MASTERING THE PRIOR AUTHORIZATION PROCESS: Assuring the Best Care for Your Patients

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This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational a guide and should not be considered a legal/consulting opinion

Disclaimer

"Few words arouse more frustration among primary care physicians than 'prior authorization.'"

-*Medical Economics*, October 2013

- Denial of a Prior Authorization is not denial of the TREATMENT

- It is a denial of PAYMENT

- Prior authorization: In pharmacy, a cost-containment procedure that requires a prescriber to obtain permission to prescribe a medication prior to prescribing it.
- Also called prior approval
  - MedicineNet

Prior Authorizations

Prior Authorizations

- Prior authorization (PA) is any process by which physicians and other health care providers must obtain advance approval from a health plan before a specific procedure, service, device, supply or medication is delivered to the patient to qualify for payment coverage.

- Other terms used by health plans for this process include:
  - Preauthorization
  - Precertification
  - Prior approval
  - Prior notification
  - Prospective review
  - Prior review

- Health plans :
  - Often used to restrict access to costly services and therapies
    - Particularly newer treatments
  - Also use to ensure that a therapy is appropriate and safe for a specific patient
    - Require kidney function laboratory results prior to approval of a medication contraindicated in patients with renal failure.
      - AMA©

Prior Authorizations

- Seen as a roadblock to patients receiving necessary treatment

- Unnecessary questioning of their medical judgement and clinical expertise

Physicians View

- Delays in patient care
- Uncompensated work for physicians and staff, which translates into increased overhead costs for practices
- Disruption in practice workflow
- Nonpayment if Prior Authorization not completed in advance of service provision

What are Consequences of Prior Authorization process?

86% physicians described the administrative burden as

"high or extremely high"

88% - burden has gone up in the last five years

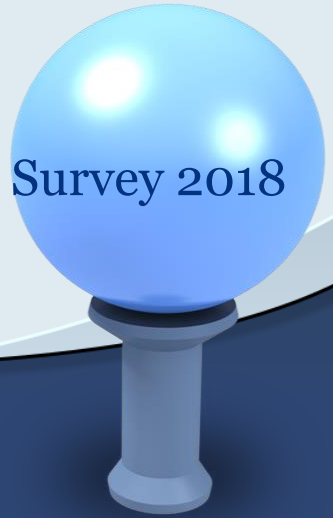
AMA Survey 2018

- 66% of prescriptions rejected by insurance require a prior authorization
- 33% of those scripts are abandoned

