RUTGERS
BIOMEDICAL AND HEALTH SCIENCES

Prior Authorizations Are Ruining Practice: How Should We Respond?

CPQI December 7, 2019

Lynn Schwenzer, MHSA
Zeeshan Khan, MD
David Swee, MD

Objectives

- Review insurance companies rationale for the use of prior authorization
- Describe the percentage of prior authorizations that are approved nationally and in New Jersey
- Discuss potential alternative ways of organizing practice and educating Physicians so as to lessen the burden of prior authorization

RUTGERS

PA's are Ruining Practice....

Prior Authorization

"Transactions which involve engagement between a provider and a health plan to clarify, request, and obtain approval for coverage of specific healthcare services for individual patients under particular circumstances"

2018 CAQH Index

RUTGERS

PA's are Ruining Practice....

Introductions and Polling

RUTGERS

AMA AMERICAN MEDICAL ASSOCIATION

PA's are Ruining Practice....

- **2017 AMA Prior Authorization Survey Respondents indicated:**
  - 92% -prior authorization delays care.
  - 78% - prior authorization results in abandoned treatment
  - 84% -the burden of prior authorization is high.
- **MSNJ supports AMA's Prior Authorization Reform Principles:**
  - Clinical validity
  - Continuity of care
  - Transparency and fairness
  - Timely access and administrative efficiency
  - Alternatives and exemptions

MSNJ

RUTGERS

American Hospital Association

AHIP America's Health Insurance Plans

AMA AMERICAN MEDICAL ASSOCIATION

APhA

BlueCross BlueShield Association

MGMA

Practice....

Consensus Statement on Improving Prior Authorization through:

- Selective Application of Prior Authorization;
- Prior Authorization Program Review and Volume Adjustment;
- Transparency and Communication Regarding Prior Authorization;
- Continuity of Patient Care; and
- Automation to Improve Transparency and Efficiency.

MSNJ

RUTGERS

Types of PA's

- Pharmacy – Tiers and stepped treatment
- DME
- Procedures
  - Imaging
  - Colonoscopy
  - Injections
  - Sleep study
- Referrals e.g.
  - infectious disease
  - neurology
  - Rheumatology
  - Et al

RUTGERS

Small Group Exercise

Why do Insurance companies use PA's?

Your responses

RUTGERS

Insurance Company Rationale for Prior Authorizations

- High quality evidence based care
- Addresses non evidence based unwarranted variations in care
- Patient Safety
- Ensure medical necessity
- *Cost Savings*

RUTGERS

Sad Fun Fact

The use of PA's essentially doubled nationally from

2016: 14% of referrals

2017: 27%

.....and only going up from here

RUTGERS

PA's are Ruining Practice....

How many PA are ultimately approved

- Nationally: Over 90 %
- New Jersey experience:
  - Commercial plans: over 90% of all PA's are ultimately approved
  - Medicaid plans: wide variability
    - » UHC 65% small # of members but large # of required PAs
    - » Horizon/AETNA Over 90%

Med Society of NJ Report to the House of Delegates 2017

RUTGERS

PA's are Ruining Practice....

CAVEAT - Limitations of this Presentation

Comparisons are Difficult

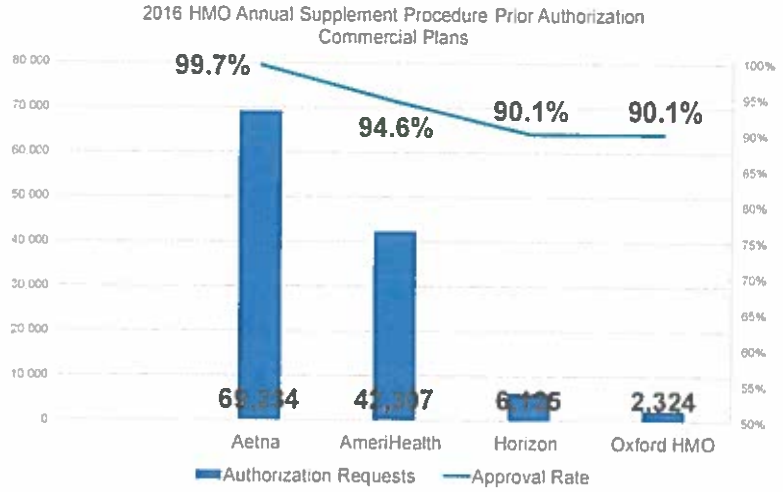
Every Plan does things differently

Difficult to get data

RUTGERS

PA's are Ruining Practice....

