REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-10

Subject: Standardized Preauthorization Forms (Resolution 729-A-10)

Presented by: William E. Kobler, MD, Chair

Referred to: Reference Committee J (Kathleen Blake, MD, Chair)

At the 2010 Annual Meeting, the House of Delegates referred Resolution 729 to the Board of Trustees. Resolution 729-A-10, introduced by the Organized Medical Staff Section (OMSS), asked that the American Medical Association (AMA) "seek a governmental mandate that requires: 1) All insurance companies to utilize a universal preauthorization form," and "2) A decision on preauthorization that must be received by the provider within 48 hours." The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2010 Interim Meeting.

This report outlines physician concerns with the current preauthorization process; identifies efforts to standardize and improve both the electronic and paper preauthorization processes; highlights related AMA activity and policy; reviews potential avenues for additional AMA advocacy; and presents policy recommendations.

BACKGROUND

Resolution 729-A-10 presented concerns that current preauthorization forms lack standardization among insurance companies resulting in burdensome hurdles for physicians and health consequences for patients. The lack of standardization makes the preauthorization process difficult and time-consuming. The forms can lack clarity and not contain all of the information required by health insurers to fulfill the requested preauthorization, potentially necessitating time-consuming communication for the physician practice with no additional reimbursement. The preauthorization process can also appear to be a delay tactic used by health insurers for financial gain and to discourage physicians from advocating for necessary services.

In addition to such hurdles, the preauthorization process can have detrimental health consequences for patients. Some health insurers are requiring preauthorization for an increasing number of routine tests and procedures, resulting in more patient-physician interactions that have health insurer input and subsequent treatment delays. Delays in treatment and interruptions of the patient-physician relationship due to the preauthorization process can result in adverse effects on the patient's health. Lengthy preauthorizations can interfere with patient follow-through if patients fail to return for needed medication or treatment. In addition, patients can be subjected to redundant tests due to some preauthorization requirements. Ultimately, the delay of preauthorization can lead to treatment denial, which negatively impacts the patient's care.

A study of the time physicians spend interacting with health insurance companies found that physician practice staff reported spending 20 hours per week on average just dealing with

preauthorizations (Casalino, 2009). The same study estimated that physician practices spent an average of $68,274 per physician annually for all types of interactions with health insurance companies. The lack of standardized paper forms among health plans and the inconsistent use of the electronic standard transaction for preauthorizations have been the focus of various efforts to improve and streamline both the paper and electronic preauthorization process.

STANDARDIZING THE PREAUTHORIZATION PROCESS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) Transaction and Code Set rule mandates standard electronic transaction formats, including preauthorizations, and their implementation guides. The latest completed version of the HIPAA electronic standard transactions, version 5010, was recommended to the Department of Health and Human Services (HHS) for adoption under HIPAA and has been adopted for implementation in January 2012. Although the administrative simplification provisions in HIPAA required the HHS to establish national standards for electronic health care transactions, including preauthorizations, uniformity has been elusive, with individual health insurers creating their own companion guides containing payer-specific transaction rules.

The Patient Protection and Affordable Care Act of 2010 (PPACA, Public Law 111-148) contained administrative simplification provisions requiring HHS to develop a complete set of requirements, processes and operating rules necessary to electronically submit and receive each HIPAA standard transaction, including preauthorizations. PPACA requires that the operating rules contain the necessary business rules and guidelines for the electronic exchange of information, which are not defined by the standard or its implementation specifications. A set of operating rules for each transaction, including preauthorizations, is to be adopted with the goal of creating as much uniformity in the implementation of the electronic standard as possible.

The HIPAA electronic transaction for preauthorizations is referred to as the “referral certification and authorization” transaction, or HIPAA ASC X12 278. Under PPACA, health plans must adopt and implement operating rules for referral certification and authorization transactions to be adopted no later than July 1, 2014, to take effect by January 1, 2016. PPACA has mandated that health plans must file a certification statement with the Secretary that their data and information systems comply with the most current published standards, including the operating rules for certain transactions. In addition, penalties will be imposed against health plans for non-compliance with the administrative simplification standards determined by HHS.

There has been some activity to collaboratively standardize a paper preauthorization form. To date, wide-spread adoption has not occurred. Examples are highlighted in the section entitled “AMA Collaboration with External Organizations” in this report.

RELATED AMA ACTIVITY AND POLICY

The AMA has long been committed to supporting administrative simplification efforts specific to the preauthorization process through various avenues, such as the legislative process, collaborating with the federation and external organizations, and developing resources and policy.

AMA Advocacy

With the passage of PPACA in 2010, the AMA is actively monitoring through the regulatory process the implementation of provisions related to developing uniform guidelines for HIPAA electronic standard transactions, including preauthorizations. The AMA is advocating for uniform

standardized rules that do not permit variation between different payers or undermine the goal of administrative simplification. The AMA is advocating for these standardized rules to be developed in a timely manner; in coordination with all the bodies involved in managing and updating the transactions, code sets and standard identifiers; in consultation with representatives of all industry segments; and pursuant to a standards process that engages in total quality management.

