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A GUIDE TO RELIEVING ADMINISTRATIVE BURDEN:

Prior Authorization

A Guide to Relieving Administrative Burden is a series of supplements developed by the American Academy of Family Physicians (AAFP) to provide information about innovations proven to relieve administrative burden and optimize your family medicine experience. It is based on AAFP Innovation Labs conducted with physicians like you, as well as a comprehensive literature review. Whether you have a solo practice or are an employee of a large health system, the guide will help you consider and adopt proven innovations.

This is the second supplement in the series. It describes key AAFP advocacy efforts and techniques, technologies, and transformations to help reduce your prior authorization burden without compromising patient care.

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Introduction

Prior authorization (PA) is a cost-control tool that requires payer approval before an order for a service or prescription is covered. The process is costly, inefficient, and opaque, and it is a leading cause of administrative burden for family physicians that continues to be overused and abused. In fact, a 2022 American Medical Association (AMA) survey found that 88% of surveyed physicians reported that PAs put a "high or extremely high" burden on their practice, with practices completing an average of 45 PAs per physician every week.[1] This high volume of PAs requires physicians and their staff to take valuable time away from patient care to make phone calls, wait on hold, obtain and fill out forms, collect and submit medical documents, and appeal denials. Chief complaints about PA include the following:

- *It's still the bane of our existence.*

- *My staff deals with it; it's a killer for them.*

- *Our approval rate is 99.87%, and we still had to hire three additional full-time equivalents this year. It's very frustrating.*

- *Why do I have to get prior auth again? It's a continuation of the same medication.*

- *It takes 40 minutes to talk to someone after a denial.*

For primary care practices, the median value of all the time spent interacting with health plans is nearly $48,000 per year per physician.[2] The PA process also harms patients by delaying care and reducing adherence to treatment. Family physicians and their staff often bear the brunt of patients' frustration with PAs and the associated care delays.
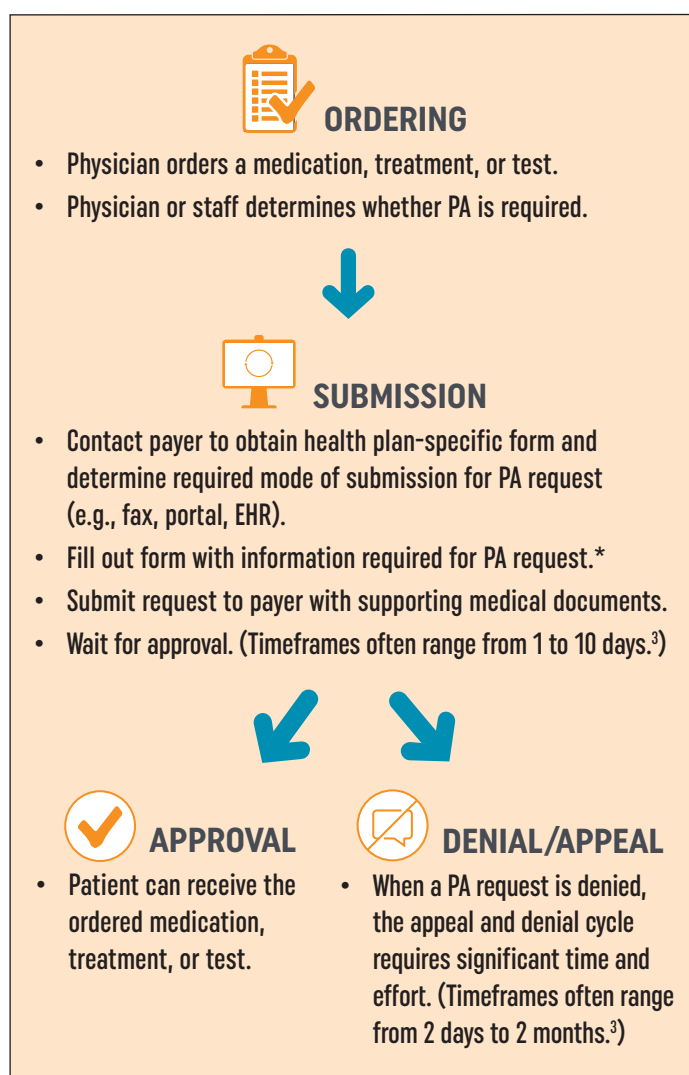
Key Points

- The burden associated with PA must be addressed with advocacy.

