

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 04-JUN-21

Subject: Promoting Accountability in Prior Authorization

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Referred to: Reference Committee G

1 At the 2019 Annual Meeting, the House of Delegates adopted Policy D-320.983, which asks that
2 the American Medical Association (AMA) study the frequency by which health plans and
3 utilization review entities are using peer-to-peer (P2P) review prior authorization (PA) processes,
4 and the extent to which these processes reflect AMA policies, including H-285.987, “Guidelines
5 for Qualifications of Managed Care Medical Directors,” H-285.939, “Managed Care Medical
6 Director Liability,” H-320.968, “Approaches to Increase Payer Accountability,” and the AMA
7 *Code of Medical Ethics* Policy 10.1.1, “Ethical Obligations of Medical Directors,” with a report
8 back to the House of Delegates.

9
10 This report provides background on PA, an overview of the P2P PA process, outlines the
11 significant AMA advocacy efforts on PA and utilization management (UM) review, and proposes
12 recommendations to strengthen AMA policy on PA and, in particular, P2P reviews.

13 14 BACKGROUND

15
16 Health plans employ PA, step therapy, and other forms of UM to control access to certain
17 treatments and reduce health care expenses. The medical literature clearly establishes the time and
18 cost burdens associated with UM requirements on physician practices. UM often involves manual,
19 time-consuming processes that can divert valuable and scarce physician resources away from direct
20 patient care. More importantly, PA and other UM methods interfere with patients receiving timely
21 and optimal treatment selected in consultation with their physicians. At the very least, UM
22 requirements can delay access to needed care. In some cases, the barriers to care imposed by UM
23 may lead to patients receiving less effective therapy, no treatment at all, or even potentially harmful
24 therapies.

25 26 PEER-TO-PEER REVIEWS

27
28 P2P conversations refer to discussions between a physician and an insurance company physician
29 employee. The discussion generally occurs after an initial PA denial that typically involves
30 questions of medical necessity or treatment requests that are considered investigational. However,
31 numerous physicians have stated that some insurers are starting to require P2Ps for first-line PAs.
32 The rationale behind P2P is to provide a more transparent PA process that is collaborative and
33 appropriately follows relevant clinical guidelines. However, for many treating physicians, P2P
34 review simply represents another time-consuming and potentially detrimental use of UM by
35 insurance companies. Peer reviewers can be unqualified to assess the need for services for an
36 individual patient for whom they have minimal information and have never evaluated or spoken
37 with. These issues are exacerbated if physicians are required to participate in P2P for first-line PAs.

1 RELEVANT AMA ADVOCACY

2
3 PA and other UM programs are a high-priority advocacy issue for the AMA. Several current AMA
4 initiatives address the concerns raised in Policy D-320.983 and strengthen the AMA’s ability to
5 effectively advocate on UM issues:

- 6
7 1. State Legislative Activity: In response to the numerous concerns raised by AMA members and
8 the Federation of Medicine, the AMA’s Advocacy Resource Center works closely with state
9 and specialty medical societies to address PA and other UM-related issues through state
10 legislation. The AMA’s model bill on PA, the “Ensuring Transparency in Prior Authorization
11 Act,” addresses a variety of concerns related to UM programs, including response timeliness,
12 duration of authorizations, public reporting of UM program results, retroactive denials, and
13 electronic PA. Additionally, the bill states that UM staff have experience treating patients with
14 the medical condition or disease for which the health care service is requested.¹ At the time of
15 writing, there were nearly 40 bills related to PA and step therapy in the state legislatures,
16 several of which are broad reform efforts based on the AMA model bill, as well as several
17 directed at reducing UM requirements for individuals with HIV/AIDS, cancer, substance use
18 disorder and other chronic diseases and conditions. Additionally, as part of the state
19 policymakers’ responses to COVID-19, commercial plans and Medicaid in many states were
20 required (or urged) to reduce certain UM requirements to ensure safe access to care during state
21 stay-at-home orders and other restrictions.
22
- 23 2. Prior Authorization and Utilization Management Reform Principles: To improve access to care
24 and reduce practice burdens, the AMA convened a workgroup of state and specialty medical
25 societies, national provider associations, and patient representatives to create a set of best
26 practices related to PA and other UM requirements. The workgroup identified the most
27 common provider and patient complaints associated with UM programs and developed the
28 Prior Authorization and Utilization Management Reform Principles to address these priority
29 concerns. These 21 principles seek to improve PA and UM programs by addressing the
30 following 5 broad categories of concern:
31
- 32 a. Clinical validity
 - 33 b. Continuity of care
 - 34 c. Transparency and fairness
 - 35 d. Timely access and administrative efficiency
 - 36 e. Alternatives and exemptions
- 37