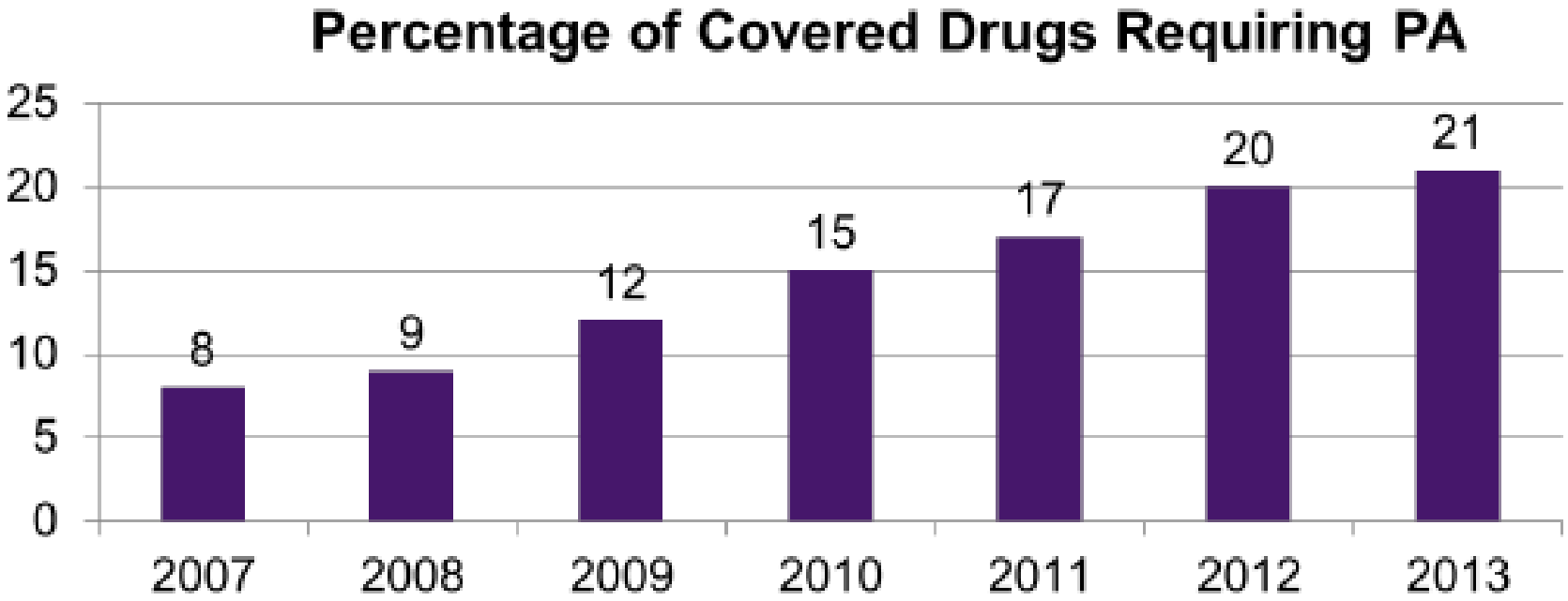
- CoverMyMeds®

- 91% Physicians reported that Prior Authorizations can have a negative effect on clinical outcomes
- 75% Physicians reported that Prior Authorizations delays lead to patients abandoning treatment
- 28% Physicians reported that Prior Authorizations have led to a serious adverse event such as hospitalization, disability or death for a patient in their care

- AMA Survey 2018



Increasing use of PA: Medicare Part D



Sources: NORC/Social & Scientific Systems analysis of data from CMS; *Medicare Part D Prescription Drug Plans: The Marketplace in 2013 and Key Trends, 2006-2013*. Available at: http://kff.org/medicare/issue-brief/medicare-part-d-prescription-drug-plans-the-marketplace-in-2013-and-key-trends-2006-2013/.

- Obtain copies of major insurance formularies
  - Create your own if needed

EXAMPLES

cc 236
Davin

AUG 27 2019

Dear Valued Provider:

The enclosed information was sent to your patient.

If you have any questions, or would like to discuss our decision to deny this request for prior authorization with a reviewing physician or pharmacist, please call PerformRx Provider Services at 1-888-989-0057, Monday through Friday from 8:30a.m. to 6 p.m. TTY users should call 1-888-9

Our criteria for this decision is available upon request.

Sincerely,

Pharmacy Management

Enclosure: Member Denial Notice
Grievance and Appeal Fact Sheet

Dear [redacted]:

Blue Cross Complete of Michigan has reviewed the request for SYMBICORT 160-4.5 MCG INHALER, # 30.6. On 8/22/2019, Davin [redacted] submitted this request for [redacted]. A pharmacist has reviewed this request.

This request is denied: according to our Prior Authorization Criteria for Non-Formulary Inhalers.
The authorization request from your doctor doesn't meet our criteria for inhalers that aren't on our formulary. This criteria says:

- SYMBICORT 160-4.5 MCG INHALER must be approved for the treatment of your condition AND
- the dose must be approved for the treatment of your condition and age AND
- you must first try 2 formulary inhalers in the same class (if available) OR
- you have a medical, physical, or other condition that makes it difficult to use a formulary inhaler (for example you need to use a spacer and our formulary inhaler can't be used with a spacer)

We can't approve this request because our records show that you haven't tried two of our formulary inhalers such as Wixela Inhub (generic Advair Diskus), Serevent Diskus or with step therapy: Bevespi Aerosphere. If you have and they didn't work, ask your doctor to provide medical records showing that you have tried two formulary inhalers.

If the other inhalers cannot be used, and your doctor can give us more information to support their decision to use SYMBICORT 160-4.5 MCG INHALER, we may change our decision. This information can include more medical history and guideline information for your condition.

Our Prior Authorization Criteria for Non-Formulary Inhalers is available upon request..

Prescriber: Tel: (517)

Please refer to the pharmacist comments and the information below when processing this request.

Pharmacist Comments:

Patient Info:

Pharmacy Info:
RITE AID

TEL:
FAX:

Prescription Info:
Rx # 17262
DEXTROAMP-AMPHETAMIN 30 MG TAB
Qty / Day Supply: 60.000 / 30
take 1 tablet by mouth twice a day

Date Filled: 08/26/2019

Patient Insurance Info:
THIRD PARTY AGENCY: MIHEALTH CARD <BIN#009737>
ID: 0038503503 GROUP:

Agency Reject Messages:
MIHEALTH CARD <BIN#009737> - 75: Prior Authorization Required. See Third Party Information.