2016 HMO Annual Supplement Data-NJ *HMOs submit an annual report to NJDOBI.*

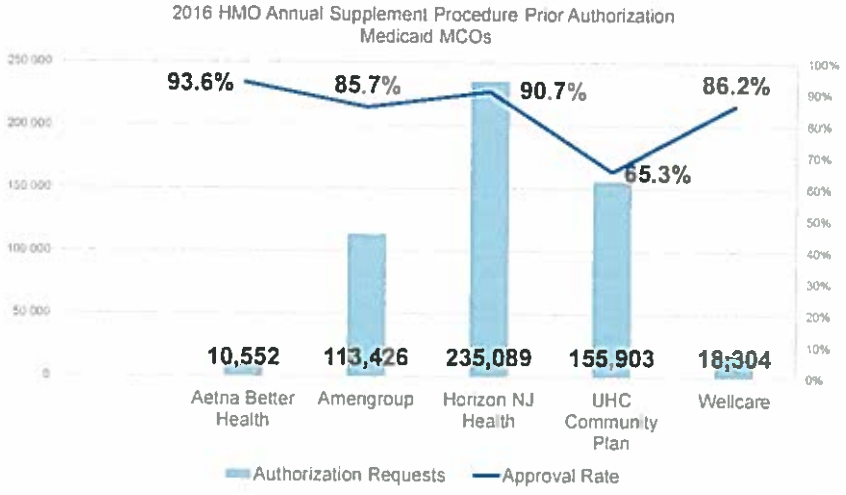


MSNJ

RUTGERS

PA's are Ruining Practice....

2016 HMO Annual Supplement Data- NJ
HMOs submit an annual report to NJDOBI

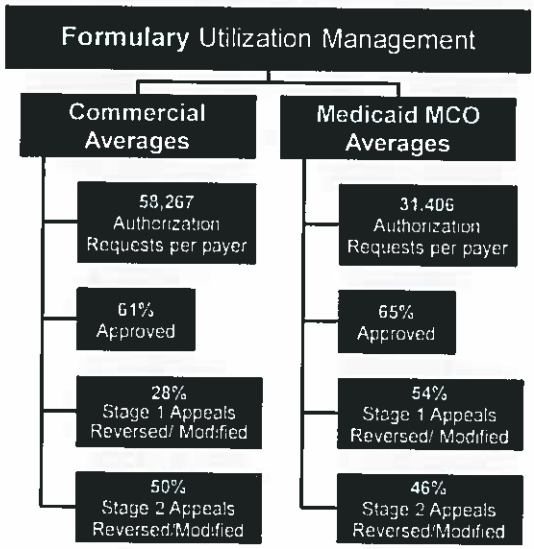


MSNJ

RUTGERS

PA's are Ruining Practice....

2016 HMO Annual Supplement Data-NJ



MSNJ

RUTGERS

PA's are Ruining Practice....

Independent Utilization Review Organization Reports (7/16/16-1/15/17)

NJDOBI submits biannual reports to the NJ Legislature.