38 These “best practice” principles have served as the foundation for an extensive, multi-pronged
39 advocacy campaign to reform and improve UM programs. Workgroup members directly
40 advocate with health plans, benefit managers, and other UM entities to voluntarily adopt these
41 principles; urge accreditation organizations, such as the National Committee for Quality
42 Assurance and the Utilization Review Accreditation Commission, to include these concepts in
43 criteria for utilization review programs; introduce bills based on these principles to state
44 legislatures; encourage technological standards organizations to support improved UM
45 processes; and launch a media campaign to raise awareness of the principles and requested
46 reforms.

47
48 Additionally, two of the PA principles specifically reference the qualifications that health plan
49 reviewers should possess. Principle 3 states that utilization review entities should offer an
50 appeals system for their UM programs that allows a prescribing/ordering provider direct
51 access, such as a toll-free number, to a provider of the same training and specialty/sub-

1 specialty for discussion of medical necessity issues. Principle 16 states that, should a provider
 2 determine the need for an expedited appeal, a decision on such an appeal should be
 3 communicated by the utilization review entity to the provider and patient within 24 hours.
 4 Moreover, providers and patients should be notified of decisions on all other appeals within ten
 5 calendar days. And all appeal decisions should be made by a provider who is not only of the
 6 same specialty and subspecialty, whenever possible, as the prescribing/order physician, but
 7 also, the reviewing provider must not have been involved in the initial adverse determination.²
 8

9 3. The Consensus Statement on Improving the Prior Authorization Process: The release of the 21
 10 PA reform principles initiated meaningful discussions with the health insurance industry about
 11 reducing PA burdens. These discussions led to the development of the Consensus Statement on
 12 Improving the Prior Authorization Process—created by the AMA, American Hospital
 13 Association, America’s Health Insurance Plans, American Pharmacists Association, BlueCross
 14 BlueShield Association and Medical Group Management Association. The AMA continues to
 15 advocate for insurers to operationalize the concepts outlined in the Consensus Statement in
 16 their PA programs.³
 17

18 4. Prior Authorization Research: The lack of alignment between physician and health plan
 19 interests on PA and other UM programs creates significant challenges in achieving meaningful
 20 reform on this issue. Recognizing the key role that credible evidence plays in successful
 21 advocacy on this topic, the AMA is engaged in research to gather data regarding the impact of
 22 PA on patients and physician practices, including an annual physician survey assessing the
 23 burdens associated with UM programs.
 24

25 PA Physician Survey – In conjunction with a market research partner, the AMA
 26 fielded a web-based survey of 1000 practicing physicians in December 2019. The
 27 survey sample comprised 40 percent primary care and 60 percent specialty physicians
 28 and only included physicians who provide at least 20 hours of patient care during a
 29 typical week and routinely complete PAs in their practice. Along with gathering data
 30 on the impact of PA on both patient access to timely care and practice burdens, the
 31 survey also assessed physicians’ perception of the frequency of P2P review
 32 requirements and the qualifications of insurer “peers.”
 33

