

8 prior authorization terms that drive every doctor crazy

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Physicians know all too well about the headaches and heartaches associated with prior authorization (PA) in medicine today. Here's a handy glossary—or perhaps a devil's dictionary—to help guide you through the madness, with pointers to how the AMA is fighting to make a big dent into this time-gobbling payer practice that delays your patients' access to care.

Prior authorization is a health plan cost-control process that restricts patient access to treatments, drugs and services. This process requires physicians to obtain health plan approval before delivery of the prescribed treatment, test or medical service in order to qualify for payment.

According to an AMA survey of 1,000 practicing physicians, more than nine in 10 respondents said PA had a significant or somewhat negative clinical impact, with 28% reporting that PA had led to a serious adverse event such as a death, hospitalization, disability or permanent bodily damage, or other life-threatening event for a patient in their care.

The vast majority of physicians (86%) described the administrative burden associated with PA as “high or extremely high,” and 88% said the burden has gone up in the last five years.

Learn more about the AMA's prior authorization reform initiatives.

But PA is just one subset of the larger field called **utilization management** (UM), which the Institute of Medicine—now known as the National Academy of Medicine—defined way back in 1989 as “a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision.” That has a familiar ring to it.

Another UM technique that can drive doctors crazy is **step therapy**, sometimes called the **fail-first requirement**. Under such a policy, payers will require that patients first try and fail lower-cost tests, drugs or other treatments before moving on to higher-cost options, sometimes in cases when

the patient has already unsuccessfully tried the therapy under a previous insurance plan.

Medical necessity. Everyone agrees that patients should not get a drug, test or surgery unless it is medically needed. The reason why this common UM term drives doctors crazy is that it seems as though each payer has its own definition of medical necessity, which makes navigating the process highly frustrating for physicians who just want their patients to get the care they deserve.

The AMA believes that what constitutes medically appropriate treatment should be based on clinical guidelines developed by the appropriate national medical specialty society and be consistent regardless of a patient's insurer. There should be a standard medical necessity definition so that all insurers in a state are playing by the same rules and everyone understands what those rules are.

Peer-to-peer review is a process in which an ordering physician discusses the need for a procedure or drug with another physician who works for the payer in order to obtain a PA approval or appeal a previously denied PA. If properly implemented, the process can be helpful, as it affords the physician the opportunity to speak with another clinician. What drives doctors crazy is that it usually comes after days or even weeks of bureaucratic wrangling.

The AMA says peer-to-peer review should be available at any point following an adverse PA determination, and that the peer to whom the physician speaks should be a genuine peer—a doctor practicing the same specialty and subspecialty as the ordering physician.

Standard pharmacy electronic prior authorization (ePA) automates PA by integrating the process into the physician's electronic prescribing workflow and can make the PA process faster, consistent across insurers, and more efficient. Unfortunately, physicians interested in using this technology are often stymied, as ePA is far from being the norm.

Too often, physician practices and health care organizations are stuck navigating telephone trees, waiting on hold, or feeding forms into their fax machines. Even when health plans offer electronic PA options, they often involve proprietary portals that require workflow disruption to exit the EHR, log into the insurer's unique website, and time-consuming reentry of patient and clinical data—not the streamlined standard ePA process embedded within the EHR. Astoundingly, the Cleveland Clinic has racked up a \$10 million annual tally just to push their PA requests through the process.

Gold carding. This is a process under which a payer exempts physicians who consistently order or prescribe treatments and drugs in accordance with evidence-based guidelines, or have high approval rates from PA requirements. So if you're not an outlier physician—if your PA requests are approved like clockwork—at, let's say, a 90% rate—then payers should be happy to grant you that proverbial gold card, allowing you to get your patients quick access to the care towards which they have been paying their premiums.

Such programs are not prevalent in health care today, and it drives doctors crazy that such a commonsense concept—one that would reduce PA burdens for both practices and insurers—hasn't yet taken hold.

The essential idea was outlined in a set of principles put forth by the AMA and 16 other physician, patient, and health care organizations: "Health plans should restrict utilization management programs to 'outlier' providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors."

Moreover, a consensus statement released last year by the AMA and national associations representing both providers and insurers encourages just these sorts of programs to lower the overall volume of PAs by selectively applying these requirements.

Find out more about what the AMA's research has uncovered about PA and share your story to help guide the Association's advocacy efforts.