

Curing the prior authorization headache

October 10, 2013

By [Jeffrey Bendix, Senior Editor](#)

Few words arouse more frustration among primary care physicians (PCPs) than “prior authorization.” And it’s easy to understand why. The time you and your staff have to spend persuading an insurance company to cover a medication or procedure is an expensive and annoying distraction from the task of caring for patients.

On the bright side, while you may not be able to avoid prior authorizations entirely, you can take steps to minimize the hassle and expense they bring.

The costs of prior authorization

Although prior authorization has been an issue among healthcare providers for at least a quarter of a century, surprisingly little is known about its cost, either to individual practices or to the healthcare system as a whole. In 2006, PCPs spent a mean of 1.1 hours per week on authorizations, primary care nursing staffs spent 13.1 hours, and primary care clerical staff spent 5.6 hours, according to [a 2009 study](#) published in *Health Affairs*. The study estimated that the overall cost to the healthcare system of all practice interactions with health plans, including authorizations, was between \$23 billion and \$31 billion annually.

More recently, [a study](#) of 12 primary care practices published earlier this year in the *Journal of the American Board of Family Medicine* put the mean annual projected cost per full-time equivalent physician for prior authorization activities between \$2,161 and \$3,430. The study’s authors concluded that “preauthorization is a measurable burden on physician and staff time.”

Focus on medications, diagnostic imaging

While insurance companies differ somewhat in the areas where they require prior authorizations, the two most common are imaging procedures such as computerized tomography (CT) scans and magnetic resonance imaging (MRI), and brand-name pharmaceuticals.

“We have to get authorization for most CTs and MRIs, along with some ultrasounds and sleep studies,” says Jeffrey Kagan, MD, an internal medicine practitioner in Newington, Connecticut, and *Medical Economics* editorial adviser. Kagan says prior authorizations and insurance referrals together consume about 25% of the time of his practice’s two billing clerks and one of the practice’s three receptionists.

The practice’s prior authorizations for medications usually involve brand-name products for which there is no generic equivalent, or a drug that a patient has taken for years but for which the insurance carrier now requires annual reauthorization.

“This all wastes a lot of our time and it’s not reimbursed,” Kagan adds. “I feel that if an authorization has to be done the insurance company should allow a higher level of billing for the visit or a surcharge. I’m sure attorneys don’t bring motions before a judge for free.”

“It’s a nuisance, it’s time-consuming, and often it’s not in the patient’s best interest,” says George G. Ellis, Jr., MD, a solo internal medicine practitioner in Boardman, Ohio, and *Medical Economics* editorial adviser. He recounts the frustration of dealing with a Medicaid health maintenance organization over the proper medication for treating a patient’s gout. The HMO wanted a prior authorization for the drug Ellis wanted to prescribe, but not for a less expensive n

EXHIBIT 1528

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felt was contra indicated. “Why should I spend 45 minutes on the phone to prescribe a drug that is indicated versus one that is contra indicated? It’s crazy,” he says.

Kevin de Regnier, DO, a solo family practitioner in Winterset, Iowa, has seen the demands for prior authorization grow steadily during his 26 years of practice. “When I started out it never came up,” he recalls. “Then we started seeing it in a small number of high-dollar medications, then it expanded into more and more branded medications, and then moved into getting procedural prior auths, especially in the radiology field,” he says.

The problem now is particularly acute in treatment involving workers compensation claims, he adds. “Now you’ve got to prior auth every procedure and every referral, even referrals for physical therapy.”

Most of the responsibility for obtaining prior authorizations falls to the practice’s three nurses. According to de Regnier, the nurses spend about 10% of their time each day on prior authorization. “It’s an unreimbursed cost of providing care, and unfortunately we don’t have the financial resources to bring in someone to do prior auth exclusively, even on a part-time basis,” he says.