34 One survey question asked physicians: “How often are you involved in a peer-to-peer
 35 review during the prior authorization process?”
 36

- 37 • Never – 6%
- 38 • Rarely – 30%
- 39 • Sometimes – 45%
- 40 • Often – 15%
- 41 • Always – 3%
- 42 • Don’t know – 1%
- 43

44 Another survey question asked physicians: “How has the frequency of peer-to-peer
 45 reviews during the prior authorization process changed over the last five years?”
 46

- 47 • Increased significantly or increased somewhat – 60%
- 48 • No change – 35%
- 49 • Decreased somewhat or decreased significantly – 5%

1 An additional survey question asked physicians: “When completing a peer-to-peer
2 review during the prior authorization process, how often does the health plan’s ‘peer’
3 have the appropriate qualifications to assess and make a determination regarding the
4 prior authorization request?”

- 5
- 6 • Always – 2%
- 7 • Often – 13%
- 8 • Sometimes – 41%
- 9 • Rarely – 28%
- 10 • Never – 4%
- 11 • Don’t know – 11%
- 12

13 *Note: Percentages do not sum to 100 percent due to rounding.*

14
15 DISCUSSION

16
17 The Council recognizes the value and importance of the AMA’s current multi-pronged advocacy
18 efforts related to PA and applauds the House of Delegates for highlighting the issue of P2P PA and
19 its effect on physicians and most importantly patients. To continue its effective advocacy efforts
20 regarding PA, the Council recommends reaffirming several AMA policies and recommends a
21 number of new policies specifically related to P2P PA. First, the Council recommends reaffirming
22 Policy H-320.939, which states that the AMA will continue its widespread PA advocacy and
23 outreach, including promotion and/or adoption of the Prior Authorization and Utilization
24 Management Reform Principles, the Consensus Statement on Improving the Prior Authorization
25 Process, AMA model legislation, Prior Authorization Physician Survey and other PA research, and
26 educational tools aimed at reducing administrative burdens for physicians and their staff; and
27 advocate for such decisions to be based on the direct review of a physician of the same medical
28 specialty/subspecialty as the prescribing/ordering physician.
29

30 Additionally, the Council recommends reaffirming Policies H-320.948 and H-320.961, which
31 encourage sufficient clinical justification for any retrospective payment denial and prohibition of
32 retrospective payment denial when treatment was previously authorized. Further, the Council
33 recommends reaffirming Policy H-320.949, which states that UM criteria should be based upon
34 sound clinical evidence, permit variation to account for individual patient differences, and allow
35 physicians to appeal decisions, and Policies H-285.998 and H-320.945, which further underscore
36 the importance of a clinical basis for health plans’ coverage decisions and policies.
37

38 While physicians have the freedom to choose their method of making a living, physicians
39 employed by insurance companies must not have their ethical obligations discharged. Insurance
40 companies know that many patients and physicians do not appeal PA decisions, and even fewer
41 seek an external review. However, when an external review is sought, nearly one-third of external
42 reviews of insurer denials are overturned.⁴ These overturned denials demonstrate that insurers’
43 processes for determining medical necessity often do not reflect current clinical standards of care.
44 It is imperative to patient safety and quality of care that physicians make utilization review
45 decisions in good faith and follow evidence-based guidelines in their work for insurers. Therefore,
46 the Council recommends reaffirming Policy H-285.939, which states that utilization review
47 decisions to deny payment for medically necessary care constitute the practice of medicine and that
48 medical directors of insurance entities be held accountable and liable for medical decisions
49 regarding contractually covered medical services.