Information: Additional agency message: MIHEALTH CARD <BIN#009737> - Call 877-864-9014 Under 6 and over 17 requires a PA

Please complete the appropriate response and contact the pharmacy via phone/fax.

Date: ____/____/_____ ____ Authorization Approved ____Authorization Denied
Comments:

PRESCRIPTION REQUIRES A PRIOR AUTHORIZATION

This prescription was rejected by the patient's PBM. You have the choice to change the drug according to the patient's formulary or call for a prior authorization. Please call the number provided on the third party reject details if available. Otherwise contact the pharmacy for details.

RETURN PRIOR AUTHORIZATION TO:

488

PHONE: (517)
FAX: (517)

PATIENT INFORMATION:

PHONE:

INSURANCE INFORMATION:
Date of Request: 08/30/2019
Patient ID:
Patient DOB:
Insurance Plan: SECURE RX PDP
BIN: 004336
PCN: MEDDADV
Ins. Phone #: (855) 538-0453

PRESCRIPTION INFORMATION:
Patient:
Doctor:
Drug: SPIRIVA HANDIHLR CAP BOEH
NDC: 00597007541

Quantity: 30
Days Supply: 30
SIG: 1QD
Rx #:

REJECT INFORMATION:
NON-FORMULARY DRUG, CONTACT PRESCRIBER (PHARMACY HELP DESK 1-866-281-0635)
Processor/PBM Help Desk: 8662810635

ADJUDICATION RESULTS:
MR DRUG NOT ON FORMULARY
569 PROVIDE MEDICARE RX DRUG COVG & RIGHT

ok - give us option

PRIOR AUTH APPROVAL: _____

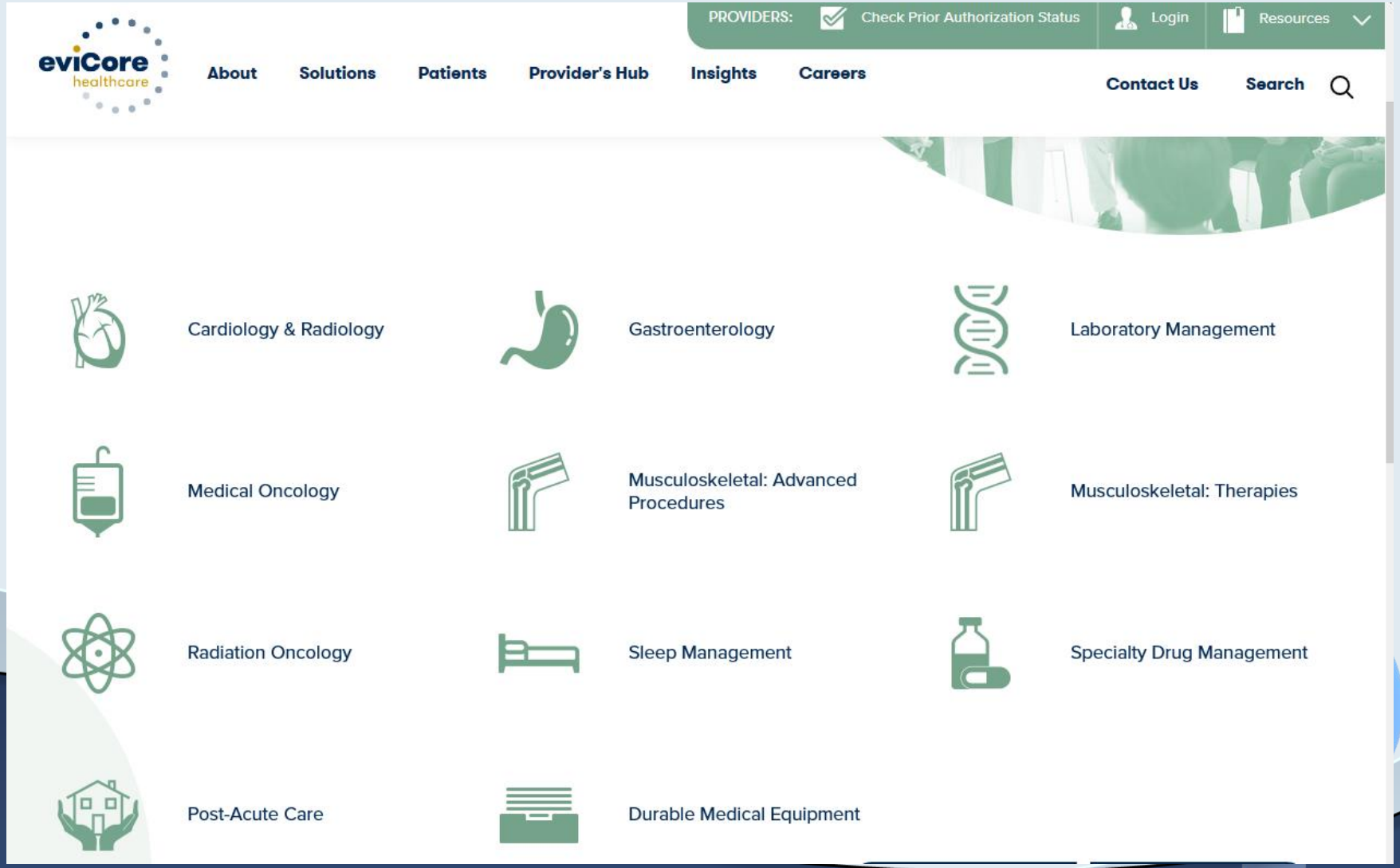
[ ] Change Drug:
[ ] New SIG if needed:

