

David Twiddy

Beating the Prior Authorization Blues

Getting insurer approval for treatment can take hours out of your week. Here are some ways to reduce the pain.

Like many family physicians, W. Ryan Neuhofer, DO, has spent his share of time on the phone asking insurers for prior authorization of medications or medical procedures for his patients.

Unlike many physicians, Neuhofer decided to videotape it. The Lawrence, Kan.-based physician recorded a

21-minute call of him seeking approval for a computerized tomography (CT) scan for a patient with a palpable mass on his skull and then posted the video on several social media platforms (e.g., <http://bit.ly/2aDXdZI>), where it attracted thousands of views.

“Apparently it struck a chord,” he said.

The call was shorter than the typical prior authorization request, Neuhofer said, but it was just the first of several prior authorization calls he had to make on

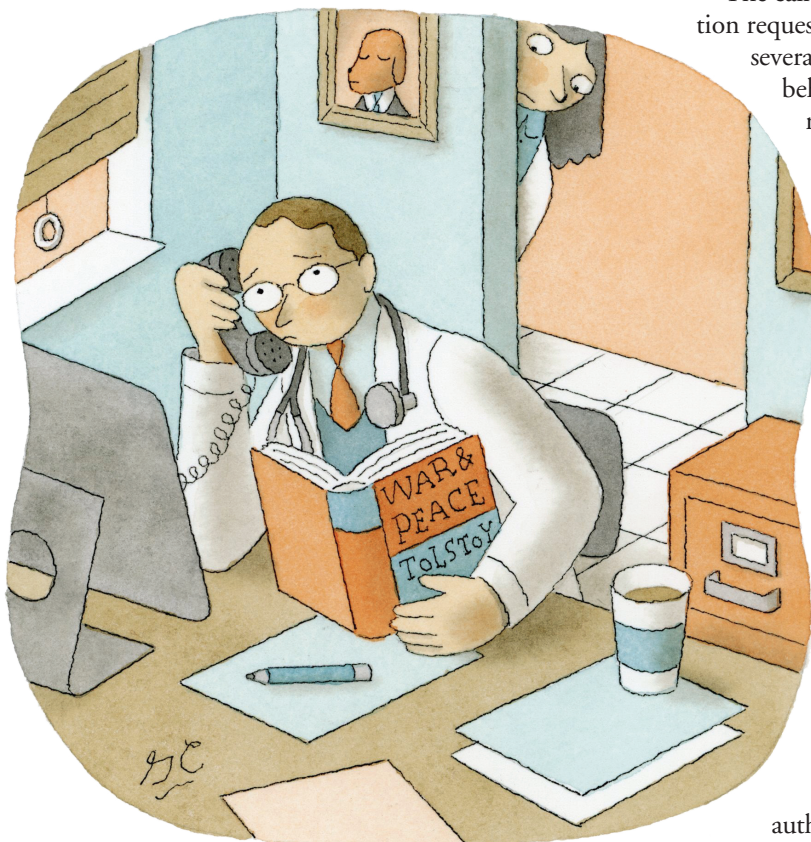
behalf of the patient as concerned radiologists requested additional CT scans, a magnetic resonance image (MRI), and nuclear bone scans to help diagnose the tumor and see if it had metastasized from elsewhere.

The insurer ultimately approved all of the tests, but delays forced the patient to decide to undergo the scans before receiving insurer approval because of the possibility of cancer, he said.

Neuhofer has to seek prior authorization only a handful of times a month in his direct primary care practice. However, he said cases like this are especially frustrating because the medical need was clear and there was little chance the procedures would be denied.

“We feel like we’re trying our best to advocate for our patient,” he said. “It creates that sense of angst that we want to help people and yet there’s someone who is not really accountable who is straining that relationship of us being an advocate.”

Insurers and other payers have long used prior authorization as a valuable tool. Lydia Bartholomew,



About the Author

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Continued pressure to hold down health care costs makes it unlikely that insurers will abandon prior authorization in the near future.