1 Furthermore, the Council recommends addressing the timeframe for PA decisions for P2P
2 discussions. Physicians generally receive the PA decision at the end of the P2P discussion.
3 However, insurers have suggested that plans should have two business days after the P2P to make a
4 decision. A recent operating rule for electronic PA has this longer specification. Specifically, it
5 states that once a health plan receives a complete PA request, including any P2P medical reviews
6 conducted, the health plan must return an approval or denial to such request within two business
7 days.⁵ Further delaying the PA determination harms all patients and has a disproportionately
8 negative effect on vulnerable populations. Therefore, the Council recommends requiring that PA
9 decisions be made at the end of the P2P review discussion notwithstanding mitigating
10 circumstances, which would allow for a determination within 24 hours of the P2P discussion. The
11 Council believes such mitigating circumstances include instances wherein a physician involved in
12 the P2P discussion requests additional time to read relevant medical literature. Importantly, the
13 Council notes that such an extension shall not be permitted where the PA request is urgent.

14
15 As highlighted in Policy D-320.983, care must be taken to ensure that plan reviewers are, in fact,
16 physician peers with the appropriate experience treating the condition in question and from the
17 same specialty or subspecialty. The AMA already has strong policy stating that any physician who
18 recommends a denial as to the medical necessity of services on behalf of a review entity be of the
19 same specialty as the practitioner who provided the services under review (e.g., Policy H-320.968).
20 Nevertheless, the Council believes that policy should be strengthened to ensure that not only is the
21 reviewing physician of the same specialty and licensed to practice in the jurisdiction, but also has
22 the expertise to treat the medical condition or disease under review according to up-to-date
23 evidence-based guidelines and has knowledge of novel treatments.

24
25 Moreover, as directed by Policy D-320.983, the Council highlights Ethics Opinion 10.1 regarding
26 ethical guidance for physicians in nonclinical roles. Ethics Opinion 10.1 states that physicians earn
27 and maintain the trust of their patients and the public by upholding norms of fidelity to patients, on
28 which the physician's professional identity rests, and that, despite not directly providing care to
29 patients, physicians employed by insurers have committed themselves to the values and norms of
30 medicine. Accordingly, the Council recommends that physicians employed by insurance
31 companies must follow current evidence-based guidelines consistent with national medical
32 specialty society guidelines where available and applicable.

33
34 The Council notes that the AMA's efforts to reduce PA burdens are particularly important during
35 public health emergencies, such as the novel coronavirus (COVID-19) pandemic. Recognizing the
36 enormous strain placed on physicians and the entire US health care system and, more importantly,
37 the impact that delayed care has on patients during the COVID-19 crisis, the AMA and other
38 organizations have successfully advocated for many commercial health plans to temporarily
39 suspend or otherwise adjust PA requirements. Meanwhile, legislators and regulators have reduced
40 PA in both the commercial and Medicaid markets via legislation, executive orders, and waivers.
41 While the AMA strongly supports relaxation in PA requirements during the COVID-19 emergency,
42 there is considerable variation in the adjustments being made across the commercial health insurer
43 market and corresponding effective dates, with some plans quickly reinstating regular PA processes
44 only a few months into the pandemic. The AMA is tracking individual health plan COVID-19-
45 related PA program updates to help physicians stay informed of these rapidly changing policies
46 (see <https://www.ama-assn.org/system/files/2020-04/prior-auth-policy-covid-19.pdf>). To that end,
47 the Council recommends that the AMA urge temporary suspension of all prior authorizations and
48 calls for the extension of existing approvals during a declared public health emergency.

1 Finally, the Council notes that PA remains a top-of-mind issue for physicians and, as such,
2 deserves substantial AMA attention and resources. As detailed in this report, the AMA prioritizes
3 PA as one of its key advocacy issues and continues to collaborate with relevant stakeholders to
4 address physician concerns on this topic. The AMA is committed to ensuring that tackling PA and
5 UM issues will continue to be a leading priority for the AMA.