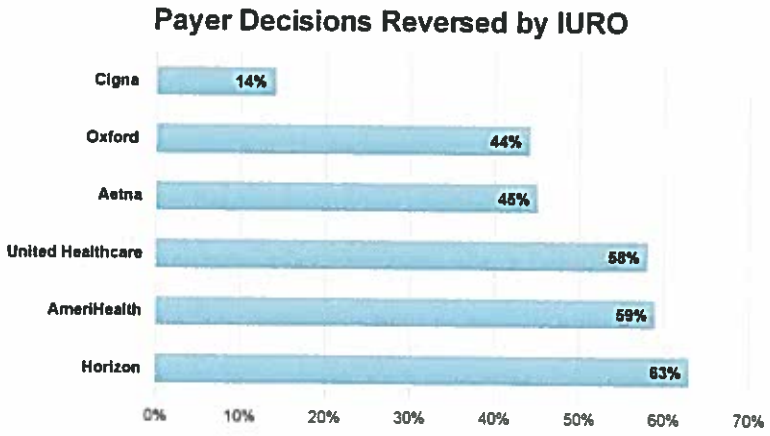
- 605 Completed Appeals
- 55% Disagreed with Payer
- Top specialties affected:
  - gastroenterology;
  - infectious disease; and
  - rehabilitation

MSNJ

RUTGERS

PA's are Ruining Practice....

Independent Utilization Review Organization Reports (7/16/16-1/15/17)



MSNJ

RUTGERS

PA's are Ruining Practice....

eviCore Annual Utilization Statistics

- Payers using eviCore's services:
  - Aetna
  - AmeriHealth
  - Cigna
  - Horizon
  - United Healthcare
- First Quarter 2017 statistics: **91% approval rate.**
- 3.73% of cases were denied for medical necessity.

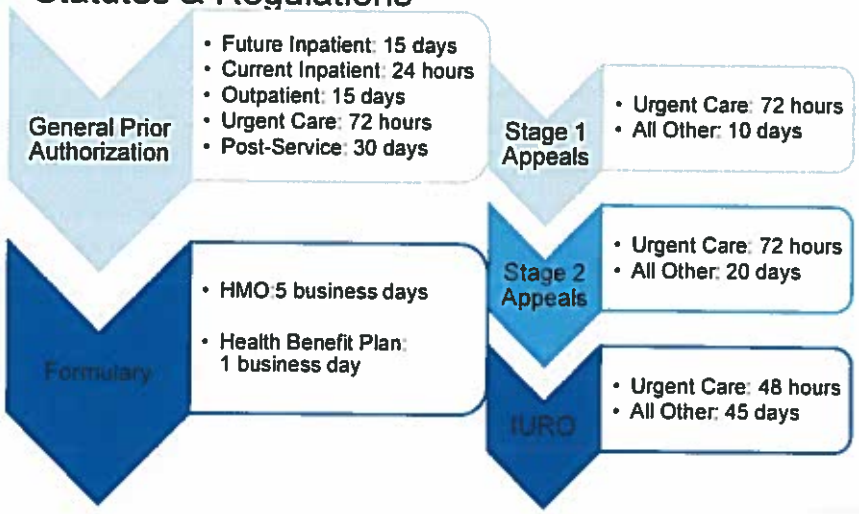
MSNJ

RUTGERS

PA's are Ruining Practice....

Time to Disposition

Statutes & Regulations



MSNJ

RUTGERS

PA's are Ruining Practice....

Consent Orders/ Fines - NJ

Year	Payer	Fine	Reason
2015	Oxford	$800,000	Erroneous Denials
2014	Horizon	$750,000	Delayed Response
2013	Aetna	$850,000	Erroneous Information
2012	AmeriChoice	$324,000	Delayed Response

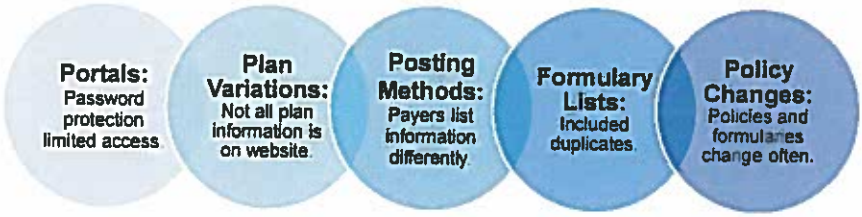
MSNJ

RUTGERS

PA's are Ruining Practice....

