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BURDA ON HEALTHCARE

Don't Hate Me Because I Love Prior Authorization

By David Burda
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Healthcare providers, especially physicians, detest prior authorization requirements dictated by payers, especially health insurance companies. I totally get it. No one, regardless of their profession or vocation, likes continuously seeking approval from third parties to do what they've been trained to do and have been doing successfully for many years.

Copy editors have been editing my stories for nearly 40 years, and I detest it. Why do I have to seek their approval before my stories run, post or air? I'm perfect, and every word that I write is perfect. But I love and need great copy editors.

Great copy editors have saved me too many time to count. Like the time I said "vain" rather than "vein" in a story on intravenous drugs. Or the time I used "CRISPER" instead of "CRISPR" in a story about DNA testing. I used it as an adjective to describe a baby. Upsetting image. More recently, a great copy editor I worked with at another job noticed that I posted a story that said, "sewing seeds of doubt" not "sowing seeds of doubt." He messaged me on LinkedIn, and I changed it immediately online. How embarrassing!

Like writers, doctors think they're perfect and that everything they do is perfect. If you don't believe me, you've never met a doctor. Doctors don't like utilization review and quality assurance people working at health insurance companies checking their work, either, as part of the PA process to determine whether a drug, procedure or treatment is covered or appropriate for their patients' condition.

Let's look at a few recent surveys of doctors to get a feel for how much they truly hate PA.

DOCTORS SAY PRIOR AUTHORIZATION DELAYS NEEDED CARE

In April 2021, the American Medical Association released the results of a survey of 1,004 physicians on PA. You can download the AMA's survey results here. Here are some highlights (or lowlights) of the AMA's survey:

- 88 percent said the burden of complying with PA requirements on their practice is "high" or "extremely high."
- 56 percent said PA requirements "always" or "often" delay care to patients.
- 40 percent said their practice has staff who work exclusively on meeting PA requirements.
- 29 percent said PA requirements are "rarely" or "never" based on evidence-based clinical guidelines or protocols.
- 27 percent said PA requirements "always" or "often" result in abandoning care.

Now, as a patient, I've never had care delayed or denied or not paid for because what my doctor wanted to do didn't pass PA muster. PA delayed my mom's back MRI for three weeks, but that only was because her doctor's office forgot to file for PA approval until I called and politely reminded them.

DRS SAY PRIOR AUTHORIZATION IS A HUGE PRACTICE BURDEN

In October 2021, meanwhile, the Medical Group Management Association released the results of a survey of more than 400 group practices on their regulatory burdens. You can download the MGMA's survey results here.

Eighty-eight percent of the MGMA survey respondents said PA was "very" or "extremely" burdensome on their practices. In fact, PA ranked first out of nine regulatory issues in terms of hassle factor. Tied for a distant second were COVID-19 workplace mandates and Medicare Quality Payment Program quality-measure reporting requirements, each cited by 71 percent of the respondents as "very" or "extremely" burdensome.

(To learn more on this topic, please read "Same Old, Same Old When It Comes to What Doctors Don't Like," on 4sighthealth.com.)

"For years, payers have required medical practices to obtain prior authorization before providing certain medical services and prescription drugs to patients," the MGMA said. "These health plan cost-control mechanisms often delay care unnecessarily at the expense of the patient's health and the practice's resources."

In a separate MGMA survey released in March 2022, 79 percent of the 644 medical-practice respondents said that PA requirements increased over the past 12 months. Nineteen percent said PA requirements stayed the same, and 2 percent said they decreased. You can download the new MGMA survey here.

"For medical groups navigating their recovery from the impacts of the COVID-19 pandemic, there's one thing nearly all of them have in common: Payer prior authorization requirements have not eased up in the past year," the MGMA said.

Professional trade associations and societies exist for one purpose: to protect the economic interests of their dues-paying members. Full stop. So, take the survey results from the AMA and the MGMA, both of whom exist to protect the economic interests of doctors and medical practices, for what they're worth.

STUDY: FEW CLAIMS DENIED BASED ON MEDICAL NECESSITY

Perhaps equaling self-serving albeit interesting is a study that ran in Health Affairs in January. You can download the study here.

Researchers from the University of Pennsylvania, CVS Health and Harvard wanted to know how often public and private insurers denied coverage for services due to the lack of medical necessity according to the insurers' coverage rules. To find out, they looked at nearly seven million claims filed from 2014 through 2019 for care provided to about three million beneficiaries enrolled in Medicare Advantage plans operated by Aetna.

The researchers broke down how many claims Aetna denied post-service (not pre-service like PA) based on national and local medical-necessity rules from Medicare as a public insurer and on medical-necessity rules from Aetna as a private insurer. They also broke down medical necessity denials by clinical service line and medical specialty.