- The AAFP strongly advocates for the automation and elimination of PA.

- The techniques, technologies, and transformations outlined in this supplement can help reduce the burden.

The Prior Authorization Process

The phases of the PA process are ordering, submission, and approval or denial/appeal (*Figure 1*). Innovations can directly address issues in the submission phase to help reduce administrative burden for physicians and their staff. **Much of the burden associated with the approval phase and the denial/appeal cycle is payer driven and must be addressed through advocacy and comprehensive policy reform.** Technological innovations to streamline the entire PA process are evolving, but they have been focused on hospital and specialty practice revenue centers that offer high-cost diagnostic tests and therapeutics (e.g., cardiology practices, specialty testing labs). In most cases, primary care PAs are not associated with any practice revenue, so family medicine practices have not been a market for PA technology and service companies.

Figure 1. Phases of the Prior Authorization Process

ORDERING

- Physician orders a medication, treatment, or test.
- Physician or staff determines whether PA is required.

SUBMISSION

- Contact payer to obtain health plan-specific form and determine required mode of submission for PA request (e.g., fax, portal, EHR).
- Fill out form with information required for PA request.*
- Submit request to payer with supporting medical documents.
- Wait for approval. (Timeframes often range from 1 to 10 days.[3])

APPROVAL

- Patient can receive the ordered medication, treatment, or test.

DENIAL/APPEAL

- When a PA request is denied, the appeal and denial cycle requires significant time and effort. (Timeframes often range from 2 days to 2 months.[3])

EHR = electronic health record; PA = prior authorization.
*Required information varies by specific medication, treatment, or test, as well as by each specific health plan and each of the plan products.

Impact of Prior Authorization

In December 2022, the AMA surveyed 1,001 practicing physicians regarding PA.[1] Key findings from respondents included the following:

- **94%** reported that PA delayed the start or continuation of necessary care.
- **88%** reported that the burden associated with PA is high or extremely high for physicians and practice staff.
- **33%** reported that a patient experienced a serious adverse event due to PA.
- On average, physicians and practice staff spend about **two days per week (14 hours)** completing PAs.

In March 2023, the Medical Group Management Association (MGMA) surveyed executives representing 601 medical group practices regarding PA in Medicare Advantage (MA) plans.[4] Key findings from respondents included the following:

- **97%** reported that PA requirements resulted in care delays or denials.
- **84%** reported an increase in PA requirements for MA in the last 12 months.
- **84%** had to reauthorize existing Medicare-covered services when their patients switched plans.
- **72%** had a required peer-to-peer discussion with a health plan clinician who was not from a relevant specialty.

Advocacy to Reduce Prior Authorization Burden

Streamlining and automating PA will not be enough to relieve the burden on family physicians and their patients. PA must be limited to far fewer products and services, and the process must be standardized and transparent.

AAFP Advocacy Goals

The AAFP fiercely drives efforts to reform PA and remains focused on enabling physicians and patients to have access to clear guidelines for PA requirements and timely responses from insurance plans. The following are key goals driving the Academy's advocacy to reduce PA burden.

PA and step therapy should be eliminated for the following[5]:

- Physicians using appropriate clinical knowledge, training, and experience
- Physicians in financial risk-sharing agreements
- Physicians who have high approval rates ("gold carding")
- Services that are evidence-based standards of care
- Services that are regularly approved
- Medications that are standard, inexpensive, and generic
- Durable medical equipment (DME) supplies for patients who have long-term or permanent chronic conditions
- Patients who have a chronic disease that is under effective medication management
- Patients already on a course of treatment under a previous plan

PA should be standardized across all payers in the following ways:

- Require standard electronic prior authorization (ePA) application programming interface (API) for payers and electronic health records (EHRs)[6]
- Standardize requests across the Centers for Medicare & Medicaid Services (CMS) and commercial payers[5]
- Set response timeframes to 24 hours for urgent requests and 48 hours for nonurgent requests[7]
- Attest that diagnosis is sufficient for medical necessity[5]

Payers should be fully transparent and provide access to the following[7]:

- Patients' PA status (*Note: This will help alleviate practice burden and prevent patients from blaming physicians and their staff for delays.*)
- Accurate, up-to-date formularies, drug tiers, and requirements for use of specific pharmacies
- Alternative medications that do not require PA
- Cost of medications, including out-of-pocket costs