AMA Collaboration with the Federation

The AMA's Private Sector Advocacy (PSA) group is working with the Federation Staff Payment Policy Workgroup, which is part of the Practice Management Federation Staff Advisory Steering Committee. The workgroup is comprised of key staff from state medical associations and national medical specialty societies that have been active throughout the years in raising private payer issues to the attention of the AMA PSA unit. Improving the preauthorization process is part of the workgroup's 2010 objectives.

Specifically, the Federation Staff Payment Policy Workgroup is seeking to: 1) identify specific physician challenges with health insurers' preauthorization and prior notification requirements; 2) identify the impact these requirements have on patients; 3) reduce administrative burdens associated with preauthorization; and 4) increase health insurers' disclosure of preauthorization and prior notification requirements. The workgroup has surveyed physicians regarding their experience with preauthorization. The survey results revealed that over half of the respondents indicated that it takes several days to receive preauthorization for services and procedures. Eliminating preauthorization hassles and streamlining the process was very important to the majority of respondents. Additional details from this survey will be forthcoming.

AMA Collaboration with External Organizations

In 2006 the AMA worked with America's Health Insurance Plans (AHIP) to develop and publicize a standardized form for physicians to use to request preauthorization and coverage for non-formulary drugs in the Medicare Part D program. The AMA has continued to work with AHIP and the Center for Medicare and Medicaid Services (CMS) to roll-out widespread use of the form.

In other efforts, the American College of Rheumatology (ACR) developed a preauthorization form that is available on its website. The one-page form was sent to more than 200 insurers for consideration of adoption. Physicians were also encouraged to add the form to their electronic medical records as a print-out option. ACR is a member of the Payment Policy Workgroup and the AMA is hopeful that the Workgroup can expand on such efforts to establish similar uniformity that can be established throughout all specialties.

As a participating organization of the Council on Affordable Quality Healthcare (CAQH), the AMA strongly supports the efforts of CAQH's Committee on Operating Rules for Information Exchange to develop standard operating rules for electronic transactions. The AMA supports efforts to create a single, binding companion guide for each HIPAA standard transaction, so that all trading partners would be required to implement and interpret all HIPAA electronic transactions in a universal manner, consistent with the administrative simplification provisions in PPACA.

The AMA is a member organization of X12N-Insurance, which is a group comprised of technical experts from payer, provider and vendor organizations. This group contains workgroups, including a workgroup entitled WG10-Health Care Services Review (278), which was created to determine how to increase the value of the current standard transaction for preauthorizations. Currently, many health insurers respond to this transaction with minimum specificity, if they respond at all.

Increasing the value of the information on the electronic preauthorization standard transaction and the use by payers can dramatically reduce the manual effort currently incurred by the practice and the payer.

The AMA and the Medical Group Management Association (MGMA) collaborated to develop an online toolkit, available at http://www.ama-assn.org/go/pmsoftware, to help physicians select and purchase the most appropriate practice management system software for their practices. The upcoming transition to the 5010 version of the HIPAA electronic standard transactions, coupled with the Medicare and Medicaid electronic health record incentive program, will require physician practices to upgrade or replace their current practice management software. Free to members of the AMA and the MGMA, the new "Selecting a Practice Management System" toolkit provides a roadmap to make this process easier for the physician practice. This resource can be used to establish a practice's needs and take advantage of recent improvements in automation.

AMA Resources

The AMA developed the "Health Insurer Code of Conduct: Standards for health insurers' administrative and clinical processes," which sets forth clear and concise principles addressing medical care policies and payment issues. The Code includes two principles related to preauthorization. The administrative simplification principle states that requirements imposed on patients, physicians and other health care providers to obtain approvals and respond to information requests must be minimized and streamlined, and health insurers must maintain sufficient staff and infrastructure to respond promptly. The medical necessity principle addresses urgent care and states that all emergency screening and treatment services (as defined by the prudent layperson standard) provided by physicians and hospitals must be covered without regard to preauthorization or the treating physician's or other health care provider's contractual relationship with the payer.

A valuable tool aimed at minimizing insurance-related administrative activities is the AMA's "National Health Insurer Report Card" (NHIRC), which is available online at http://www.ama-assn.org/go/reportcard. The NHIRC provides physicians with a reliable source of critical metrics, including one for preauthorization, for seven commercial health insurers and Medicare.

Another resource, the National Managed Care Contract (NMCC), is a comprehensive contracting tool that offers model contract provisions based on the most physician-favorable managed care statutes and regulations from all 50 states and the District of Columbia. Initially released in 2009, the NMCC was developed by the AMA in consultation with state medical association attorneys with extensive expertise in managed care contracting laws and regulations. The NMCC contains highly-detailed provisions that address many of the concerns physicians face when analyzing and negotiating managed care contracts, and during the subsequent business relationship, including provisions regarding the preauthorization process. Associated with the NMCC is the NMCC Database, which contains the full text of the thousands of state managed care statutes and regulations that were used to develop the NMCC. The contents of the NMCC database are easily accessible through varying search functions (e.g., keyword searches), and searches can be restricted to focus on the applicable laws and regulations of multiple states or even a single state. The NMCC database contains relevant AMA policies and includes issue briefs that provide in-depth discussions of some of the most important physician concerns associated with manage care contracting.