MD, of Edmonds, Wash., is a medical director for a national insurer and a member of the American Academy of Family Physician's (AAFP's) Commission on Quality and Practice. She said insurers require prior authorization to confirm that the treatment prescribed by the physician is covered by the patient's health plan and is the most appropriate care in the best setting. This helps insurers control health care costs by reducing duplication, waste, and unnecessary treatments, as well as identifying patients who might benefit from case management services, she said.

Of course, the tactic has real costs for physicians and their practices. One study estimated that primary care physicians spend an average of 3.5 hours a week dealing with insurers, and the entire medical community spends the equivalent of between \$23 billion and \$31 billion annually in time on insurance matters, including prior authorization.¹

Prior authorization can also negatively affect quality of care. According to an American Medical Association survey, two-thirds of physicians said they waited at least a few days for preauthorization on tests, procedures, or medications, and between 10 percent and 13 percent said they waited for more than a week.²

Prior authorization on the rise?

Whether insurers are increasingly requiring prior authorization is difficult to assess. Anthony Akosa, MD, MBA, chief medical officer of HealthEC, which advises accountable care organizations and other large provider groups, believes insurers are reining in their prior authorization requirements to some degree. They are responding to customer frustration over delays or denials of medical treatment, he said. However, growth in high-deductible health plans, which tend to have more coverage limitations, might be contributing to a perception that prior authorization requirements are increasing when in

fact more services are being denied for lack of coverage, he said.

Family physician Catherine Varney, MD, of Richmond, Va., is among those who say they are definitely dealing with more prior authorization requests than in the past.

Varney's multispecialty clinic used to have one staff member handling prior authorization requests for all 10 family medicine providers. Now, the practice has one person processing requests for every three providers, which of course generates added overhead cost.

Terry L. Mills Jr., MD, medical director for primary care at the St. John Clinic in Tulsa, Okla., and a member of the AAFP's Commission on Quality and Practice, said he has noticed many more instances of prior authorization for medication. In many cases, Mills said, physicians submit medication orders and then hope the patient does not get bad news at the pharmacy.

"Like most prior authorization, it feels like Russian roulette with prescriptions most of the time," Mills said.

Continued pressure to hold down health care costs makes it unlikely that insurers will abandon prior authorization in the near future. That means practices will need to work harder and smarter to prevent insurer approval processes from interfering with the quality of care they give their patients and the speed with which they deliver it.

What can you do?

Although it takes concerted effort, family physicians and their staff can reduce the burden of prior authorization, whether through better preparation, more streamlined workflow, or more successful negotiations with insurers.

Identify equally safe and effective but cheaper alternatives to any high-cost drugs you prescribe. Use websites such as <http://www.epocrates.com/> or <https://www.drugs.com/> to learn the prices of medications.

■ Insurers use prior authorization to help control costs and discourage inappropriate care.

■ Physicians must spend significant time seeking prior authorization, and it can delay treatment.

■ Some physicians report that prior authorization requests are increasing.

Create master lists of medications and procedures that require prior authorization, broken down by insurer. Your electronic health record (EHR) may already have a database of drug tiers that you can use to estimate whether a particular prescription is likely to require prior approval, but some physicians have expressed frustration that these databases are often out-of-date or inaccurate. Ask your largest payers for copies of their prior authorization guidelines and drug formularies, and use the information you gather to create up-to-date lists of the medications and procedures for which your insurers require prior authorization. If an insurer is unwilling to provide this information, point out that reducing the time spent on prior authorization requests, or eliminating them entirely, helps decrease the company's overhead as well as yours.

If possible, use this list to program your EHR to alert physicians when they order something that requires prior authorization. This may require working with your vendor if your EHR does not already offer this function.

Use evidence-based guidelines. Insurers are likely to require prior authorization for orders outside those recommendations.

Prescribe generic drugs when possible. These usually do not require prior authorization, although some physicians report having to seek prior authorization even for generics, often in the case of high-deductible plans. In any event, the idea is to look at frequently prescribed medications that require prior authorization and determine if prescribing a generic version or other alternative would be more worthwhile.