- Explanation of medical necessity determinations
- Clinical criteria used for each denial
- Coverage criteria summaries

AAFP Advocacy Win: 2024 Medicare Advantage and Part D Rule

In a win for the AAFP's advocacy efforts, the final 2024 Medicare Advantage and Part D rule improves MA coverage criteria, increases transparency of PAs and medical necessity determinations, and prevents inappropriate coverage denials.[8] It includes the following improvements[9]:

- Requires plans to only use PA to "confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary," not to delay or deter care.
- Sets a minimum 90-day transition period for enrollees currently undergoing treatment who change to a new MA plan. During this period, the new plan cannot require PA for the active course of treatment.
- Ensures that approval of a PA request for a course of treatment remains valid "for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation."
- Requires all MA plans to establish a utilization management committee "to review policies annually and ensure consistency with traditional Medicare's national and local coverage decisions and guidelines."

The Three T's for Addressing Prior Authorization Burden

In *Tables 2, 3,* and *4,* you will find a list of techniques, technologies, and transformations for addressing PA burden that have been identified in the literature and by family physicians working with the AAFP Innovation Lab. A relative estimate of potential burden reduction and probable cost range for each innovation is also shown. Actual impact will vary based on the practice environment and the baseline level of burden associated with PA. More information about these innovations and others is available at aafp.org/simplification.

Table 2. Techniques to Address Prior Authorization Burden[10,11]

	Impact[a]	Cost[a]
Prescribe Mindfully • Identify safe but cheaper alternatives to high-cost drugs. • Prescribe based on evidence-based guidelines. • Choose generic drugs when possible.	+++	-
Streamline Workflows • Create master lists of medications and procedures that require PA, broken down by insurer, and alternatives that do not require it. Program your EHR to alert you when you order something that regularly requires PA. • Be especially thorough with your documentation when ordering treatments or services you know do not follow the standard guidelines. • Create prepopulated forms, ideally using the insurer's own forms, listing codes, diagnoses, and other information the insurer typically requires to process a PA. • Submit requests electronically and use technology (a portal or EHR) to upload supporting documentation instead of faxing it.	+	$
Delegate PA • Designate one or more dedicated staff members to submit PAs.	++	$$
Push Payers • Push insurers to meet their own deadlines for turning around PA requests. • If denied, use the payer's appeals process. Keep track of appeals and how long until an insurer must make a decision. • Leverage a payer's peer-to-peer process. Speaking with the insurer's medical director or other physician available to speak with physicians about PA issues can clear up problems much faster. • When all else fails, fight. Some physicians send a form letter defending their use of a particular medication or pointing out the dangers of changing patient drug regimens, while others threaten to send the insurer a bill for their time. Some also recruit their patients to send letters to their insurer. Consider also sending letters to your state insurance commissioner.	+	$$

EHR = electronic health record; PA = prior authorization.

a. This information is meant to give you a relative estimate of the impact and cost for each innovation. It should be seen as a guide for the category. Specific products or services may vary widely in cost to implement, and their impact can vary based on practice environment and implementation.

Table 3. Technologies to Address Prior Authorization Burden

Pick the Most Efficient Submission Technology	Impact[a]	Cost[a]

Fax and Telephone – Medical and Prescription
Traditionally, physicians and their staff have requested PA via fax or phone. These widely available and commonplace methods require significant time and effort.
• **Fax**[12]
  Practices that fax their PA submissions can streamline the process by assembling a library of health plan-specific request forms; however, each form must be filled out by hand. In addition, response to a faxed PA submission is often delayed by the payer requesting additional information.
• **Telephone**[12]
  In many cases, practices that request PA by phone can report all required information verbally at once, which may minimize delays in either receiving approval or starting an appeal. However, because reported information is not automatically documented in the EHR, practices do not have any independent proof of PA submission. Long hold times are common, and health plans may still require that supporting medical documents be faxed. Further, the pharmacy has to be notified once a prescription PA request is approved.
	+/-	-

ePA With EHR Integration
Ask your EHR vendor or IT department if your EHR supports ePA. Using this technology can save the practice time compared to a manual PA process.
• **ePA – Medical (Standard: ASC X12 278)**[12]
  – Potential standard process across EHRs and payers
  – Not widely available yet
  – Manual processing by payer means response is often not in real time
• **ePA – Prescription (Standard: NCPDP SCRIPT ePA)**[12]
  – Potential standard process across e-prescribing, EHRs, and payers
  – Not widely available yet
  – Alerts prescriber of PA requirement so PA can be completed before the prescription is sent
  – Allows for electronic appeal and cancellation of PA requests
  – Manual processing by payer means response is often not in real time
	++	-

