

# compliance

## Jumping Through the Hoops of Prior Authorizations and Denials to Deliver Comprehensive Cancer Care

BY TERI BEDARD, BA, RT(R)(T), CPC

Comprehensive cancer care is not just a tag line, it is a mindset and practice afforded to patients with cancer no matter where or by whom they are treated. With a focus on comprehensive cancer care comes the requirement by health plans and payers to support and justify what may be viewed as costly, experimental, and outside-the-standard care. To do so, health plans and payers often require providers to “jump through hoops” like prior authorizations and potential denials of payment to show why the selected modality or regimen is necessary for the patient. The better equipped providers are about how to handle and plan for the various “hoops,” the better the chance of avoiding unnecessary treatment delays and excessive administrative burdens.

### Prior Authorization Burdens

A prior authorization (also referred to as prior approval, predetermination, or precertification) is an approval from a health plan or its intermediary, such as a benefit management company, for coverage of a service before any services are administered or delivered to the patient. The word “prior authorization” invokes negative connotations for most providers. Although not all services require a prior authorization, if providers do not obtain a prior authorization for a service that requires one, the services will be denied coverage. Additionally, a prior authorization for coverage does not guarantee payment(s) will be made. The provider must still support the services provided and bill with appropriate

documentation.

To highlight just how difficult and egregious the prior authorization process has become, the American Medical Association (AMA) conducted a 2021 survey (an update to a previous survey), and the results did not paint a pretty picture for health plans and providers.<sup>1</sup> Survey results highlight that providers and their staff spend approximately 2 full business days (13 hours) per week completing 41 prior authorizations on average. Other data show that most providers do not have dedicated staff for prior authorizations; 41 percent indicate they do. This means the other 60 percent of prior authorizations are done by physicians or other staff, piling these tasks on top of direct patient care responsibilities and other work assignments.

Survey results show that various health plans and benefit management companies have different processes to submit and approve prior authorizations, which also impacts patient care. Of those responding to the survey, 93 percent of physicians report that care was delayed and 82 percent indicate that the resultant delays could lead to abandonment of treatment. One of the most alarming survey results: 34 percent of physicians report that prior authorizations have led to a serious adverse event for a patient in their care.

### Legal Changes to Prior Authorizations

As with most aspects of healthcare, progress of regulations and reimbursement moves slowly, but the prior authorization issue is on the radar of many, including Congress. This

past year, legislation was introduced at different times by both the House of Representatives and the Senate. In late July, the House of Representatives' Ways and Means Committee unanimously voted to advance this legislation, Improving Seniors' Timely Access to Care Act of 2022 (HR 8487).<sup>2</sup> This bill would require Medicare Advantage health plans to provide real-time decisions for routinely approved services, release annual information on the number of prior authorizations approved and average response times, and meet other standards set by the Centers for Medicare & Medicaid Services related to quality and timeliness.

The push for legislation was in response to a report released by the Office of Inspector General (OIG) due to concerns with Medicare Advantage health plans inappropriately denying coverage for services to increase profits. The OIG found that from 2014 to 2016, Medicare Advantage organizations overturned 75 percent of its prior authorization denials when appealed. Approximately 216,000 denials were overturned, but only 1 percent of providers appealed denials to the first level.

### Building an Offense

To help ease the burden created by the prior authorization and denial processes, providers should consider taking these actions:

- **Create a health plan workbook** for staff tasked with obtaining prior authorizations and appealing denials. Every payer and/or benefit management company should have their own page with links to forms, contact information, clinical and billing guidelines, and timelines for

**Table 1. Medicare Parts A and B Appeals Process**

	DESCRIPTION	TIMING
1	Redetermination by a Medicare Administrative Contractor	Submitted within 120 days of receipt of denial
2	Reconsideration by a qualified independent contractor	Submitted within 180 days of receipt of notice of redetermination
3	Disposition of Office of Medicare Hearings and Appeals (OMHA)	Filed within 60 days of receipt of reconsideration letter
4	Review by the Medicare Appeals Council	Filed within 60 calendar days of OMHA decision
5	Judicial review in U.S. District Court	Filed within 60 days of Council's decision or after Council decision time frame expires

applying and appealing denials, which are outlined and accessible.

