Prior Authorization

Important Oversight or Delay Tactics?

Doctors push back against prior authorization complications

BY ELIZABETH SAMPSON

Oncologists like Banu Symington, MD, are used to having tough conversations with patients. Telling someone they have cancer is never easy, but when an insurance company denies coverage for cancer treatment, the conversation becomes something else altogether.

Recently Dr. Symington, who is the medical director of the Sweetwater Regional Cancer Center in Rock Springs, had to have this exact conversation with one of her patients. The patient, having already faced job loss and a cancer diagnosis, now had to contend with being denied coverage for medicine that could save his life. He made an appointment with Dr. Symington to ask what was going to happen to him.

"I've done what I can do several times, and I can't get your current insurance company to approve it," Dr. Symington told him. "I'm going to have to hope for the best that the treatment they will approve is going to keep you alive, but I can't guarantee it."

As for her patient?

"He's distraught, but what can he say?" Dr. Symington said.

Unfortunately, Dr. Symington is one of many doctors who has had to battle to help their patients get coverage for the care they need. Many doctors across Wyoming say the insurance prior authorization system has become burdensome for them and harmful for their patients.

Meanwhile, a recent and distressing insurance mandate is angering Dr. Symington and putting her patients in danger. She said some insurance companies are starting to say they will only pay for cancer treatments that are administered at an off-site infusion center with no doctors on staff, rather than at a cancer center.

"I'm responsible medically and legally for the side effects, but they will not deliver it where I am physically," she said. "They are coercing patients through financial pressure to get their infusions at an off-site location to save themselves money. It is not with patient comfort, convenience or safety in mind. It is their bottom line."

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She said if a patient has a bad reaction to the cancer treatment at the cancer center, the ER's code team can be there to help in a minute—not so at an infusion center.

"The private infusion center calls 911 when there's a reaction," she said. "The patient at the private infusion center

will be waiting for the ambulance to come and transport them to the emergency room."

She knows that if a patient does have a bad reaction while at the infusion center, she could be sued because she wrote the order for the treatment, but if she refuses to write the order she could be accused of abandoning her patients.

She wonders if these tactics are being implemented first in rural states, which frustrates her even more.

"They're rolling this out in rural centers because we don't have the might to fight it," she said. "I feel there is urgency, and we're not acting urgently enough. It's going to take action by patients—not doctors—but patients to make this different."

Tyler Quest, MD, a dermatologist with his own practice in Casper, described a patient of his who spent a miserable two months covered in a full-body rash after an initial prescription was denied by the patient's insurance company. The denial letter suggested that the patient try medications from a different brand name in the same drug class that patient had already tried.

Dr. Quest began working on an appeal process, which involved filling out many pages of information, wasting time on hold and even making a call to the insurance company to tell them that his patient was at risk of hospitalization if he did not get medication.

As a dermatologist, Dr. Quest said he knows that the complex medical dermatology cases he and his colleagues treat require extremely expensive medication, and he understands why these costly medications can trigger a review from insurance companies. However, the same review and prior-authorization processes can occur for $5 and $10 medications as well, he said.

"I'm not against insurance companies having formularies, but the suggestion of trying one medicine when he had already tried almost an identical medication before was just another delay and not appropriate for him," Dr. Quest said.

Kevin Helling, MD, a general surgeon in Casper with a focus on bariatric surgery, said when he is helping a person plan for a weight-loss surgery, he likes to give them a month or two to have time to be medically prepared and well-informed about life post-surgery, but some insurers require as long as six months waiting time before they will cover the surgery.

"I can say with certainty I've had patients who have had medical conditions that have worsened to the point where it definitely has impacted their lives because they're waiting for months to get a service," he said. "It's been studied and there's no evidence base whatsoever to demonstrate making someone wait six months gives them a safer or better outcome after the surgery."

On the other hand, if he can get the patients into surgery quickly, they spend less time suffering with whatever caused them to seek surgery in the first place.

"If we can get their surgery done, their medical conditions melt away," Dr. Helling said.

Administrative burdens and costs leading some doctors to leave medicine

It's not just patients who are suffering as they wait for treatment and medications to be approved. Doctors are struggling as well with the added workload that takes them away from time with their patients.

"It is not uncommon for a patient's care to be delayed for 30 days or longer while prior authorization steps are being completed," Dr. Quest said. "Our office will receive confusing forms that are 14 or more pages, and then the next day you will get additional forms asking similar questions in different ways, asking for laboratory work, etc. As a very small practice we have to have an additional employee just to work on these forms that otherwise could focus on clinical work."

