

compliance

The Broken Prior Authorization Process and the Push to Fix It

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Ask any oncologist—or healthcare provider, for that matter—what their least favorite part of their job is and the overwhelming response would be the process of obtaining prior authorization for care. Over the last several months, this has been the discussion topic at national conferences for a variety of specialties but particularly for medical and radiation oncology. Additionally, several groups of specialty organizations have taken the lead in statements calling for change, even proposing solutions.

Recent studies highlight just how broken the prior authorization process is and the impact it has on patient care. The American Medical Association (AMA)¹ and American Society for Radiation Oncology (ASTRO)² both initiated surveys in 2018 with similar outcomes; the Office of Inspector General conducted a survey of Medicare Advantage plans from 2014 to 2016 and found similar results.³

AMA Survey Highlights

Of the 1,000 practicing physicians who participated in the AMA survey, 91 percent indicated that the prior authorization process can delay necessary patient care. Seventy-five percent indicated that it can lead to treatment abandonment, 91 percent indicated that it can have a negative impact on clinical outcomes, and 28 percent indicated that the process can lead to serious adverse events such as hospitalization, disability, permanent bodily damage, or death. Additionally, programs reported that an average of 31 prior authorization requests were completed per week, resulting in approximately 14.9 hours of physician and staff time per week.

ASTRO Survey Highlights

Of the 673 radiation oncologists who participated in the survey, 93 percent indicated that patients were delayed from receiving life-saving treatments because of the prior authorization process, and 31 percent indicated delays of more than 5 days (a full week of radiation treatments) in initiating care. Patients regularly expressed concern about the delays in initiating treatment (per 73 percent of radiation oncologists), and approximately 32 percent of radiation oncologists were forced to use a different therapy than desired for more than 10 percent of patients.

Requests for additional documentation by radiation oncology benefit management companies also added to the burden. Approximately 85 percent of these benefit management companies required radiation oncologists to submit additional or multiple treatment plans, 77 percent required additional consultation notes, and 21 percent required pathology notes during the process. This extra work prevents some providers from spending necessary time with patients; 18 percent of radiation oncologists indicated that they spend more than 10 percent of their day working on paperwork for additional information requests.

Commercial payers made up 96 percent of the prior authorization requests; Medicare Advantage made up 54 percent of requests, and Medicare made up 20 percent. When it comes to denials and appeals, only 51 to 75 percent of requests submitted were approved initially; when providers appealed requests that were denied, appeals were 76 to 100 percent successful for 41 percent of respondents.

Office of Inspector General Survey Highlights

Approximately 216,000 requests were denied each year from 2014 to 2016, and 75 percent of these were overturned on appeal. Treatments initially indicated not to be medically necessary—possibly impacting patient outcomes and care—were ultimately found medically necessary after all. Shockingly, providers rarely used the appeals process; only 1 percent of denials were actually appealed. If the process had not been so burdensome, it is unclear what impact appealing these denials would have had on patient outcomes.


Responses to Survey Results

At the recent American College of Radiation Oncology Meeting in Orlando, then AMA President Barbara McAneny, MD, spoke about the prior authorization process. Dr. McAneny highlighted many of the same concerns expressed in the ASTRO and AMA survey findings and stated that the AMA is working to find a way to automate the process, base the results on clinical guidelines, and provide an immediate response to the request for authorization.

In January 2018, the AMA, the American Hospital Association, America's Health Insurance Plans, the American Pharmacists Association, the Blue Cross Blue Shield Association, and the Medical Group Management Association issued "A Consensus Statement on Improving the Prior Authorization Process."⁴ The statement outlined opportunities for improvement of the prior authorization process and highlighted the following key principles for industry-wide improvements to alleviate the burden:⁴

1. The selective application of prior authorization
2. A prior authorization review and volume adjustment
3. The improvement of transparency and communication of prior authorization
4. The continuity of patient care
5. Automation to improve transparency and efficiency.

In February 2019 a letter was sent to CMS Administrator Seema Verma by 53 healthcare organizations and 45 state medical societies, asking CMS to provide necessary oversight and guidance to Medicare Advantage (MA) plans on the prior authorization process.⁵ The letter asked CMS to direct plans to alleviate prior authorization where it is needed most—specifically providing examples of criteria for ordering and prescribing services that align with evidence-based guidelines. As highlighted in the letter, CMS has stated that it is focused on reducing the administrative burden with programs like the Patients Over Paperwork initiative, addressing the current prior authorization process employed by MA plans.

Examples in which prior authorization might be most beneficial include new technologies or areas where there is high error in billing and coding, resulting in high denials. Areas where prior authorization is seen as unnecessary include standards of care, areas that have little to no utilization, or areas that have low variation in the way the care is administered. This is an ongoing process, and it is unclear where prior authorization process reform is headed. What is clear is that change is needed—and needed fast. 

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