[ ] New Prescribe Quantity:
[ ] DISPENSE AS WRITTEN

Physician's Signature: _____ Date: _____

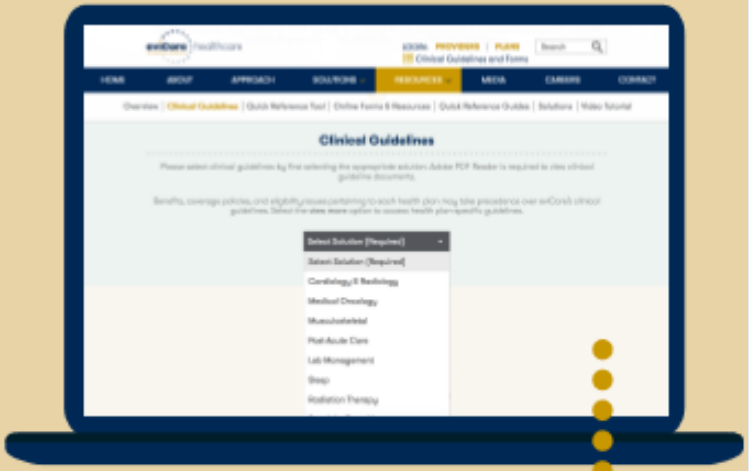
PRESCRIPTION REQUIRES A PRIOR AUTHORIZATION
Please notify pharmacy when prior authorization is approved.

KNOW YOUR CLINICAL GUIDELINES


eviCore healthcare
About
Solutions
Patients
Provider's Hub
Insights
Careers
PROVIDERS:
Check Prior Authorization Status
Login
Resources
Contact Us
Search
Cardiology & Radiology
Gastroenterology
Laboratory Management
Medical Oncology
Musculoskeletal: Advanced Procedures
Musculoskeletal: Therapies
Radiation Oncology
Sleep Management
Specialty Drug Management
Post-Acute Care
Durable Medical Equipment

How to Avoid Peer to Peer Phone Calls

The "Keys" to Prior-Auth



Key #1

Download eviCore's Guidelines

Check out the eviCore guidelines. We use a rigorous process of accumulating and assessing the best available evidence, in accordance with the standards of our accreditation agencies (URAC and NCQA). In short, each chapter in the eviCore guidelines reflects the most current and authoritative evidence-based recommendations created by well-respected national organizations and made available to the public.

Key #2

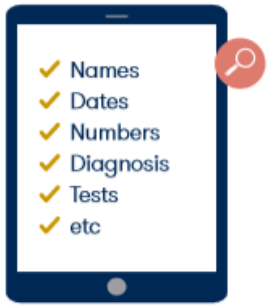
Provide Clinical Information Up Front

To avoid denials and P2Ps, be proactive; anticipate and prepare the clinical information that eviCore will likely need, and provide that information to your prior-authorization employee to get approval during the initial request.