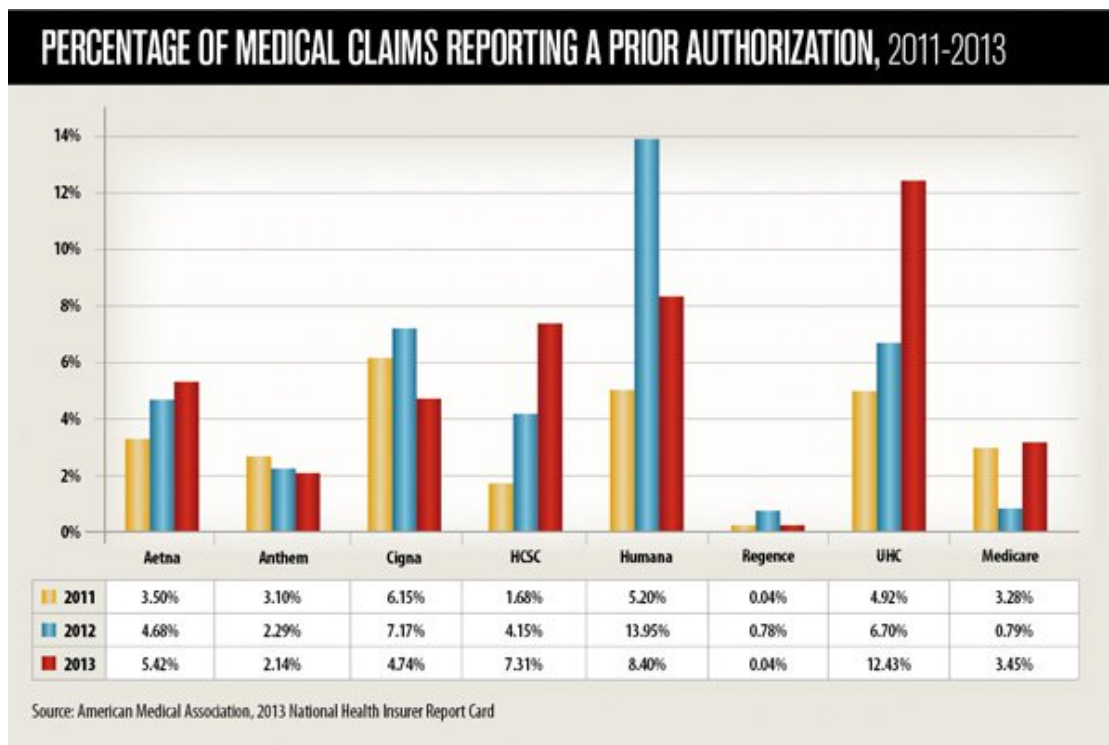
‘We get numb to it’

Yul Ejnes, MD, MACP, an internal medicine practitioner in Cranston, Rhode Island, and past president of the [American College of Physicians](#) Board of Regents, regards prior authorization as “one of the many hassles we have to deal with, but it’s kind of in the background except when things heat up for one reason or another.” Such a situation occurred at the start of 2013, Ejnes says, when the state’s largest insurer changed its pharmacy benefits manager (PBM). The new PBM had different rules for drugs it would cover, resulting in a flurry of new prior authorizations.

“That reminded us all that it (prior authorization) exists, but on any given day we get numb to it, like we do to a lot of the other hassles we deal with,” Ejnes says.

The payers’ perspective

Despite PCPs’



complaints about prior authorization, it’s used less frequently now than in the past, says Susan Pisano, vice president for communications for [America’s Health Insurance Plans](#), the trade association

surgery and high-tech imaging, where there's clear documentation that something is being overused or misused, and where there's both a patient safety and cost implication.

"There's clear evidence that overuse of high-tech imaging may in some cases be contributing to cancers," she adds. "So you want to make sure the benefit outweighs the risks."

Pisano cites a [2008 study](#) from the U. S. General Accounting Office showing that spending on advanced imaging rose by 17% annually between 2000 and 2006, far faster than less-expensive procedures.

Regarding medications, Pisano says the widespread availability of generics has made prescription drugs more affordable for many patients. "There will always be patients who require the brand name for one reason or another, but when you've got something that works as well and is less costly, you want to make that available to consumers," she says.

Easing the prior authorization burden







Although prior authorizations may be an unavoidable part of doing business for primary care practices, there are still plenty of steps practices can take to reduce the time and financial burdens associated with them. A good start is to look at how frequently a payer requires prior authorizations and balance that against the payer's level of reimbursement, says Judy Bee, medical practice management consultant in La Jolla, California and *Medical Economics* consultant.

"If you have a plan that is ho-hum in its reimbursement and is requiring a lot of time (for prior authorizations) you probably should rethink whether you need to participate, because that's coming right out of your wallet," she says.

In addition, practices should go through payers' Web sites to obtain prior authorizations whenever possible, says Bee. Going online usually gets a quicker response and avoids wasting time on hold on telephone calls.