Number of Services/ Medications Subject to Prior Authorization

Comparative analysis was not feasible due to:



MSNJ

RUTGERS

PA's are Ruining Practice....

CAQH

Council for Affordable Quality Healthcare

- The 2016 CAQH Index indicated:
  - Manual PA costs industry **$11.18** per transaction
  - ePA costs industry **$1.93** per transaction
  - ePA = potential industry savings of **$412 million**

MSNJ

RUTGERS

PA's are Ruining Practice....

CAQH.

Council for Affordable Quality Healthcare

The movement toward Electronic Transactions

MSNJ

RUTGERS

PA's are Ruining Practice....

CAQH.

Council for Affordable Quality Healthcare

The 2018 CAQH Index Report - COST $$$$$

- Provider cost

  Manual PA's second most costly transaction for providers

  $6.61/Transaction ($2.80 elec)

- Health Plan cost

  Manual $3.50/transaction ($0.03 electronic)

MSNJ

RUTGERS

PA's are Ruining Practice....

CAQH

Council for Affordable Quality Healthcare

2018 CAQH Index- The Move to electronic transactions

Moving to Electronic Systems supposed Cost savings

Total potential savings by going electronic 417 M

278 M for Provider
139 M for Health Plans

RUTGERS

PA's are Ruining Practice....

2018 CAQH Index- Electronic transactions

As of 2018 only 12% of EHR's have the capability allowed Providers to process PA's electronically

RUTGERS

CAQH.

PA's are Ruining Practice....

Council for Affordable Quality Healthcare

2018 CAQH Index – Cost - Time

Manual - 16 minutes of provider/staff time
Electronic - 9 minutes

However Providers report more time
Manual 30 min
Electronic 25 min

RUTGERS

PA's are Ruining Practice....

Unseen cost of PA's

- Case study -

RUTGERS

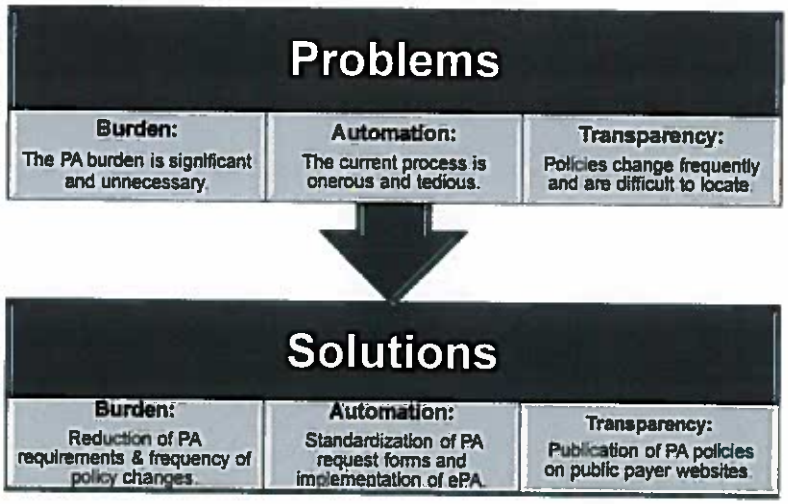
PA's are Ruining Practice....

Is this Healthcare Rationing ?

RUTGERS

PA's are Ruining Practice....

Conclusion



MSNJ

RUTGERS

PA's are Ruining Practice....

What do we do about the Bad Actors ?

RUTGERS

PA's are Ruining Practice....

CAQH Rulemaking 2018

- CAQH CORE is currently developing operating rules to further improve the PA process. Now have "Draft Phase V Operating Rules"
  - Looking to standardize requirement
    - Technical Connectivity- closing gaps in electronic data exchange
    - System Availability –
    - Clarifying "next steps" required by provider
    - Response time and timeframes for final determinations
    - Error codes so provider knows why a PA has been denied
    - Standard Data fields to reduce variation and ease provider burden

RUTGERS

PA's are Ruining Practice....