Although the NMCC contains provisions specifically discussing preauthorization, those provisions do not address all aspects of preauthorization. The AMA is in the process of adding a section to the NMCC that will comprehensively address utilization review, which will include, but not be

limited to, preauthorization. The section will be based on all state and federal laws and regulations governing managed care organizations' and health benefit plans' use of utilization review. These laws and regulations will be added to the NMCC database.

AMA Policy

The AMA has a strong foundation of policies pertaining to preauthorization, utilization management and medical necessity. The AMA advocates that utilization review efforts should focus on outliers rather than on all physicians or all instances of particular services (Policy H-320.950 [1,2], AMA Policy Database). In addition, the AMA strongly supports fair compensation for administrative costs when providing services to managed care patients (Policy H-385.948). Specific to standardized preauthorization forms, Policy H-320.968 [1b] supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on preauthorization or other review requirements. In addition, Policy H-320.968 [2e] supports the development of draft state and federal legislation to require that review entities respond within two business days to patient or physician requests for preauthorization.

DISCUSSION

Through the AMA's PSA group and its work with the Federation Staff Payment Policy Workgroup, the AMA is gaining a comprehensive perspective on the issues facing physicians during the preauthorization process. Results of the Federation Staff Payment Policy Workgroup survey indicate that physicians desire to eliminate the hassles associated with preauthorization and to streamline the process. The Council believes that these results will help guide the AMA's advocacy efforts to simplify and standardize the preauthorization process for physicians and patients.

While the AMA supports greater adoption of electronic preauthorizations, the Council understands that the adoption of electronic transactions is not realistic for all physicians. Given physician concerns and preliminary efforts to standardize a paper preauthorization form, the Council believes that supporting widespread adoption by health insurance companies of a standardized paper preauthorization form would alleviate some of the burdens physicians face with obtaining preauthorizations.

While Resolution 729-A-10 refers to a universal preauthorization "form," focusing solely on standardizing paper preauthorization forms independent of the HIPAA standard electronic transaction would impede the automation process. Physicians who submit paper claims are not required by HIPAA to implement electronic standard transactions, although health insurers are mandated to do so. HIPAA does require any physician who chooses to transmit these transactions electronically to comply with the HIPAA standards. Some health insurers still have not adopted all of the standard transactions, although the AMA strongly encourages the use of standard electronic transactions by both physicians and health insurers. Accordingly, the Council believes that the AMA should publicize and support the PPACA mandated adoption of HIPAA electronic standard transactions by health plans and encourage adoption of HIPAA electronic standard transactions by physicians.

The AMA will continue to work through the regulatory process to include physician concerns regarding HIPAA electronic standard transactions as the relevant administrative simplification provisions in PPACA are implemented. Specifically, the Council believes it is important for the

AMA to actively support efforts to develop clear and complete requirements for each HIPAA electronic standard transaction.

Policy H-320.968 [2e] supports the development of draft state and federal legislation to require that review entities respond within two business days to patient or physician requests for preauthorization. The Council believes that this policy addresses the request in Resolution 729-A-10 for the provider to receive a decision on a preauthorization within 48 hours and therefore suggests that it be reaffirmed. AMA policy is routinely reviewed for relevant implementation opportunities in the context of AMA advocacy efforts. With respect to preauthorization policies, the AMA's Advocacy Resource Center is developing model legislation regarding the appropriate use of preauthorization that includes language pertaining to providers receiving a decision on a preauthorization request within 48 hours.

Policy H-385.948 supports fair compensation for a physician's administrative costs when providing service to managed care patients. The Council believes that this policy should be reaffirmed to highlight and direct the AMA's focus on ensuring fair compensation for administrative costs.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 729-A-10 and that the remainder of the report be filed:

1. That our American Medical Association support the simplification and standardization of the preauthorization process for physicians and patients. (New HOD Policy)

2. That our AMA support the adoption of a standardized paper preauthorization form by health plans for those physicians who choose to submit paper preauthorization forms. (New HOD Policy)

3. That our AMA publicize and support the legislatively mandated adoption of HIPAA electronic standard transactions by health plans and encourage adoption of HIPAA electronic standard transactions by physicians. (New HOD Policy)

4. That our AMA support efforts to develop clear and complete requirements for each HIPAA electronic standard transaction. (New HOD Policy)

5. That our AMA amend Policy H-320.968[2e], which supports the development of draft state and federal legislation to require that review entities respond within ~~two business days~~ 48 hours to patient or physician requests for preauthorization. (Amend HOD Policy)

6. That our AMA reaffirm Policy H-385.948, which supports fair compensation for a physician's administrative costs when providing service to managed care patients. (Reaffirm HOD Policy)

Fiscal Note: Staff cost estimated to be less than $500 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.