6
7 RECOMMENDATIONS

8
9 The Council on Medical Service recommends that the following be adopted and that the remainder
10 of the report be filed:

- 11
12 1. That our American Medical Association (AMA) reaffirm Policy H-320.939 which states
13 that the AMA will continue its widespread prior authorization (PA) advocacy and outreach,
14 including promotion and adoption of the Prior Authorization and Utilization Management
15 Reform Principles, the Consensus Statement on Improving the Prior Authorization Process,
16 AMA model legislation, the Prior Authorization Physician Survey and other PA research,
17 and educational tools aimed at reducing administrative burdens for physicians and their
18 staff; and advocate for such decisions to be based on the direct review of a physician of the
19 same medical specialty/subspecialty as the prescribing/ordering physician. (Reaffirm HOD
20 Policy)
- 21
22 2. That our AMA reaffirm Policies H-320.948 and H-320.961 which encourage sufficient
23 clinical justification for any retrospective payment denial and prohibition of retrospective
24 payment denial when treatment was previously authorized. (Reaffirm HOD Policy)
- 25
26 3. That our AMA reaffirm Policy H-320.949 which states that utilization management criteria
27 should be based upon sound clinical evidence, permit variation to account for individual
28 patient differences, and allow physicians to appeal decisions. (Reaffirm HOD Policy)
- 29
30 4. That our AMA reaffirm Policies H-285.998 and H-320.945 which underscore the
31 importance of a clinical basis for health plans' coverage decisions and policies. (Reaffirm
32 HOD Policy)
- 33
34 5. That our AMA reaffirm Policy H-285.939 which states that utilization review decisions to
35 deny payment for medically necessary care constitute the practice of medicine and that
36 medical directors of insurance entities be held accountable and liable for medical decisions
37 regarding contractually covered medical services. (Reaffirm HOD Policy)
- 38
39 6. That our AMA advocate that peer-to-peer (P2P) PA determinations must be made and
40 actionable at the end of the P2P discussion notwithstanding mitigating circumstances,
41 which would allow for a determination within 24 hours of the P2P discussion. (New HOD
42 Policy)
- 43
44 7. That our AMA advocate that the reviewing P2P physician must have the clinical expertise
45 to treat the medical condition or disease under review and have knowledge of the current,
46 evidence-based clinical guidelines and novel treatments. (New HOD Policy)
- 47
48 8. That our AMA advocate that P2P PA reviewers follow evidence-based guidelines
49 consistent with national medical specialty society guidelines where available and
50 applicable. (New HOD Policy)

- 1 9. That our AMA continue to advocate for a reduction in the overall volume of health plans'
2 PA requirements and urge temporary suspension of all PA requirements and the extension
3 of existing approvals during a declared public health emergency. (New HOD Policy)
4
- 5 10. That our AMA rescind Policy D-320.983, which directed the AMA to conduct the study
6 herein. (Rescind HOD Policy)
7
- 8 11. That our AMA advocate that health plans must undertake every effort to accommodate the
9 physician's schedule when requiring peer-to-peer prior authorization conversations. (New
10 HOD Policy)
11
- 12 12. That our AMA advocate that health plans must not require prior authorization on any
13 medically necessary surgical or other invasive procedure related or incidental to the
14 original procedure if it is furnished during the course of an operation or procedure that was
15 already approved or did not require prior authorization (New HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

¹ Model Bill: Ensuring Transparency in Prior Authorization Act. American Medical Association. Available at: <https://www.ama-assn.org/system/files/2019-08/model-bill-ensuring-transparency-in-prior-authorization.pdf>

² Prior Authorization and Utilization Management Review Principles. American Medical Association. Available at: <https://www.ama-assn.org/system/files/2019-06/principles-with-signatory-page-for-slsc.pdf>

³ Consensus Statement on Improving the Prior Authorization Process. Available at: <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf>

⁴ Private Health Insurance: Data on Application and Coverage Denials. Government Accountability Office. Available at: <https://www.gao.gov/new.items/d11268.pdf>

⁵ CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule Version PA.2.0. CAQH CORE. Available at: https://www.caqh.org/sites/default/files/core/phase-iv/452_278-infrastructure-rule.pdf