Hot off the Presses from CMS

Jan 1 2020 Testing and training throughout 2020
for Advanced Diagnostic Imaging Orders

Appropriate Use Criteria (AUC) that will require ordering professionals to consult a qualified Clinical Decision Support Mechanism (CDSM) prior to ordering part be ADI services

Full implementation Jan 2021.

RUTGERS

PA's are Ruining Practice....

Hot off the Presses from CMS

- MGMA 19 Reports no progress to fix prior authorizations, as Practice leaders say it has gotten worse

RUTGERS

PA's are Ruining Practice....

Hot off the Presses from CMS

- CMS will ultimately use the AUC data to identify "Outliers"
- Starting I n 2021 CMS will collect 2 years worth of AUC data in order to identify up to 5% of ordering professional whose ordering patterns are an anomaly and subject them to PA's. Outlier ID will start in 2023 at the earliest

RUTGERS

PA's are Ruining Practice....

Thanks!!!!

Questions

References

1. *Report on 2017 House of Delegates Resolutions, Substitution 4A: Prior Authorization,* 2018 Lawrence Downs, CEO Medical Society of New Jersey

2. *Physician Frustration With Prior Authorizations Hits a New High,* June ,9,2017, Staff, AAFP News American Academy of Family Medicine

3. *Top Reasons for Prior Authorization Request Rejections and Denials,* September 20.2012 CGS Medicare, CGS Medicare .com

4. *What is the rationale behind requiring a prior Authorization for low cost, time proven medications?* March 24 2016 Blog Quora

5. *My pharmacist says he needs "prior authorization" what's that all about* April 6, 2015 Ron Gasbarro Consumer Affairs on line Consumeraffairs.com

6. *2018 CAQH Index. "A report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings"* Oct 2019

7. *2016 CAQH Index. "A report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings"* Oct 2016

8. *Prior Authorization: The AmeriHealth New Jersey Approach* a report to NSNJ Frank Urbano, MD Senior Medical Director. 7/2018

9. I. Insurance companies use prior authorizations to keep healthcare costs in check. Michael Bihari, MD 1/2018

10. Testimony before the NJ Senate Health Committee Re A3176 Prior Authorizations Larry Downs, 2018CEO MSNJ

11. WEDI *Working Group for Electronic Data Interchange Subworking Group on Prior Authorizations 2017*

12. Fierce Healthcare: CMS to implement New appropriate Use Criteria for advanced diagnostic imaging in 2020 Joanne Finnegan Nov 15, 2019

