REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-16)
Prior Authorization Simplification and Standardization
(Resolutions 705-A-15 and 712-A-15)
(Reference Committee G)

## EXECUTIVE SUMMARY


At the 2015 Annual Meeting, the House of Delegates referred Resolution 705, “Pre-Authorization Simplification and Standardization,” sponsored by the Washington Delegation. Resolution 705-A-15 asked the American Medical Association (AMA) to develop best practice recommendations for prior authorization (PA), to include requirements for timely responses and binding decisions, and advocate for accreditation bodies, such as the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), to adopt these recommendations. Resolution 705-A-15 also called for the AMA to study options for PA simplification, including a single browser-based portal.

At the same meeting, the House also referred Resolution 712, “Increasing Prior Authorization Requirements,” submitted by the New Mexico Delegation. Resolution 712-A-15 asked the AMA to study the burdens imposed on physician practices by PA requirements and evaluate possible solutions. The resolution also called for the AMA to consider the inclusion of PA in the AMA’s Professional Satisfaction and Practice Sustainability strategic focus area and the development of model state legislation that would (a) allow physicians to bill health plans for time spent on PA requirements and (b) prohibit rescission of PA determinations.

In its study of this issue, the Council noted significant problems associated with PA for both patients and physicians. The Council reviewed extensive relevant AMA policy and ongoing AMA advocacy to address several of the issues raised by the resolutions. The Council considered the potential for unintended and/or undesirable consequences with the specific actions called for in the referred resolutions. Accordingly, this report summarizes AMA policy related to PA, outlines relevant AMA advocacy activities, and identifies where concerns were found with the activities recommended in Resolutions 705-A-15 and 712-A-15. The review and analysis contained in this report conclude with recommendations that build upon, rather than duplicate, existing AMA policies and efforts and avoid inadvertent, unfavorable outcomes.

In the discussion section of this report, the Council notes ongoing AMA activities consistent with the intent of Resolutions 705-A-15 and 712-A-15, such as the development of a Federation staff workgroup tasked with developing a set of best practices and alternate resource management approaches. The workgroup’s efforts will support AMA advocacy with health plans and accreditation organizations.

The Council also emphasizes the importance of an evidence-based advocacy approach on PA, given the lack of alignment between physician and health plan interests on this issue. Both the 2015 AMA/Dartmouth-Hitchcock administrative burden time study and a forthcoming 2016 PA-specific research project will inform and strengthen the AMA’s ongoing efforts to reduce the practice burdens associated with utilization management programs.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-16

Subject: Prior Authorization Simplification and Standardization
(Resolutions 705-A-15 and 712-A-15)

Presented by: Robert E. Hertzka, MD, Chair

Referred to: Reference Committee G
(Steven Hattamer, MD, Chair)

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At the 2015 Annual Meeting, the House of Delegates referred Resolution 705, "Pre-Authorization Simplification and Standardization," sponsored by the Washington Delegation. Resolution 705-A-15 asked:

> That our American Medical Association (AMA): (1) study and develop best practices recommendations for simplification and timeliness of preauthorization and admission notifications, and report back to the House at the 2015 Interim Meeting, with such recommendations to include timely and binding preauthorization procedures for expensive procedures when requested by a physician or a patient; (2) advocate that NCQA, URAC, and ERISA adopt these recommendations; and (3) study all options including the option for developing a single interactive, browser-based portal for pre-authorization or admission notification and report back to the House at the 2015 Interim Meeting.

At the same meeting, the House also referred Resolution 712, "Increasing Prior Authorization Requirements," submitted by the New Mexico Delegation. Resolution 712-A-15 asked:

> (1) That our AMA study the burdens imposed upon physician practices and patients as a result of growing requirements by payers to obtain prior authorization for medications, other forms of treatment, diagnostic procedures and referrals, and include in its study possible solutions such as: (a) Alternative models of quality-based and shared-risk reimbursement that reduce or obviate the need for prior authorization; (b) Reimbursement of physicians for time and resources spent on compliance with prior authorization requirements, taking into consideration recent legal precedent; (c) Whether new CPT codes would need to be developed in order for physicians to bill for reimbursement for time and resources spent on compliance with prior authorization requirements; (d) Regulations or legislation that prohibit retroactive rescission of prior authorization or clawback of reimbursement after prior authorization has been given, provided that information for the prior authorization was not fraudulent; (e) Standardization of formulary formats, including new requirements that formularies be importable into ONC certified electronic health records; (f) Requirements that insurance company practices regarding medication substitution meet accepted standards developed by medical specialty societies for patient safety, efficacy and equivalence; and (g) Requirements that insurance companies not use lack of an FDA indication or designation of a medication as a "high risk" as justification for denial, overriding clinical judgment and accepted standards of care; and (2) That our AMA consider the inclusion of prior authorization requirements in the AMA's Professional Satisfaction and Practice Sustainability strategic focus; and (3) That our AMA consider the

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development of possible model state legislation that allows physicians to bill payers or benefit managers for the time and resources spent in compliance with prior authorization requirements, and model state legislation that prohibits retroactive rescission of prior authorization or clawback of reimbursement after prior authorization has been given, provided that information for the prior authorization was not fraudulent.