Educate patients about prior authorization and coverage limitations. This can help establish realistic expectations and reduce anger at the practice when a medication or procedure is delayed or turned down.

"We don't request prior authorization until we feel that a test or procedure is indicated," said Robert Eidus, MD, of Cranford, N.J. "We educate patients that an MRI in the first week of back pain is not going to be approved." Although this education is an additional burden for your staff, and one for which you are not paid, it can be beneficial, especially if it leads patients to complain to their insurer and possibly force a change in the company's policies.

Spend more time on documentation, particularly when ordering things you know do not follow the standard guidelines. Unusual or poorly documented cases most often get rejected. An EHR alert can be customized to remind physicians what specific information the practice will need to include in a prior authorization request. This can be particularly important for insurers that have "fail first" or "step therapy" policies – i.e., they cover more expensive treatments only if less expensive treatments failed to solve the patient's problem.

Michael Holliday, MD, a family physician in Cincinnati, said he programmed a shortcut in his EHR to remind him what to include for specific tests, such as an MRI for lower spine. "If there are no documented prior attempts at conservative treatment, such as physical therapy, they won't approve the test," he said, adding that the shortcut also reminds him to note if he's using a test to rule out a more serious condition.

Systematize the process by creating pre-populated forms. For those prescriptions or tests that most often require prior authorization, it can be helpful to create forms that already include the codes, diagnoses, and other information that insurers typically require to process prior authorization requests. Better yet, use the insurer's own forms, if available. The physician just needs to add the patient's name and identifying information. Although it may be tempting during a busy day to fill out the bare minimum of information on an insurer's prior authorization form, you will save yourself and your staff time and headaches by filling out the form completely, Bartholomew said, because someone in your practice will have to provide the other information eventually.

Designate one staff member (or a small group of staff in larger practices) to handle all prior authorization requests. This strategy prevents the physician from sitting on the phone with insurers instead of treating patients, allows designated staff to become knowledgeable and efficient in dealing with insurers, and makes it easier for a practice to remain up-to-date with prior authorization requirements because fewer staff have to be informed of every change. The obvious drawback of this model is if the staff member gets sick, goes on vacation, or leaves the practice, there is a knowledge gap. One way to prepare for this situation is to store all of the prior

■ Learn which medications and procedures require prior authorization, and look for alternatives.

■ Use evidence-based guidelines, prescribe generic drugs, and explain to patients why you do this.

■ Carefully document any treatment that does not follow standard guidelines.

Unusual or poorly documented cases most often get rejected for prior authorization.

authorization information, including requirements broken down by insurer and alternative medications or procedures, in a format that all staff can access. Cross training a staff member to serve as backup can help as well.

Use technology whenever possible. Filling out an online preauthorization form is generally quicker and easier than speaking with a payer over the phone or filling out and faxing a form. In addition, you can submit requests outside of normal business hours.

Set a deadline. Find out, if possible, your insurers' turnaround times for providing prior authorization. Push them to meet these deadlines.

Use the appeals process. If a request for prior authorization is denied and you believe the denial is inappropriate, submit additional documentation to establish medical necessity and ask the insurer to reconsider. If that doesn't work, file an appeal as soon as possible. Make sure to keep track of appeals and how long until an insurer must make a decision.

Take advantage of a payer's peer-to-peer process. Insurers generally have a medical director or other physician available at certain times to speak with physicians about prior authorization issues. These discussions can often solve problems that could have taken hours to fix at the staff level. Bartholomew said that although she can't say how often a conversation between a treating physician and medical director led to a different prior authorization decision, it can be helpful.

"I can certainly say that those conversations do make clear the issues at hand and sometimes can be a learning opportunity on both sides," Bartholomew said. "A common conversation occurs over the lack of information on a form, which is then provided and allows a decision to be made. I think it's a good idea, and we certainly encourage the physicians to have the conversation. It doesn't always result in the decision that you want, but it results in more clarity around the situation."