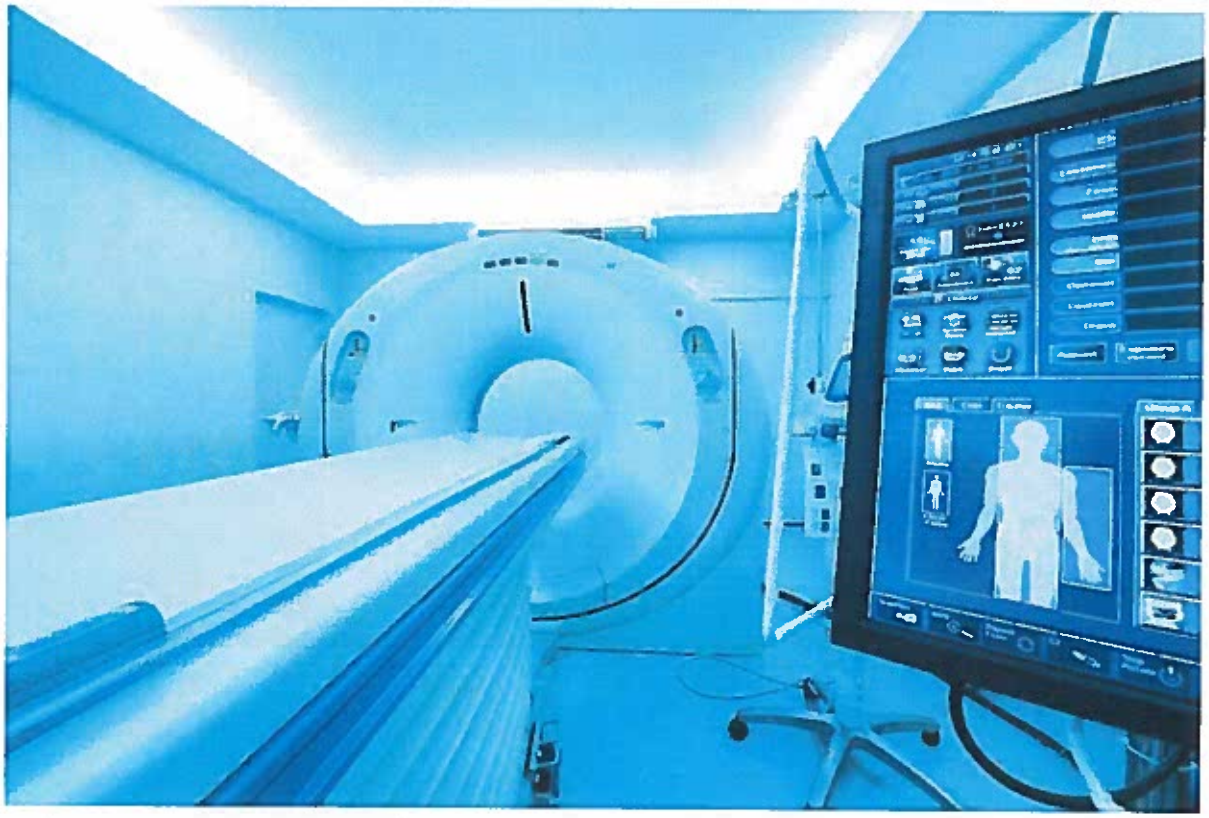
FierceHealthcare

BREAKING: Trump admin releases plan to make hospitals and insurers post prices
CMS issues final hospital price transparency rule and proposes transparency rule for insurers

Practices

CMS to implement new appropriate use criteria for advanced diagnostic imaging in 2020

by Joanne Finnegan | Nov 13, 2019 4:36pm



Practices need to get familiar with new appropriate use criteria for advanced diagnostic imaging (nimon/Shutterstock)

There's a change coming for advanced diagnostic imaging services furnished in a physician's office, hospital outpatient department or ambulatory surgery center.

Starting Jan. 1, the Centers for Medicare & Medicaid Services (CMS) will implement new appropriate use criteria (AUC) that will require ordering professionals to consult a qualified Clinical Decision Support Mechanism (CDSM) prior to ordering Medicare Part B advanced diagnostic imaging services for a patient that will take place in those settings.

Physician practices need to be aware of the change, said Robert Tennant, who provided a health IT policy update during the Medical Group Management Association (MGMA) annual conference last month.

RELATED: **3 tips to stay in compliance with HIPAA patient access, data security regulations**

CMS has been testing the program with voluntary participation but will start an educational and operating testing period next year, said Tennant, director of health information technology policy for MGMA's government affairs. Full implementation of the program will occur in January 2021.

"We'll continue to fight this," said Tennant about the AUC program that eventually may mean more medical professionals will be subject to **prior authorization** when ordering these services for patients.

The requirement that physicians get prior authorization from insurers before providing a medical service, diagnostic test or medication is already a **major headache** for physicians.

But initially, the AUC program will require health professionals to report a code on their claims for advanced diagnostic imaging services covered by the program including diagnostic magnetic resonance imaging, computed tomography, nuclear medicine and positron emission tomography. Starting in 2021, without a code, the claim will be rejected.

RELATED: **MGMA19—No progress to fix prior authorization, as practice leaders say it's gotten worse**

As well as checking clinical decision support tools to help make appropriate treatment decisions for the specific clinical condition, medical professionals ordering the imaging services will also need to provide the information to furnishing professionals and facilities, because they must report an AUC consultation code on their Medicare claims, according to a CMS **fact sheet** (PDF).

The furnishing professional and facility will need to append a new HCPCS modifier to the CPT code on the claim to denote AUC consultation occurred.