The Council readily acknowledges the significant problems associated with prior authorization (PA) for both patients and physician practices and agrees with the underlying intent of these resolutions. However, extensive existing AMA policy on PA and ongoing AMA advocacy activities already address several of the issues raised by the resolutions. The Council also notes that a few of the recommended actions could have unintended and/or undesirable consequences. Accordingly, this report summarizes existing AMA PA policy related to these resolutions, outlines relevant AMA advocacy activities, and identifies concerns with a few of the recommended activities. This review and analysis allow the Council to provide recommendations that build upon, rather than duplicate, existing or ongoing AMA policies and efforts and avoid inadvertent, unfavorable outcomes.

## BACKGROUND

PA requires providers to obtain advance approval from a health plan before service delivery to qualify for payment coverage. PA is often a very manual, time-consuming process that can divert valuable and scarce resources away from direct patient care. The medical literature clearly establishes the time and cost burdens associated with PA on physician practices, although results vary depending on study methodology. An often-cited study by Casalino and colleagues found that physicians spend an average of one hour a week completing PA requirements, while nursing and clerical staff average 13.1 and 6.3 hours per week on PA tasks, respectively.[1] Another study by Morley and colleagues estimated that practices spend $2,161 to $3,430 annually per full-time equivalent physician completing PA requirements.[2] Overall, practices spend nearly $83,000 annually per physician on interactions with health plans.[3] Even more concerning is the negative impact that PA can have on patient care, given the treatment delays associated with health plans' PA requirements. A 2010 AMA survey of 2,400 physicians showed that two-thirds of physicians reported waiting several days to receive PA for drugs, while 10 percent waited more than a week.

Given the negative impact of payers' PA requirements on both patient care and practice efficiency, it is no surprise that existing AMA policy and current advocacy activities address many of the facets of Resolutions 705-A-15 and 712-A-15. PA is a complicated issue that requires a comprehensive advocacy strategy. The referred resolutions, current policy, and ongoing AMA efforts all reflect this broad approach and address a variety of PA-related topics, including research, state legislation, policy reform, process automation, payment for administrative tasks, and issue priority.

## ADMINISTRATIVE BURDEN AND PA RESEARCH

AMA policy calls for research that establishes the time burdens of administrative activities such as PA on physician practices (Policies D-330.909 and D-320.988). In response to these directives, the AMA is engaged in several research endeavors seeking to better quantify the time and costs associated with meeting health plans' requirements. The AMA partnered with Dartmouth-Hitchcock in a 2015 joint research project to establish the amount of time that physicians spend on administrative tasks vs. clinical care. Board of Trustees Report 11-A-15 outlined the methodology and research plan for this study, which involved direct observation of physicians in 16 practices across four medical specialties and four geographic regions. At the time that this report was

written, AMA and Dartmouth-Hitchcock authors had prepared a manuscript describing the results of this study for submission to a peer-reviewed journal.

The AMA plans an ambitious related project for 2016 that will specifically focus on PA. Through rigorous analysis of claims and clinical data, this study will assess the impact of PA on resource utilization, costs (both for a particular service and overall health care expenditures), and patient outcomes. While health plans endorse PA as a mechanism to control costs, the more holistic analysis proposed for this study may show an overall lack of value for the health care system. The AMA issued a Request for Proposal for this project and will be selecting a research partner by early in the second quarter 2016.

The results of both the AMA/Dartmouth-Hitchcock project and the 2016 PA-specific study may provide valuable information to support future AMA advocacy activities to reduce PA burdens and drive industry interest in exploring alternative and potentially less onerous approaches to resource utilization management. Armed with quantitative data that clearly establish the health care dollars being wasted on administrative tasks, the AMA can present a strong argument with both legislatures and health plans that PA burdens must immediately be addressed.