Key #3

Prepare for Clinical Questions

The fastest and most reliable way to avoid P2P phone calls and other appeals and obtain the prior authorization number "right out of the gate" on the very first submission is to be prepared to answer the clinical questions that will be asked.



Key #4

Refer to the Guidelines

Paste the eviCore guidelines on your desktop and refer to them whenever you are uncertain about the best imaging study request when you are treating your patients.

AIM Clinical Appropriateness Guidelines and Cancer Treatment Pathways

The AIM Specialty Health Clinical Appropriateness Guidelines and Cancer Treatment Pathways are clinical tools designed to help providers choose the most appropriate treatments and tests for health plan members with complex clinical needs.

RADIOLOGY

Guidelines for imaging modalities, including CT, MRI, MRA, and PET. Also available are guidelines for pediatric imaging.

FIND THE GUIDELINES →

CARDIOLOGY

Guidelines for cardiac imaging modalities, including echocardiography, nuclear cardiology, cardiac CT, cardiac MRI, cardiac PET, and arterial ultrasound.

FIND THE GUIDELINES →

SLEEP

Guidelines for testing and treatment of sleep disorders, including obstructive sleep apnea.

FIND THE GUIDELINES →

RADIATION ONCOLOGY

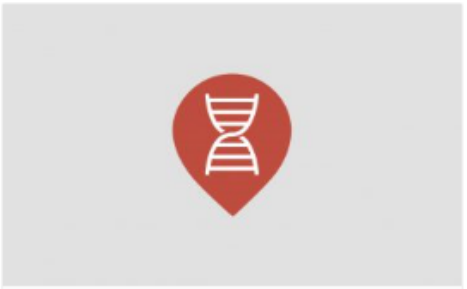
Guidelines for radiation therapies, including brachytherapy, image-guided radiotherapy (IGRT), intensity-modulated radiation therapy (IMRT), and proton beam therapy.

FIND THE GUIDELINES →

MUSCULOSKELETAL

Guidelines for spine surgeries, joint surgeries, and interventional pain management.

FIND THE GUIDELINES →



GENETIC TESTING

Guidelines for genetic testing, including for pharmacogenomics, prenatal diagnosis, cardiac disease, cancer susceptibility, and tumors and malignancies.

FIND THE GUIDELINES →

Indications For In-Lab (Attended) Sleep Studies In Adult Patients (Age 19 Years or Older)

Suspected OSA (in patients with unspecified sleep apnea and nocturnal desaturation, OSA should be suspected and excluded if clinically appropriate):

An in-lab sleep (attended) study is indica[illegible]f the patient meets any of the following criteria (1–3) **AND** has a contraindication to a home sleep study (as listed in tab[illegible]above):

1. Observed apneas during sle[illegible]**OR**
2. A combination of **at least two (2)** of the following (a–e):
    a. Excessive daytime sleepiness evidenced by an Epworth sleepiness scale score greater than ten (10), inappropriate daytime napping (e.g., during driving, conversation, or eating), or sleepiness that interferes with daily activities and is not explained by other conditions;
    b. Habitual snoring or gasping/choking episodes associated with awakenings;
    c. Treatment-resistant hypertension (persistent hypertension in a patient taking three or more antihypertensive medications);
    d. Obesity, defined as a body mass index greater than 30 kg/m² or increased neck circumference defined as greater than seventeen (17) inches in men or greater than sixteen (16) inches in women;
    e. Craniofacial or upper airway soft tissue abnormalities, including adenotonsillar hypertrophy, or neuromuscular disease; **OR**

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Clinical & Regulatory Guidelines
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South Tower - Suite 800
Chicago, IL 60631
P. 773.864.4600
www.aimspecialtyhealth.com

Suspected sleep disorder other than OSA

An in-lab supervised sleep study is appropriate when there is suspicion of any of the following (1–7):

1. Central sleep apnea
2. Narcolepsy
3. Nocturnal seizures
4. Parasomnia
5. Idiopathic hypersomnia
6. Periodic limb movement disorder (PLMD) – In order to support the suspicion of PLMD in this context, one of the following (i-vi) must be documented: (i) Pregnancy, (ii) Renal failure, (iii) Iron deficiency anemia, (iv) Peripheral neuropathy, (v) use of antidepressant or antipsychotic medications, or (vi) continued hypersomnia and clinical symptoms of PLMD after sleep disordered breathing is ruled out by home sleep testing.