Overall, Aetna MA plans denied only 1.4 percent of services based on medical necessity over that six-year period. Aetna MA plans denied 61 percent of the claims because the services were "experimental or investigational." They denied 20 percent of the claims because the services had "no proven efficacy." The largest service category of claims denied based on medical necessity was laboratory procedures. Of all the claims denied, claims for lab services represented 69.1 percent of the total.

Still, the service denials equated to only 0.68 percent, or $416 million, of the total payments sought by the providers for care to beneficiaries over the study period.

The researchers called the amount "modest but nontrivial."

Now, before we say, "Hey, that's not too bad! Why all this complaining about prior authorization?" let's remember who we're talking about: Aetna. You know, the commercial health insurance giant bought by CVS Health? Four of the seven credited researchers on the study were from CVS Health. So, like the AMA and MGMA surveys, take this study for what it's worth.

REPLACING MANUAL PA WITH ELECTRONIC PA SAVES TIME, MONEY

For the sake of argument, let's say both sides are right. PA is a real pain to do, but ultimately it doesn't result in a lot of care being denied or not paid for. It's a lot of work for essentially the same outcome. To me, that makes PA ripe for innovation. There's got to be a better way to do it, and there is, according to the Council for Affordable Quality Healthcare.

In January, the CAQH released its ninth annual CAQH Index. You can download the 61-page index here. The index tells both providers and payers how much they can save by automating various business processes, including PA.

According to CAQH's latest report, 35 percent of providers and payers were still doing PA manually (by phone, mail, fax or email) last year at a cost of $14.49 per manual PA request. With 43 million manual PA requests, that's more than $623 million. By automating PA requests electronically, the cost per PA request would drop to $3.50, saving hundreds of millions of dollars along with countless hours of work and aggravation.

AUTOMATING PA PROCESSES WITH SMART TECHNOLOGY

There's also another way to improve PA for both providers and payers, and that's something referred to as "exceptions-based utilization management," which I know a little bit about, but would take too long to explain how I do know as little as I do.

Exceptions-based utilization management is technology that could go beyond automating PA requests electronically. It's technology that could use machine learning to get smarter as it processes PAs. Over time, it could learn which PAs are routinely approved based on a provider's clinical documentation, a patient's benefits and a health plan's medical-necessity rules. It could learn to automatically OK routine PAs and to spit out only PA requests that are exceptions to the rules and require further review by the health plan. Given that plans approve most PA requests, this makes a lot of sense to me.

But hey, I'm a journalist, not a data scientist, and I don't know how to write an algorithm let alone how to spell it without looking it up.

PA IS FOR PEOPLE, NOT PROVIDERS OR PAYERS

But what I do know as a journalist is this. Great copy editors aren't doing what they do for me. They're doing it for my customers — all the people who read, watch or listen to the stories I tell. They want all those people to understand and ideally benefit from what I have to say.

Providers and payers should see PA in the same way. It's not about their time or their resources or their money. It's about patients accessing the right care in the right setting at the right time at the right price. Done well, PA could be the vehicle to drive the transition to value-based reimbursement.

Instead of hating on prior authorization, it's time to show PA some love so it can reach its full potential.

Thanks for reading.

And if you find any typos, spelling errors, grammatical mistakes or usage problems, talk to my copy editor.

AUTHOR

Dave Burda began covering healthcare in 1983 and hasn't stopped since. Dave writes this monthly column "Burda on Healthcare," contributes weekly blog posts, manages our weekly newsletter 4sight Friday, and hosts our weekly Roundup podcast. Dave believes that healthcare is a business like any other business, and customers—patients—are king. If you do what's right for patients, good business results will follow.

Dave's personnel experiences with the healthcare system both as a patient and family caregiver have shaped his point of view. It's also been shaped by covering the industry for 35 years as a reporter and editor. He worked at Modern Healthcare for 25 years, the last 11 as editor.

Prior to Modern Healthcare, he did stints at the American Medical Record Association (now AHIMA) and the American Hospital Association. After Modern Healthcare, he wrote a monthly column for Twin Cities Business explaining healthcare trends to a business audience, and he developed and executed content marketing plans for leading healthcare corporations as the editorial director for healthcare strategies at MSP Communications.

When he's not reading and writing about healthcare, Dave spends his time riding the trails of DuPage County, IL, on his bike, tending his vegetable garden and daydreaming about being a lobster fisherman in Maine. He lives in Wheaton, IL, with his lovely wife of 35 years and his three children, none of whom want to be journalists or lobster fishermen.

Visit 4sight.com/insights to read more from Dave Burda.