STATE LEGISLATIVE ACTIVITY

While most physicians would prefer to see an outright elimination of PA programs, steadily increasing health care costs and the availability of innovative—yet expensive—new therapies that will undoubtedly require PA suggest that this is not an attainable goal for the near future. Instead, AMA advocacy efforts have focused on placing limitations on health plans' PA programs and reducing the impact of these programs on physician practices. State legislation has proven to be one effective avenue for this work, and the AMA works closely with state and specialty medical societies to address PA-related issues through introduction of bills restricting the parameters of utilization management programs. AMA resources offer talking points and model legislation to support medical societies in protecting physicians' interests related to PA requirements. These include the AMA's model bill on PA, the "Ensuring Transparency in Prior Authorization Act," which incorporates various limitations on PA programs called for under AMA policy, including the following points raised by the referred resolutions:

1. *PA response timeliness:* The model bill requires health plans to respond to PA requests in two 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. The bill also prohibits health plans from requiring PA for emergency health care services. These restrictions are consistent with Policies H-130.970, H-285.998, and H-320.968.

2. *Binding PA decisions:* The AMA model bill prohibits health plans from revoking or restricting a PA for a period of 45 working days from the date the health care provider received the PA, as well as sets the duration of PA validity at one year from the date the health care provider received PA. These provisions mirror Policy H-320.961, which calls for the AMA to support legislation or regulations that would prevent the retrospective denial of payment for any services for which a physician previously obtained PA.

3. *Step therapy limitations*: The bill sets limits on health plans' use of step therapy (programs requiring patients to first try and fail less expensive medications before permitting access to more costly drugs) if such requirements interfere with the physician's clinical judgment or are not in the patient's best interests. This restriction is consistent with Policy

D-330.933, which states that the AMA will work to eliminate PAs that undermine a physician's best clinical judgement.

4. *Electronic PA:* The AMA's model PA bill requires health plans to accept and respond to pharmacy PA requests using standard electronic transactions, consistent with Policies H-320.944 and H-160.906.

The AMA is also developing model state legislation to address the accuracy and completeness of the drug formulary data available in electronic health records (EHRs), as referenced in Resolution 712-A-15. The unreliability of the formulary data currently provided in EHRs prevents physicians from determining PA requirements at the point of prescribing and results in significant workflow inefficiencies, as well as delays in patient care. The AMA is researching the magnitude of this problem and plans to include requirements regarding the provision of accurate EHR formulary data to physicians in a future model bill. This activity aligns with Policy H-125.979, which calls on the AMA to work to enable physicians to receive accurate, real-time formulary data at the point of prescribing.

## PA BEST PRACTICES, PRINCIPLES, AND ALTERNATIVES

In addition to state legislative advocacy, health plans and their accreditation organizations should be directly approached to improve PA programs. Resolution 705-A-15 asks the AMA to develop best practices for PA and advocate for adoption of these recommendations by health plan accreditation bodies. The existing and extensive AMA policy on PA could easily function as a starting point for a core set of PA best practices to be used in advocacy with health plans and their certification bodies. For example, the issues outlined above and addressed in the AMA's model PA bill, such as PA response timeliness, prohibition of PA for emergency services, and the binding nature of PA decisions, could serve as the basis for the AMA's initial PA best practices.

However, there are undoubtedly other potential best practices that merit inclusion in this list and that warrant further discussion and consideration. Additionally, Resolution 712-A-15 asks the AMA to study alternative models of quality-based and shared-risk reimbursement that reduce or obviate the need for PA. PA alternatives such as "gold card" programs (under which physicians with a high PA approval rate are excused from PA programs), appropriate use criteria/clinical decision support tools, PA sunset programs (which discontinue PA for services with universally high PA approval rates), and programs granting physicians a certain number of PA waivers per year are currently being explored by health plans. Although these programs are not widely available across all health plans and in all regions of the country, they deserve further discussion and study.

To ensure creation of the most robust and inclusive set of PA practices, as well as to evaluate alternative approaches to resource utilization control, the AMA plans to convene a PA staff workgroup in 2016, which will include representatives from the Federation and patient advocacy groups. The workgroup will be tasked with developing the initial set of PA best practices, starting with existing AMA policy but expanding to other concepts as necessary to ensure maximal protections of patient and physician interests. The workgroup will also evaluate and recommend alternative approaches to utilization management. When finalized, these best practices and recommendations will be shared with health plan accreditation bodies, such as the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), and the AMA will advocate for the inclusion of these concepts in URAC and NCQA criteria for utilization review programs. These best practices and PA alternatives will also be used

in the AMA's discussions with major national health plans to effect changes in PA programs and encourage pilot use of PA alternative programs.