When all else fails, fight. When Jessica

Triche, MD, a family physician in Chocowinity, N.C., receives a prior authorization request driven by changes in the payer's drug formulary, she routinely sends a form letter. It explains the dangers of changing patient drug regimens and makes the point that her prescription decisions are driven by medical judgment, not "because I saw it on TV, received a free lunch, or found coupons on my desk," she says.

Brian Forrest, MD, a family physician in Apex, N.C., goes a step further when he receives prior authorization inquiries from insurers, faxing a letter that demands they pay him for his time seeking prior authorization or determine by themselves if a medication should be covered based on past claims data for the patient. He includes a copy of a court judgment involving an Ohio physician who successfully sued a medical insurance administrator for the cost of his time responding to prior authorization inquiries. "While no insurer to date has sent us a check, several have decided that they would just approve it so that they are not the second successful court case," Forrest said.

The future of prior authorization

Physicians and health consumers, frustrated with prior authorization, are demanding change. Industry groups and state legislatures have considered such ideas as requiring that insurers develop universal paper forms or online transaction processes that physicians can use to provide prior authorization details to any insurer. Some companies are embedding these transaction standards in physician EHRs, so that prior authorization questions are presented at the point of care as part of the e-prescribing process. Advocates have also asked for more uniformity and transparency in terms of what medications and procedures require prior authorization and how prior authorization decisions are reached, as well as defined deadlines for payers to respond to prior authorization requests.

Others are asking insurers to recognize individual physicians who responsibly prescribe the

■ Limit prior authorization work to a small number of employees to encourage proficiency and consistency.

■ For problems or denials, make sure to use the payer's appeals process or speak with a medical director.

■ Industry and government leaders are looking for ways to make prior authorization less of a burden.

medications or procedures insurers are trying to control. Sometimes called “gold carding,” the idea is that physicians who can show that they are efficient and cost-effective and that their rates of prescribing these medications or ordering these services are lower than average would not be required to seek prior authorization for a given amount of time.

Akosa said this kind of approach will become more prevalent as value-based care becomes more common. In the meantime, much of this performance information is already available and physicians should try using it now when negotiating contracts with insurers, he said. “Most insurers will not come to you offering that benefit,” he said. “You will need to call them and use your good performance as leverage to get that.”

Others cautioned that insurers would need robust data systems capable of gathering and processing such information annually and then would need to make their decisions transparent to physicians.

Similar proposals include developing appropriate use criteria and clinical decision support

modules in EHRs in lieu of prior authorization and eliminating prior authorization requirements for those medications and procedures that are almost always approved anyway.

In an age of medical wonders that give physicians and their patients access to new drugs, more accurate tests, and ground-breaking procedures at high costs, insurer controls are a fact of life. But by practicing evidence-based medicine, maintaining good documentation, smartly using technology and staff, and following other ideas described in this article, physicians are trying to make prior authorization less of a burden. **FPM**

1. Casalino LP, Nicholson S, Gans DN, et al. What does it cost physician practices to interact with health insurance plans? *Health Aff (Millwood)*. 2009;28(4):533-543.
2. Commins J. Prior authorization hurts patient care, AMA survey finds. *HealthLeaders Media*. Nov. 23, 2010. <http://bit.ly/29rg5Lx>. Accessed July 6, 2016.

Send comments to fpm@aad.org, or add your comments to the article at <http://www.aafp.org/fpm/2016/0900/p15.html>.

Advocates want greater transparency and consistency in prior authorization policies.

“Gold carding” would allow physicians with a history of cost-effective treatment to avoid prior authorization requirements.

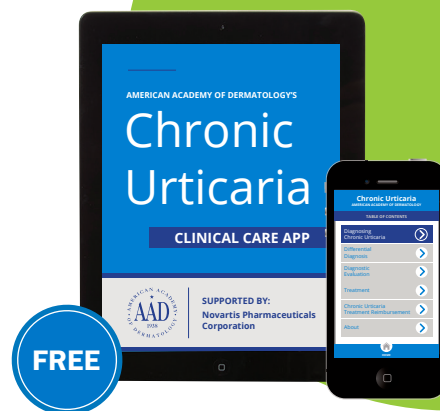
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