

Putting patients first means tackling prior authorization

MAY 26, 2022

Gerald E. Harmon, MD

Immediate Past President

Excessive delays and improper denials of medically necessary care to Medicare Advantage patients—as well as wrongfully rejected payments to physicians caring for them—only bolster our AMA’s resolve to ensure patients receive quality, timely care whenever they need it.

A new federal review (PDF) conducted by the Office of Inspector General (OIG) for the Department of Health and Human Services examined hundreds of prior authorization requests and payment denials issued by Medicare Advantage organizations (MAOs), finding “widespread and persistent problems related to inappropriate denials of services and payment” in Medicare Advantage, widely known as Medicare Part C. This analysis would come as no surprise to anyone who practices medicine today and, in fact, underscores what previous studies have shown for many years.

Effective action needed now

Unless corrective action is taken now, this situation is likely to worsen as enrollment in Medicare Advantage plans grows. More than 26 million Medicare beneficiaries were enrolled in such plans last year, or more than twice as many as a decade earlier. And while it is true that MAOs routinely approve most of the prior authorization and payment requests they handle each year, they also deny millions of such requests.

The OIG investigation determined that a portion of the service and payment denials it scrutinized were made erroneously, either because of human error on the part of an MAO’s claim review staff or due to a glitch in the MAO’s computerized claims processing system. These denials were typically reversed upon appeal or when the error was discovered—but not before delays numbering in days or weeks occurred that also imposed a wholly unnecessary administrative burden on patients and physicians.

One of the conditions placed on Medicare Advantage plans requires approval for all prior authorization and payment requests for services covered under original Medicare. With a view toward controlling

their own costs, MAOs are allowed to adopt additional rules, such as requiring that in-network physicians be used exclusively, specifying that prior authorization must be obtained before a particular service can be rendered, or requiring referrals for specialty care. These additional limits cannot reflect any provision not contained in original Medicare, however.

MAOs must also have an appeals process in place upon denying a prior-authorization request, or rejecting a request for payment by a provider for services already rendered. A previous OIG investigation determined that roughly three-fourths of all denials are reversed upon appeal, which reflects both the widespread nature of the problem, and the inability or reluctance on the part of insurers to correct it.

Report findings are disturbing

The latest OIG report found that 13% of the prior-authorization denials it studied were inappropriate because the services requested met Medicare coverage requirements, which most likely delayed or entirely prevented medically necessary care. Similarly, 18% of the payment denials reflected claims that met Medicare coverage rules as well as the internal reimbursement guidelines implemented by the MAO itself, which meant providers were not paid for services they had already delivered to patients.

Advanced imaging, stays in post-acute care facilities, and injections administered in physician offices were among the services frequently flagged for denial even though they met Medicare coverage rules, according to the investigation. Two examples cited by the OIG can be found in our May 16 letter to CMS Administrator Chiquita Brooks-LaSure urging a holistic approach to reforming prior authorization.

Whenever and wherever they are in place, excessive prior-authorization controls pose a threat by delaying, disrupting and denying necessary medical care—not only for Medicare beneficiaries but also for the wider patient population. The consequences can be severe, as reflected in a recent AMA survey that showed 82% of physicians have had patients abandon treatment due to prior-authorization struggles with health insurance plans.

Attacking unnecessary prior auth

Our AMA continues to fight excessive and unnecessary prior authorization through a multifaceted approach focused on comprehensive research, a broad range of practice resources, and reform initiatives underway at both the state and federal levels. The “Prior Authorization and Utilization Management Reform Principles” (PDF) we helped draft in cooperation with patients, hospitals and

pharmacists are helping to advance patient-centered care by knocking down barriers to timely access to treatment.

To correct many of the problems identified in the latest OIG report, we are urging Congress to pass “*The Improving Seniors’ Timely Access to Care Act*” (HR 3173; S. 3018), which would require Medicare Advantage plans to streamline and standardize prior-authorization processes and improve the transparency of requirements. We believe Congress must act now to ensure that patients can receive the quality, evidence-based health care they deserve in a timely manner.

Excessive prior authorization and other unnecessary utilization management practices are not going away anytime soon—but neither are our AMA’s efforts to eliminate their negative impact on patients.