- **Organize a clinical process workbook** created by physicians and clinical staff to outline various treatment modalities and regimens and the common codes and quantities related to each. This tool can be an interactive form or some other way to communicate what information should be applied for authorization based on the patient and planned therapy.
- **Dedicate space in the health record** where all communications and applications for prior authorization and appeal of denials are documented. Ensure that all documentation has a date, time, the individual contacted, and details of the communication.
- **Appeal all denials.** Health plans must have a process for providers to appeal prior authorization denials. Familiarize yourself with the appeals process. With the volume of denials found in previous reporting for prior authorizations, it is best to adopt the philosophy of appeal, appeal, appeal.

- **Review your state laws.** Understand what additional support you may have at the state level. The AMA has dedicated a section of its website to the 2021 Prior Authorization State Law Chart,<sup>3</sup> which outlines each state's legal requirements for health plans. This information may give the added support you need to identify what legally is expected of health plans, but information does vary greatly by state.
- **Compile a list of patient resources.** Review and update (as necessary) resources for patients when care is denied coverage. Does your organization have or provide resources to assist patients when their insurance will not cover their treatment and/or when patients cannot afford their treatment? Does your organization have a financial navigator or billing representative to review with patients their options for payment or financial responsibility? What other treatment options that are covered by the health plan would still be medically and clinically appropriate for treating the patient?

### Building a Defense

A mentor of mine instilled the motto, “prior planning prevents poor performance;” however, there are times when being on the offense does not make a difference. Some modalities, treatment regimens, and/or health plans or payers may not require prior authorization. Some payers may give prior authorization for coverage but when billed they deny the claim or charges. This is a big problem because the services have already been provided and now time must be spent backtracking in an attempt to obtain payment. Prior planning using the steps outlined below can help providers respond to payers when payment is denied:

- **Identify an individual(s) to receive denial notifications.** Designate a backup if this individual(s) is out of office.
- **Know the deadlines for appeals and make sure that deadlines are not missed.**
- **Know if the payer has a policy or if your specialty society has information or a stance to help support medical**


**necessity documentation for a patient's denied treatment.** Providing this information, along with any studies or other information supporting the selected modality, can assist in the appeals process.

- **Identify an individual(s) to collect this documentation and ensure they know what this information looks like or where to find it.** The biggest reason denials are not overturned is because incorrect documentation is submitted for appeal. Not all documentation is a narrative note; most documentation for radiation oncology services is not a narrative. Ensure that staff who are dealing with denials and appeals know who to reach out to and/or where to find documentation.
- **Annotate documents.** Sometimes it helps to annotate PDFs that will be sent to payers. Highlight and use arrows or other annotations to identify and point out supporting components or statements for the treatment.
- **Provide adequate documentation.** Typically, the procedure note or specific document for the code is not enough. Providing documentation on the patient's initial or most recent visit,

treatment order(s), and other information to tell the story of the patient will assist in the appeals process.

- **Know the appeals process.** Medicare has five levels of appeals (Table 1, page 9). Providers should use all of them as needed. Providers can learn about the Medicare Parts A and B appeals process through MedLearn Matters.<sup>4</sup> Medicare also has a website section for patients who need help filing an appeal.<sup>5</sup> Do not stop at the first level of appeal if treatment is denied. Use the other levels if you have the support and medical necessity documented for the regimen or treatment course.
- **Remember that arguing for change starts at the patient level.** You may not be successful in getting a policy changed, but you may be successful for an individual patient. Start there and the potential for a bigger change is more likely.

Continuous reimbursement cuts and restrictive and burdensome payer provisions against comprehensive cancer care are challenging for providers. Having processes in place may not guarantee 100 percent success, but they create a game plan that

can help decrease the stress and uncertainty of the overall prior authorization and denials process. Healthcare technology is always evolving—unlike the regulatory aspect. 

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## References

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Recognizing the burden prior authorizations pose to its provider membership, ACCC developed a Prior Authorization Clinic to address key issues surrounding prior authorizations, to streamline efficiencies, and to minimize access challenges and treatment delays. As part of this education project, ACCC held three focus groups in August and September 2022 to:

- Better understand the administrative burden of prior authorization processes by sharing best practices
- Address key areas of prior authorization, including new technologies or areas where there are high errors in billing and coding resulting high denials
- Provide examples of standardized criteria for ordering and prescribing services that align with evidence-based guidelines
- Gather case-based prior authorization scenarios that cancer programs and practices can use to advocate for change, locally and nationally
- Discover successful methods and processes to track prior authorizations.

Learn more and read recommendations and key takeaways at: [accc-cancer.org/projects/prior-authorization-clinic/overview](https://accc-cancer.org/projects/prior-authorization-clinic/overview).