Each payor has their own rules for what needs prior authorization, what forms they want filled out and different lengths of response time, which makes it difficult for medical practices to streamline their part of the process.

"Patient harm is a primary driver for prior authorization reform, but so is the drain on healthcare resources and the burden on physician practices," said Jack Resneck, Jr. MD, immediate past president of the American Medical Association. "Physician offices find themselves using inordinate amounts of staff time and resources submitting requests to health plans for the authorization of medically necessary care. While health plans may eventually authorize most requests, the process can be a lengthy administrative nightmare of recurring paperwork sometimes transmitted by fax, multiple phone calls arguing with health plan employees who often aren't qualified to assess care plans, layers of appeals, and bureaucratic battles that can delay or disrupt a patient's access to vital care. AMA survey data show that, on average, physician practices complete 45 prior authorizations per physician per week. This adds up to nearly two business days, or 14 hours, each week dedicated to completing prior authorizations.

Dr. Quest said the prior authorization process is so time consuming he has considered selling his practice to a larger group or joining a hospital, and said it can feel like the insurance company is trying to get him to give up when they send him 14-page documents to fill out over and over.

"I know it is definitely impacting physicians like me all over the state," he said. "I've been on Facebook groups where people say they don't know if I can be a doctor anymore because of

Prior Authorization

all this paperwork we're dealing with. It feels like you're just sometimes fighting an invisible person. Sometimes there's no name attached to these denials, and you don't know where to turn."

Dr. Helling said he pays a full-time employee whose only job is to interface with the insurance companies trying to get treatment approved for his patients.

"I have a medical practice of one doctor—just me," he said. "I don't know what a large group of 10-12 doctors would have to put into this.

Doctors take issue with insurance company claims

There are several things doctors are saying they take issue with when it comes to prior authorization. For one, several doctors said insurance companies have indicated doctors may not be up to date on current guidelines and therefore prior authorization can be a helpful tool.

Kris Schamber, MD, Wyoming Medical Society president, disagrees. He said if he treats 100 patients for a particular illness, and prescribes a tried-and-true, older medication to 80 of them, but discovers that 20 patients don't respond to the old medication, he must go through the prior authorization process because the insurance company assumes he is not practicing evidence-based medicine. They are aware of and track the prior authorizations, but he does not believe they track the other care provided that does not raise to the level of prior authorization.

"In their minds, these providers are always sending these crazy things, or they don't know how to practice," he said. "When denying a prior authorization, they almost always comment on guideline-based care, 'The guidelines don't support this treatment or diagnostic.'"

Dr. Schamber said he always considers guidelines when discussing treatments or diagnostics with his patients, but he said a guideline is not an absolute referendum on care for a given medical condition or treatment course.

"Individual patients frequently do not fit within the confines of the studies that guide care," he said. "If they don't fit within those guidelines for whatever reason, I'm using my medical judgment to guide treatment, understanding 'the guidelines,' other studies, and individual patient characteristics. I need something different, but insurance companies are forcing us to work through the guidelines on every single patient, which is not appropriate."

In fact, Dr. Schamber said there can be potential harm if patients are forced to go through the steps required by an insurance company. While they may require patients to try a set list of medications before they can have coverage for the medication their doctor believes is best for them, those medications may not work for a variety of reasons.

"It takes many months or longer to jump through the hoops, proving that a number or treatments don't work until we finally get approval for the initial requested medication," Dr. Schamber said. "It costs money, and it takes away from our patients' care."

Dr. Helling said he actually finds himself waiting for insurance companies to catch up with the latest recommendations.

"In October the guidelines for who qualifies for weight loss surgery were officially updated to lower the BMI requirement," he said. "I have yet to see a payor adopt these formally published expert guidelines, at least in Wyoming."

Dr. Resneck noted health plans suggest prior authorization requirements are limited to high-cost medications and procedures and are necessary to make sure lower-cost alternatives are the norm.

"This may have been true decades ago, but in my experiences, and the experiences of my colleagues, that is simply no longer the case," he said. "The prior authorization burden has spiraled out of control, and most of authorization requests I now fill out are for generic, long-standing medications for which there is no obvious, cheaper alternative. This is not money or resources well spent."

In addition, the approval process health insurers impose on medical services or drugs is generating a toll that far exceeds any purported benefits.

