattern compliance to clinical guidelines, provision of regular program vendor reports to ordering physicians, etc.
- Appropriately address the reasons why an imaging test is ordered beyond just the clinical diagnosis, e.g. sub-specialist request, patient preference, medical liability concern, etc.
- Conduct or support research to determine the total administrative costs for all parties involved in prior authorization programs for imaging services.

AAFP Administrative Simplification Activities

AAFP holds that health information technology should adhere to the four (ACID) principles: Affordability, Compatibility, Interoperability, and Data Stewardship¹.

A summary of the AAFP Administrative Simplification activities is available [here](#) or at www.aafp.org/privatesector > What We're Working On > Administrative Simplification, under “OUR STANCE.” AAFP wants to reduce unnecessary administrative complexity and duplication of effort in the healthcare system leaving more time for direct patient care.

¹ AAFP Center for Health Information Technology, Guiding Principles, <http://www.centerforhit.org/online/chit/home/about/principles.html>.