A "QQ" code will indicate that the ordering professional consulted a qualified clinical decision support mechanism for this service and the related data were provided to the furnishing professional.

For this first year, CMS will not require the AUC consultation code on advanced imaging orders or require the AUC consultation code on Medicare claims. However, starting January 2021, an AUC consultation must take place at the time of the order for imaging services that will be furnished in one of the designated settings and paid for under one of the designated payment systems that include the physician fee schedule, outpatient prospective payment system and ambulatory surgical center payment system.

RELATED: **Industry Voices—5 steps to address prior authorization burdens and improve patient care**

But particularly worrisome for practices is that CMS will ultimately use data collected from the program to identify "outlier" ordering professionals who will become subject to prior authorization when ordering these services for patients. Advanced diagnostic imaging services covered by the AUC program include diagnostic magnetic resonance imaging, computed tomography, nuclear medicine and positron emission tomography.

Starting in 2021, CMS will collect a minimum of two years of AUC data in order to identify up to 5% of ordering professionals whose ordering patterns are considered "outliers" and subject them to prior authorization requirements. That outlier provider identification will start in 2023 at the earliest.

To help practices prepare for the changes, the MGMA has prepared a **toolkit** that explores how AUC can potentially alter practice workflows and action steps practices can take.

The AUC program was established by the Protecting Access to Medicare Act of 2014 **legislation** to reduce overutilization of services. The law included a provision seeking to increase the rate of appropriate advanced diagnostic imaging services provided to Medicare beneficiaries.

RELATED: **Telehealth, CDS provisions outlined in proposed physician fee schedule**

The program applies to physicians, other practitioners and facilities ordering advanced diagnostic imaging services and/or furnishing Part B advanced diagnostic imaging services to Medicare beneficiaries and billing Medicare Administrative Contractors.

Ordering professionals will be required to consult a qualified CDSM—an interactive, electronic tool for clinicians—to determine whether the order adheres to appropriateness criteria.

CMS identified eight priority areas that it may use in determining outlier ordering professionals in the future. The initial list of priority clinical areas, defined by the agency as clinical conditions, diseases or symptom complexes, released in the CY 2017 Physician Fee Schedule Final Rule include: coronary artery disease (suspected or diagnosed), suspected pulmonary embolism, headache (traumatic and nontraumatic), hip pain, low back pain, shoulder pain (to include suspected rotator cuff injury), cancer of the lung (primary or metastatic, suspected or diagnosed), and cervical or neck pain.

Read More On

Physician Practice	Imaging	Billing and Coding	Prior Authorization	Clinical Decision Support
Outpatient Care	Ambulatory Surgery Centers	Centers for Medicare & Medicaid Services (CMS)		
Medical Group Management Association	Robert Tennant			

Suggested Articles

Payer

CMS releases transparency measures for hospitals, payers

by Robert King
Nov 15, 2019 8:47am

Hospitals & Health Systems

Children's National Health System, Virginia Tech team up

by Tina Reed
Nov 14, 2019 4:46pm

Payer

AAFP

AAFP to CMS: Cut Prior Authorization to Preserve Programs

Academy's RFI Responses Call on Agency to Align Rules With Reality

December 03, 2019 02:03 pm News Staff (mailto:aafpnews@aafp.org) – The Academy recently pushed CMS for regulations that would reduce physicians' administrative burden and financial risk while ensuring higher-quality medical outcomes and improved interoperability.

"The AAFP strongly supports streamlining prior authorization requirements and reducing administrative burden in all health care programs -- both public and private," said the Academy in one of two Nov. 20 letters calling on the agency to tighten its focus on patient care.