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- Expedite process
  - Patient gets care sooner
  - Avoid delays in testing/treatment
- Allows staff to aid in process
- Include in note for today
  - Succinctly documenting
    - Specific details
    - Dates and services/medications

Know What Information Is Needed

- Time saving in overall process
- Time NOT spent by you
- Cost saving
  - Physician vs Staff $$

Know What Information Is Needed

- Know your practice
  - What medications require Prior Authorizations?
    - May differ by insurance carrier
    - Does your EHR system help
    - Succinctly placing information in todays chart record helps make meeting conditions easy to submit to carrier
  - Create a Master Grid of information

For this medication patient must have
- failed on Inhaler A
- failed on Inhaler B

How To Combat Delays to Patient Treatment - Prior Authorization for Medications

- Know your practice
  - What Tests/Treatment require Prior Authorizations?
    - May differ by insurance carrier
    - Does your EHR system help
    - Succinctly placing information in todays chart record helps make meeting conditions easy to submit to carrier
  - Create a Master Grid of information

For this CT scan, patient must have had Signs & Symptoms for 6 months with a negative x-ray within the past 30 days

How To Combat Delays to Patient Treatment - Prior Authorization for Testing/Treatment

- Check coverage PRIOR to issuing script or ordering test
- Establish protocol
  - Avoid delays in patient care
  - Prevent potential follow-ups with patients for additional information
- Track progress
  - Avoid delays in patient care
  - Prevent delays “waiting” for “call back”
- Submit documentation

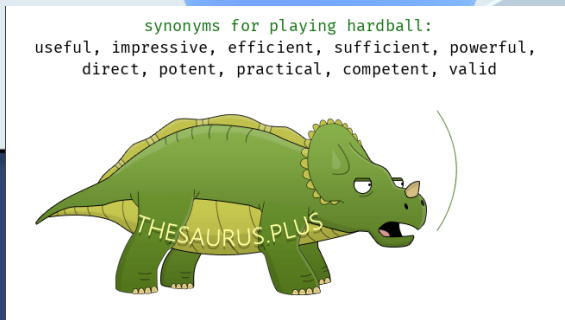
GOING FORWARD

- 83% of survey respondents request PA using faxes
  - 63% use a paper form
  - 35% direct through a payer Web site
  - 14% use an electronic standard transaction either through their practice management system or an electronic medical record

- AMA/Federation 2010 Survey

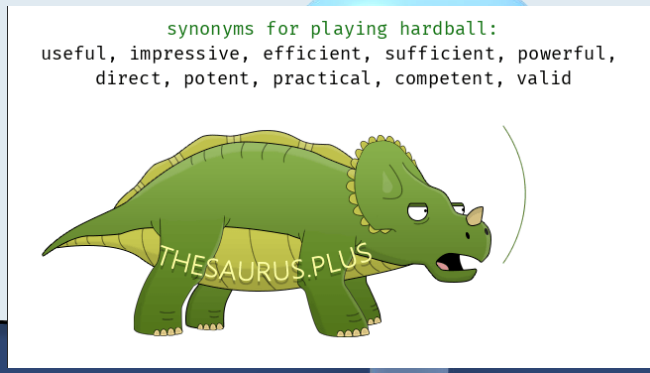
Automation Needed

- Have a discussion about the most expensive way to get a test done
  - Send the patient to the Emergency Room, who will most likely order and get the test performed
    - Additional expense of Emergency room and emergency physician
  - Send the patient to another doctor, a specialist who will probably order the test
    - Additional expense of additional doctor – something you are explaining you would avoid



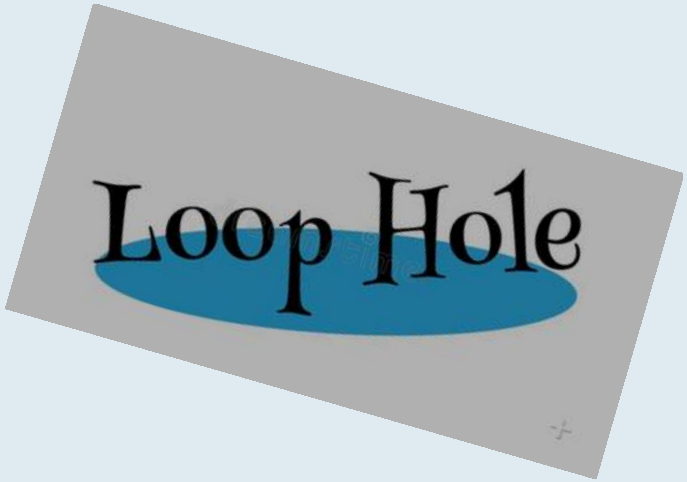
Playing Hard Ball

- Ask the insurance's physician their name
- Tell them:
  - You are going to document in the patient's record of their denial of the test you are trying to get approval for
  - That information (the denial, the doctors name, the phone number you called) will be in the clinical summary that the patient receives for completeness of documentation
- The insurance's physician will say they have no liability