Payer Portals – Medical and Prescription
If your EHR does not provide ePA, accessing an external portal is likely a better process than manually submitting requests. There are two types of portals: single payer and multipayer.
• **Single Payer Portals – Medical and Prescription**[12]
  Many large insurers have an electronic portal through which physicians and their staff can submit and track the status of PA requests. However, most payers still require prescription PA requests to be faxed rather than submitted via a portal. Single payer portals offer the benefit of collecting all required information in one location, but since they are not integrated into EHR or e-prescribing workflows, practices have to re-enter information from their EHR manually into each payer's web form. In addition, practices have to manage access to multiple portal websites that require separate login information.
• **Multipayer Portals – Prescription**
  Currently, there are two multipayer portals that allow practices to connect to the network of payers, pharmacies, and PBMs in order to centralize, streamline, and standardize prescription PA submissions.
  – SureScripts ePA network
  – CoverMyMeds PA portal
(Note: These portals are listed for illustrative purposes only. Links to their websites are provided as a courtesy and are neither a guarantee nor an endorsement by the AAFP of the products or services offered on these websites.)
	+	-

Third-party Services A growing number of companies are working on solutions to the PA burden problem. To date, their focus has been on high-priced diagnostics and therapeutics, so primary care practices do not have many service options yet.	++	$$

ASC = Accredited Standards Committee; EHR = electronic health record; ePA = electronic prior authorization; IT = information technology; NCPDP = National Council for Prescription Drug Programs; PA = prior authorization; PBM = pharmacy benefit manager.

a. This information is meant to give you a relative estimate of the impact and cost for each innovation. It should be seen as a guide for the category. Specific products or services may vary widely in cost to implement, and their impact can vary based on practice environment and implementation.

The AAFP's Administrative Simplification webpage (aafp.org/simplification) highlights the Academy's ongoing advocacy efforts and offers practice resources to help you take back your time and safeguard your well-being.

Table 4. Transformations to Address Prior Authorization Burden

	Impact[a]	Cost[a]
Team-based Care • In concept, team-based care helps physicians manage administrative burdens. PA is a nonclinical process that can distract the team from care tasks, so practices often dedicate specific staff resources to separate the physician and care team from the PA burden.	+	$$
Value-based Payment • Although VBP promises to help alleviate much of the administrative burden associated with FFS care, PA burden may persist or even worsen. • Risk-bearing organizations—whether payer, practice, or hospital—will continue to want to control the costs of medications, tests, and treatments, especially as more expensive specialty drugs flood the market. • Once physicians are in a VBP arrangement, they may be able to get "gold carded" by demonstrating they do not overuse certain medications, tests, and treatments and achieving high-quality, cost-effective outcomes.	+/− Gold cards: +++	$$
Direct Primary Care • Since PAs are frequently for treatments or referrals outside of primary care, patients may ask DPC physicians to complete PAs that are required by their insurance. • Many DPC patients do not have insurance or associated PA requirements. However, out-of-pocket costs can still constitute a burden for patients, as well as for DPC physicians looking for other treatment options or establishing relationships for low-cost cash pay options for treatments and services.	++[b]	$$

DPC = direct primary care; FFS = fee-for-service; PA = prior authorization; VBP = value-based payment.

a. This information is meant to give you a relative estimate of the impact and cost for each innovation. It should be seen as a guide for the category. Specific products or services may vary widely in cost to implement, and their impact can vary based on practice environment and implementation.

b. May add other challenges associated with finding affordable options outside the DPC practice for patients

Addressing the burden associated with PA requires significant advocacy efforts with the federal government, private payers, purchasers, and health information technology (IT) developers. The AAFP strongly advocates on behalf of its members in all of these arenas and will continue to do so. Adopting the techniques, technologies, and transformations outlined in this supplement can help family medicine practices reduce their PA burden. More work is needed to study the real-world impact of these innovations to help family physicians know what will truly work in their practices. The future holds great promise for the automation of PA through interoperability and the application of artificial intelligence, and the AAFP will continue to support advances in these areas.

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