Both letters addressed the integrity of the nation's public health care programs -- one specifically focusing on the future of such programs (https://www.aafp.org/content/dam/AAFP/documents/advocacy/health_it/emr/LT-CMS-FutureProgramIntegrity-112019.pdf) and the other on technology used to support them. (https://www.aafp.org/content/dam/AAFP/documents/advocacy/health_it/emr/LT-CMS-UsingAdvTechProgramIntegriy-112019.pdf) They were sent to Alec Alexander, deputy administrator and director of CMS' Center for Program Integrity, in response to a pair of requests for information: "The Future of Program Integrity" (https://www.cms.gov/About-CMS/Components/CPI/Downloads/Center-for-Program-Integrity-Future-of-PI-RFI.pdf) and "Using Advanced Technology in Program Integrity." (https://www.cms.gov/About-CMS/Components/CPI/Downloads/Center-for-Program-Integrity-Advanced-Technology-RFI.pdf) Both letters were signed by AAFP Board Chair John Cullen, M.D., of Valdez, Alaska.

Regarding the future, the agency's RFI had posed questions about fraud, waste and abuse in value-based payment programs.

The Academy's response was straightforward: It's time to align the rules with reality.

The AAFP urged CMS to "focus more on outcomes related to quality and utilization and less on procedural safeguards" -- an approach the Academy said would be "more consistent with the guiding principle of choice and competition in the market based on quality, costs and outcomes than the current approach of subjecting beneficiaries and physicians to increasingly stringent forms, coverage criteria and documentation requirements."

To wit: prior authorization.

"Onerous and unnecessary prior authorization requirements top the list of physician complaints on administrative burdens," the Academy said. "This uncompensated work for physicians and staff translates into increased overhead costs for practices, significantly reduced time spent with patients, disruption of workflows that result in costly inefficiencies, and delayed care and worse outcomes."

Whereas Medicare's program integrity efforts in fee-for-service environments have centered on guarding against overpayment and unnecessary utilization, the Academy pointed out that in value-based models, "CMS and other payers are increasingly asking physicians to take financial risk for the services they provide and, in some cases, the total cost of care for attributed patients."

"The program integrity strategy needs to change accordingly," the Academy advised.

The letter went on: "For instance, instead of relying on prior authorizations and other tactics that seek to restrain the volume of services rendered, CMS needs to rely on tactics that ensure appropriate patient attribution" while also ensuring that "patients receive the services needed for positive health outcomes."

Elsewhere in its RFI, CMS had asked how it could "better connect ordering physicians, rendering providers and suppliers with respect to their responsibility to provide proper documentation."

Again, the Academy had a ready answer: Support regulations proposed by the Office of the National Coordinator for Health IT. Specifically, CMS should require use of the Fast Healthcare Interoperability Resources standard, which would ease the exchange of data. (https://www.aafp.org/content/dam/AAFP/documents/advocacy/health_it/emr/LT-House-ApplicationProgrammingInterfaces-091119.pdf)

Likewise, the AAFP's second letter on the impact of advanced technology on program integrity advocated for regulations that would reduce administrative complexity.

CMS had asked about the potential uses of artificial intelligence and machine learning in streamlining medical data review and determining coverage compliance.

Such tools, the Academy answered, aren't here yet -- but they shouldn't encumber physicians when they arrive, especially if CMS is involved in their deployment.

New technology must be able to be integrated into physicians' workflow without requiring physicians to enter any additional data, the Academy said, and it must be affordable.

"It would also need to be tied to some specific CMS policies that clearly defined how the tool could be used," the letter went on. "Additionally, if the tool is not highly accurate or if there is no payment assurance based on the results of the tool, adoption is likely to be low."

Related *AAFP News* Coverage

AAFP Guides CMS on Administrative Simplification Efforts (https://www.aafp.org/news/government-medicine/20190813adminsimpletter.html)
(8/13/2019)

AAFP Advises CMS on Making Value-based Model Work for FPs (https://www.aafp.org/news/government-medicine/20190605geopbp.html)
(6/5/2019)

2 comments

Sign In () to comment

AAFP to CMS: Cut Prior Authorization to Preserve Programs
https://www.aafp.org/news/government-medicine/20191203programintegrity.html

11400 Tomahawk Creek Parkway • Leawood, KS 66211-2680
800.274.2237 • 913.906.6000 • Fax: 913.906.6075 • aafp@aafp.org