KANSAS MEDICAL SOCIETY
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Prior authorization: recommendations for improvement

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Background

Patient-centered care has emerged as a major, common goal across the health care industry. By empowering patients to play an active role in their care and developing individualized health care plans, we can increase patients' satisfaction, improve treatment quality and enhance overall outcomes. Yet despite the clear advantages to adopting patient-centered care, health care providers and patients often face significant obstacles in putting this concept into practice.

Utilization management programs, such as prior authorization, can create significant barriers for patients by delaying the start or continuation of necessary treatment and negatively affecting patient health outcomes. The very manual, time-consuming processes used in these programs burden physicians and divert valuable resources away from direct patient care. However, health plans contend that utilization management programs are effective in controlling costs and ensuring appropriate treatment.

The Kansas Medical Society has surveyed its members and it is clear that the burden of prior authorization is significant. It impacts both physicians and patients—delaying necessary care, intruding on the physician-patient relationship and causing unnecessary frustration.

Principles

Recognizing the investment that the health insurance industry will continue to make in prior authorization, KMS has adopted the following principles to reduce the negative impact prior authorization has on patients, physicians and the health care system. The recommendations are based on principles already adopted by the American Medical Association. We believe adherence to these principles will ensure that patients have timely access to treatment and reduce administrative burdens in the health care system.

1. Prior authorization programs should be based on accurate, current clinical criteria not solely on cost; that criteria should be readily available to physicians and other providers.
2. Prior authorization programs should be flexible, recognizing that the most appropriate course of treatment for any given medical condition depends on a patient's unique clinical situation.

3. Any prior authorization appeal system should allow a physician direct access to a physician of the same training and specialty/subspecialty for medical necessity issues.
4. A prior authorization approval should be valid for the duration of the prescribed course of treatment.
5. Payers should publicly disclose, in a searchable electronic format, the prior authorization process applied to drugs and medical services. Additionally, payers should clearly communicate the supporting documentation needed to complete every prior authorization appeal request.
6. Payers should make statistics regarding prior authorization approval and denial rates available on their website in a readily accessible format. This data should inform efforts to refine and improve prior authorization programs. The statistics should include but are not limited to:
    - Physician specialty
    - Procedure, medication or diagnostic test
    - Indication
    - Total annual prior authorization requests, approvals and denials
    - Reasons for denial
    - Denials overturned on appeal
7. Payers should provide detailed explanations for prior authorization denials including an indication of any missing information. Denials should also include the clinical rational for the adverse determination, the plan's covered alternative treatment and detail the provider's appeal rights.
8. Prior authorization processes should be conducted exclusively through a secure electronic transmission.
9. Physicians and patients should be able to rely on a prior authorization approval as a commitment to coverage and payment of the corresponding claim.
10. If prior authorization is required for non-urgent care, payers should make a determination and notify the provider within 48 hours of obtaining all necessary information. For urgent care, the determination should be made within 24 hours of obtaining all necessary information. Prior authorization should never be required for emergency care.
11. Payers should restrict prior authorization programs to "outlier" providers whose prescribing and ordering patterns differ significantly from their peers (after adjusting for patient mix and other relevant factors).
12. Physicians who participate in financial risk-sharing payment plans should be exempt from prior authorization requirements for the services covered under the plan's benefits.

Note: Material adapted from American Medical Association's consensus statement addressing prior authorization reform