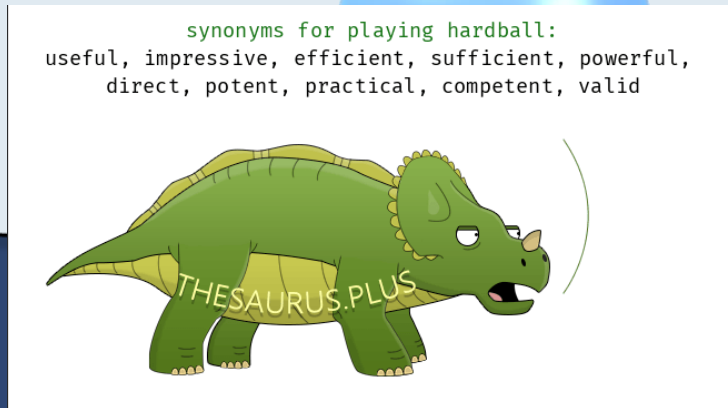


Playing Hard Ball

- Check your participation contract



Playing Hard Ball



- Overall reduction in health plans' use of Prior Authorizations
- Limitation of Prior Authorizations
  - True utilization outliers vs. current broadly applied programs
- Exploration of alternative approaches to address utilization issues
- Implementation of standardized electronic transactions when Prior Authorizations is used

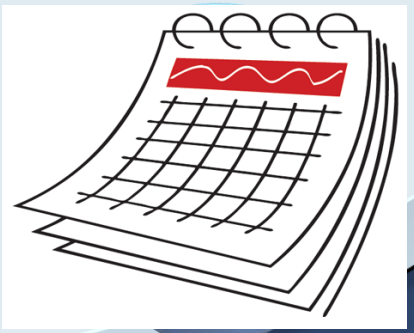
Regulations

- National Committee on Vital and Health Statistics recommended that the Department of Health and Human Services
  - Mandate the NCPDP SCRIPT Standard Version 2013101 ePA transactions as the adopted standard for the exchange of Prior Authorization information for the pharmacy benefit
  - Adopt the ePA transactions "under the most appropriate regulatory sections and processes that would enable prompt industry implementation and at the earliest possible implementation time"
  - Unclear if ePA transactions will be mandated as national standard under Health Insurance Portability and Accountability Act (HIPAA) or Medicare Modernization Act (MMA)

- National Council for Prescription Drug Programs (NCPDP) created a suite of electronic transactions to support automated pharmacy PA (ePA)
-
- ePA transactions are part of NCPDP SCRIPT standard for electronic prescribing and reuse SCRIPT functions and elements

- Approved and published by NCPDP in 2013

- HHS staff have indicated that proposed rule on ePA transactions will be released soon
- NCPDP has recommended that the effective date for compliance with the ePA transactions be 18 months following the final rule



Future of ePA Federal Mandate

- *PA sunset programs*
  - PA requirements removed for services with universally high PA approval rates
- *"Gold card" programs*
  - Physicians with high rates of PA approvals over a specified period of time are exempt from PA requirements
- *PA waivers*
  - Physicians using approved, clinically based appropriate use criteria (AUC) and/or clinical decision support excluded from PA programs

Alternatives

- Ask health plans to offer PA automated tools that will integrate with your practice management system (PMS) and EHR—and use them
- Request that your PMS/EHR vendors offer automated PA functionalities that use standard electronic transactions and fit in your practice's workflow

Alternatives

- Display current PA requirements, including clinical criteria, on their websites and make this information available to all stakeholders
- Provide contracted health care providers notice of 60 days before implementing a new PA requirement or amending current requirements
- Display statistical information regarding PA approvals and denials on their Web site

Prior Authorization Act

- Respond to PA requests in 2 business days for non-urgent services, one business day for urgent services and 60 minutes for post evaluation or post-stabilization services following emergency care
- Offer ePA as an option for physicians