## PA AUTOMATION: STANDARD ELECTRONIC TRANSACTIONS AND PORTALS

Physicians and their staff currently face a very manual PA process. In the AMA's 2010 physician PA survey, 83 percent of survey respondents indicated that they request PA using faxes, 63 percent reported using a paper form, 35 percent completed PA through a payer website, and 14 percent used an electronic standard transaction either through their practice management system (PMS) or EHR. While it would be preferable to have more current data, all indications suggest that these numbers are still reflective of the manual PA system currently used by most health plans.

Process simplification and automation could significantly reduce the practice burdens associated with PA. As previously noted, Policies H-320.944 and H-160.906 call for the AMA to support streamlining of the PA process through the adoption of standard electronic transactions. The AMA strongly advocates for widespread adoption of standard electronic transactions for PA in a variety of arenas and regularly participates in the standards development organizations charged with creating and maintaining the transactions that support automated pharmacy and medical services PA. The AMA also recently updated its PA Toolkit (available at www.ama-assn.org/go/priorauthorization) to include tips for simplifying the PA process and an overview of the current status of electronic PA implementation.

Resolution 705-A-15 called for the AMA to study the development of a single, interactive, browser-based portal for PA. This request undoubtedly resulted from physician frustrations with the multitude of proprietary Web portals that health plans use to support their current PA processes. These portals burden practices, as each website requires a unique login/password and re-entry of all supporting PA data into the portal. Portals also do not support existing practice workflows, since staff must exit the EHR or PMS to access the health plan website.

While a multi-payer portal could eliminate some of the burdens associated with multiple websites and logins, it would still require physicians and practice staff to exit the EHR or PMS, login to a different system, and manually re-enter data contained in the EHR. In contrast, the standard electronic transactions that the AMA currently favors allow practices to communicate PA-related information in a uniform manner across health plans using the practice's PMS or EHR and do not require workflow disruption or logging into different systems.

## COMPENSATION FOR PA

Along with process automation, payment for the time practices spend on fulfilling PA requests is often discussed as another mechanism to reduce the impact of PA on physicians. Existing AMA policy supports payment of physicians for the time required to complete PAs on behalf of their patients. For example, Policy H-320.968 supports state or federal legislation that would require health plans to compensate physicians for work required to comply with utilization review requirements that are more costly, complex, and time consuming than the completion of standard health insurance claim forms. Policy H-385.951 states that insurers should pay physicians fair compensation for work associated with PAs, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.

Available billing codes also support payment for fulfilling PA requirements. Current Procedural Terminology (CPT) code 99080 is to be used for "special reports such as insurance forms, more

than the information conveyed in the usual medical communications or standard reporting form" and therefore supports physicians billing insurers for administrative tasks such as PA. However, although the tools exist to bill for time spent completing PA requirements, the AMA is unaware of any major health plans that are currently providing payment for PA completion using this code. Assigning a specific payment amount to CPT code 99080 may be challenging, as time and administrative costs likely vary greatly by the specific PA request. Due to the unlikelihood that health plans would agree to pay for PA, the AMA has prioritized other advocacy activities seeking to reduce PA burdens, as outlined above.

## PA ISSUE PRIORITY

Due to the high volume of member and Federation questions and concerns, the AMA gives PA-related activities top priority and attention. Although PA is not specifically mentioned in the AMA's Professional Satisfaction and Practice Sustainability (PS2) strategic focus, reducing administrative hassles such as those associated with PA clearly fit within PS2's scope of work. Burdensome PA requirements impact both physicians' enjoyment of their work and practices' bottom line. The PS2 Group works to better quantify and understand the impact of PA on practices through research activities, such as the 2015 AMA/Dartmouth-Hitchcock administrative burden study. The AMA Advocacy Group joins PS2 in these important efforts and works to reduce the impact of PA on practices through the state legislative activities, automation advocacy, physician education efforts, and collaborative industry work described above. As indicated earlier, PA is a complex issue that requires a multi-pronged advocacy approach. As such, AMA staff from various work units, including PS2, the Advocacy Resource Center, Government Affairs, and Health Policy, regularly collaborate to ensure the most productive approach to addressing the multitude of member concerns on this issue.