"While health insurers claim prior authorization requirements are used for cost and quality control, a vast majority of physicians report that health plans impose authorization policies that conflict with evidence-based clinical practices, waste vital resources, jeopardize quality care, and harm patients by delaying, denying, or disrupting access to appropriate care," Dr. Resneck added. "The byzantine system of authorization controls needs reform that reduces waste, improves efficiency, and protects patients from obstacles to medically necessary care."

He shared results from the AMA's annual survey that physicians confirm patient harm from the prior authorization requirements. The survey noted 94% of physicians report care delays, 80% report treatment abandonment, and 89% report a negative impact on patients' clinical outcomes.

"But perhaps most disturbing is that 33% report that prior authorization has led to a serious adverse event for their patients such as hospitalization, permanent impairment or even death," Dr. Resneck said. "The negative impact of prior authorization requirements on patients' health and well-being is really staggering."

Prior Authorization

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WMS advocates for change

As doctors grow more frustrated, the Wyoming Medical Society is advocating for change. WMS representatives testified at a June 22 Wyoming Legislature Joint Labor, Health and Social Services meeting as legislators discussed a draft bill for the upcoming 2024 session. The bill draft, 24LSO-0068, addresses insurance company prior authorization regulations.

Currently, Wyoming has no laws in place concerning prior authorization limitations or timelines.

"Wyoming has a lot of work to do in terms of prior authorization reform, but Wyoming physicians and patients have reason to be hopeful as the Wyoming Medical Society is pushing hard for action from the state legislature–and lawmakers are listening," said Dr. Resneck.

Neighboring states are already enacting prior authorization reforms.

"Montana has pushed ahead with small reforms to reduce the volume of prior authorization to complement some existing transparency requirements and is likely to come back to the table for broader legislation next year," Dr. Resneck said. "North Dakota established a study committee this year to look at the impact of prior authorization on patients, providers, insurers–including the burden, time, costs, utilization. States like Colorado, Texas, Illinois, Ohio, Michigan, and others have been able to implement broader reforms that address response times, prior authorization volume and transparency. And states like Oregon and Washington have also enacted reform laws that require prior authorization data reporting, improve the clinical validity of the coverage criteria, promote continuity of care, and streamline the process."

Suggested changes

There are a variety of ways the process could be streamlined to eliminate the heavy administrative burden of prior authorization, according to the Wyoming Hospital Association.

"We think that there needs to be some regulation, and that insurance companies need to be reined in on how they manage those processes," said Josh Hannes, vice president of the WHA.

From drastically reducing the number of procedures that require prior authorization to limiting the amount of time insurance companies have to respond, the WHA is looking for practical steps to eliminate the bureaucratic burden on hospitals.

"If something is going to be denied, then you get that physician or somebody in their office on the phone with the insurance company so they can talk through it," Hannes said. "We don't want to have to jump through all these hoops to get care approved. If there is something that can be handled in a phone call and quickly explained, we want to make sure that process is a lot easier."

The WHA is also working with the Wyoming Department of Insurance to require insurance companies to share data on their prior authorization processes—how many they receive for what services, how many are denied and why, the time it takes them to get responses out.

"We think that's critically important because it's a truly opaque process right now where there's not a lot of insight outside of the insurance company into the effectiveness," Hannes said.

Hannes said in some cases the data could prove there is a legitimate reason for insurance companies to require a standard of proof before a physician proceeds with certain procedures.

"It could very well be that there could be some value sometimes to doing this, but right now it seems they're implementing this process to delay payment or to deny payment, and we're asking for evidence that that's not the case," Hannes said.

Dr. Helling suggested that one way to make the process better is to require peer-to-peer reviews be done by an insurance doctor of the same specialty.

"Historically that would be another gastrointestinal surgeon," Dr. Helling said. "Lately the peer review discussion is with a physician that is not specialty specific. I could be talking to a pediatric endocrinology physician about an adult gastric bypass patient—and they always say no."

For the WMS, the bottom line is medical decisions should be made by patients and their doctors, and insurance companies should not dictate what care is appropriate.

"We don't believe the legislature nor the insurance companies should be dictating the practice of medicine," Dr. Schamber said. "Insurance companies, in addition to their original purpose of covering medical care, are now deciding what medical care is appropriate, effectively practicing medicine. And it's all about saving money for the company, at the expense of the patients they deny care for."