Prior Authorization Act

- Also prevents utilization-review entities from:
  - Requiring PA for emergency services
  - Engaging in restrictive step-therapy requirements at the expense of patients' health
  - Revoking or restricting a PA for a period of 45 working days from the date the health care provider received the PA


HOPE

- Response Time:
  - 24 hours for urgent services
  - Within 5 days for non-urgent services
- 1 year coverage of prescriptions for chronic-condition maintenance drugs
  - Any change in dosage during this period will be covered
- Prior Authorization procedures will be posted online as well as a complete list of services requiring Prior Authorization
- Insurer Prior Authorization reviewers
  - Licensed physicians
    - When possible, of the same specialty as the requesting physician
- Physicians and other clinicians will be able to electronically request and transmit Prior Authorizations.

State of Kentucky – Passed :March 2019
Effective: January 1, 2020

- A health insurer that requires prior authorization shall
  - Use the uniform prior authorization forms developed by the office for medical care, for pharmaceutical benefits or related benefits
  - Establish electronic portal system for electronic and secure transmittal of prior authorization requests
    - 24 hour 7 day per week
      - Medical care
      - Pharmaceutical benefits
      - Related benefits
  - by January 1, 2021
    - Auto-adjudication of prior authorization requests

State of New Mexico:
Proposed January 4, 2019
Passed: April 4, 2019
Effective : September 1, 2019

- An adjudication shall be made within twenty-four hours
- Or shall be deemed granted if not made within twenty-four hours, when a covered person's health care professional requests an expedited prior authorization and submits to the health insurer a statement that, in the health care professional's opinion that is based on reasonable medical probability, delay in the treatment for which prior authorization is requested could:
  - (a) seriously jeopardize the covered person's life or overall health
  - (b) affect the covered person's ability to regain maximum function or
  - (c) subject the covered person to severe and intolerable pain

State of New Mexico:
Proposed January 4, 2019
Passed: April 4, 2019
Effective : September 1, 2019

- After December 31, 2020, an insurer may automatically deny a covered person's prior authorization request that is electronically submitted and that relates to a prescription drug that is not on the covered person's health benefits plan formulary
  - Provided that the insurer shall accompany the denial with a list of alternative drugs that are on the covered person's health benefits plan formulary.
- Non-compliance fine $5,000.00

State of New Mexico:
Proposed January 4, 2019
Passed: April 4, 2019
Effective : September 1, 2019

- Denial of a Prior Authorization is not denial of the TREATMENT

- It is a denial of PAYMENT

Sleep Disorder Management
Diagnostic & Treatment Guidelines

Clinical Appropriateness Guidelines

Effective Date: June 29, 2019

Approval and implementation dates for specific health plans may vary. Please consult the applicable health plan for more details.
AIM Specialty Health disclaims any responsibility for the completeness or accuracy of the information contained herein.

Proprietary

providers and reviewers to the most appropriate services based on a patient's unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice should be used when applying the Guidelines. Guideline determinations are made based on the information provided at the time of the request. It is expected that medical necessity decisions may change as new information is provided or based on unique aspects of the patient's condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient and for justifying and demonstrating the existence of medical necessity for the requested service. The Guidelines are not a substitute for the experience and judgment of a physician or other health care professionals. Any clinician seeking to apply or consult the Guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient's care or treatment.

ABM executive leadership **team**

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Ellen Clarke

Chief Information Officer

Elias G. Wahesh

EVP Corporate Operations

Associate Medical Directors

Our Associate Medical Directors are empowered to make a difference in people's lives by improving the quality of care for patients, providers, and payers. This team reviews clinical requests. Physicians review cases on the eviCore portal or on peer-to-peer calls to determine the appropriate evidence-based clinical decision. This model allows Associate Medical Directors to make a difference by supporting over 100M patients annually.

eviCore

Respected clinical expertise

Highly qualified clinical leadership team assures credibility.
Provider-friendly technology, communications and engagement resources promote collaboration and ease market acceptance.

AIM SpecialtyHealth.
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www.aimspecialtyhealth.com

- PA – Prior Authorizations
- PM – Practice Management systems
- ePA – Electronic Prior Authorization
- AUC – Area Under the Curve
- AUC – Appropriate Use Criteria
- CDS – Clinical Documentation Specialist
- AIM Specialty Health ?

Acronyms

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Questions?