TIPS FOR HANDLING PRIOR AUTHORIZATIONS

Here are steps you and your practice can take to minimize the costs and time required to obtain prior authorization from a payer for a medication or procedure:

-  **Whenever possible, use the payer's Web site rather than the telephone.**
-  **Look at how many prior authorizations each of your payers required during the past year, and consider dropping them if the payer's reimbursement rates don't justify your time spent obtaining the authorizations.**
-  **If you're in a multi-site practice, designate one or two individuals to handle prior authorizations for the entire practice. Make sure those individuals have access to patients' records and providers' notes from throughout the practice.**
-  **Make sure you are following recommended treatment guidelines before ordering a high-cost procedure for a patient.**
-  **Unless contraindicated, always start patients on the generic form of a medication if one is available in the same therapeutic class.**
-  **Make sure you've met all of the payer's criteria before submitting a prior authorization request.**

Practices with more than one location often can create greater efficiencies by centralizing the prior authorization responsibility, says Owen Dahl, MBA, FACHE, principal of Owen Dahl Consulting in The Woodlands, Texas. Putting just one or two individuals in charge of prior authorizations for the entire practice will enable those employees to become highly skilled in the process and develop relationships with the payers.

Dahl also recommends seeking pre-approval from payers for a plan-of-care if it has proven successful with multiple patients. "Tell the payer that if the patient presents with this disease, this is what we will do, can we get blanket approval for this without having to call every time for authorization if the patient needs a procedure under this treatment plan?" says Dahl. Even if the payer declines, he

adds, you've at least opened a dialogue with the payer that could prove useful later on.

The next step is to try and minimize the number of times you're required to get a prior authorization. For medications, Ejnes recommends becoming familiar with insurers' formularies, and developing a list of drugs they all cover for common diseases. For example, he says, if there are multiple choices for medications to treat high blood pressure, but you know all your insurers will cover Losartan as a generic angiotensin receptor blocker, "then just get in the habit of prescribing that drug—always assuming it's appropriate for the patient—and you avoid having to deal with a multitude of prior auths," he says.

Ejnes also instructs his staff to have the forms required for the drugs and procedures that most commonly require a prior authorization easily available, either in hard copy on their computers. "That way when a 'prior authorization necessary' alert comes in, they're not scrambling to download a form," he says.

Minimize high-cost imaging tests

Robert Eidus, MD, MBA, a family practitioner in Cranford, New Jersey, also tries to avoid prior authorizations, both by minimizing the number of high-cost imaging tests he orders, and by starting patients on generic medications whenever possible. But if ordering an MRI or other high-cost test is called for, he tries to simplify the process with the help of his practice's electronic health record (EHR) system. His practice developed a customized form on its EHR that automatically captures the demographic information the radiology utilization review company usually requires before authorizing payment for a procedure.

The form also includes a reminder at the bottom to see the most recent clinical note for the patient. "When we do a prior auth, a clerical person generates the form and they attach the last note, which streamlines the administrative process," Eidus says.

To reduce the number of what he terms "inappropriate denials," Eidus recommends learning each payer's criteria for authorizing coverage of an imaging procedure and ensuring that the data sent to the approving body clearly meets the criteria.

"When I know I have to do a prior auth, my progress note for that day is designed to clearly justify why I need it," he says. "So it might say the patient has had physical therapy or has severe intractable pain, and make it very clear and distinct so that a reviewer can't miss it."

An additional challenge PCPs sometimes face is patients requesting a brand-name medication before trying a generic. de Regnier says he addresses that situation by asking the patient his or her reasons for requesting the brand-name.

"Usually what you find is they're basing the request on a TV commercial," he says. "If it's appropriate I'm willing to go to bat for them, but usually it's not what they need and won't be approved, so I try to explain that to them."

Target the outliers

Although many physicians recognize the need to minimize inappropriate use of costly radiology procedures and prescription medications, they say the solution is to find and penalize the relative handful that do so, rather than all physicians.

Such an approach would benefit both payers and providers, says Reid Blackwelder, MD, president of the [American Academy of Family Physicians](#). "Insurance companies don't want to practice medicine," he says. "The costs, in both time and resources, to obtain prior authorization is high for everyone involved."

"Insurance companies should focus on the outliers, those who order tests or utilize services that are not consistent with similar clinical circumstances," Blackwelder adds.

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