## DISCUSSION

The Council recognizes the value and importance of an evidence-based advocacy approach, particularly on issues such as PA where physician and health plan interests are not well aligned. Quality data regarding the time and resource burdens associated with PA will support the AMA's efforts to place restrictions around utilization control programs and minimize burdens for practices. The Council recommends reaffirmation of Policies D-330.909 and D-320.988, the directives are policy which are currently being addressed by the AMA/Dartmouth-Hitchcock administrative burden time study and the 2016 PA research project. The results from these studies, which are targeted for publication in peer-reviewed journals, will inform and support the AMA's future PA advocacy activities.

A review of existing policy and ongoing AMA activities indicates that the state legislative work recommended by Resolution 712-A-15 is already being accomplished. The AMA's model PA bill addresses many of the concerns outlined in both resolutions, including timely PA responses, prohibition of PA for emergency services, the binding nature of PA decisions, limitations in pharmacy step therapy programs, and requirements for electronic PA. The AMA also is further evaluating current issues surrounding the accuracy of formulary data in EHRs and the ability of physicians to discern PA requirements at the point of prescribing. Given the high level of PA state legislative activity that aligns with existing AMA policies, the Council recommends reaffirmation of policies addressing PA response timeliness, finality of PA decisions, and PA automation and creating new policy to address the intrusion of step therapy programs on physicians' clinical decision-making and patients' health needs.

The Council recognizes the importance of advocacy with health plans and their accreditation organizations regarding PA policies. A set of PA best practices based on, but not limited to, existing AMA PA policy would serve as a valuable tool in discussions with payers and their certification bodies. Additionally, alternatives to PA, including "gold card" programs and appropriate use criteria, should be explored and piloted as means to reduce administrative practice burdens. The impact of the health care industry's movement from a fee-for-service model to value-based systems on the use of PA programs should also be assessed. The Council supports the AMA's plans to create a Federation staff workgroup tasked with developing a set of PA best practices and alternative resource management approaches and recommends that the work product of this group be used in advocacy with health plans and accreditation organizations.

The current manual PA process is ripe for process standardization and automation. The Council recommends reaffirmation of Policies H-320.944 and Policy H-160.906 and the continuation of the AMA's ongoing work to spur the industry to adopt standardized electronic transactions to support automated pharmacy and medical services PA. While the Council understands the intent behind the resolution's call for a single PA portal and agrees that the current multitude of payer portals places undue hardships on physician practices, the AMA should continue to prioritize adoption of standard electronic transactions as the preferred approach for PA automation due to the associated workflow and efficiency advantages.

Physicians have legitimately requested compensation for the time that they and their staff spend on health plans' burdensome PA requirements. As previously noted, existing AMA policies and an available CPT code both support payment for PA-related tasks. However, the Council notes that no major health plan currently compensates physicians for PA using CPT code 99080. Beyond health plans' general objections to offering additional payment for administrative tasks, obtaining compensation for PA would be challenging due to the difficulties in assigning value to the 99080 code when time requirements could vary significantly between individual PA requests. The Council harbors additional concerns that achieving widespread compensation for PA could have the perverse and unintended consequence of increasing payers' PA requirements: health plans could use provider compensation as justification for additional utilization review. The Council therefore recommends reaffirmation of the policies cited above that call for AMA advocacy to restrict PA programs and minimize associated administrative hassles. Prioritizing more realistic goals, such as reducing the impact of PA on practices through adoption of best practices, and achieving measurable success would preempt the need for PA payment and address the underlying concerns of Resolution 712-A-15's authors.

The Council concurs that PA is a top-of-mind issue for physicians and, as such, deserves substantial AMA attention and resources. As previously detailed, both the AMA PS2 and Advocacy Groups prioritize PA as one of their key issues and effectively collaborate to address physician concerns on this topic. The high volume of member and Federation inquiries on this issue ensure that PA will continue to be a leading priority for the AMA.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policies D-330.909 and D-320.988, which call for study of the time burdens associated with administrative tasks such as prior authorization (PA). (Reaffirm HOD Policy)

2. That our AMA reaffirm Policies H-130.970, H-285.998, and H-320.968, which address the timeliness of health plans' responses to PA requests and prohibit PA requirements for emergency services. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-320.961, which calls for the AMA to support legislation or regulations that would prevent the retrospective denial of payment for any services for which a physician previously obtained PA. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policies H-320.944 and Policy H-160.906, which call for the AMA to support the adoption of standard electronic transactions to facilitate PA automation. (Reaffirm HOD Policy)

5. That our AMA address the negative impact of medication step therapy programs on patient access to needed treatment by supporting state legislation that places limitations and restrictions around the use of such programs and their interference with a physician's best clinical judgement. (Directive to Take Action)

6. That our AMA, in collaboration with state medical associations and national medical specialty societies and relevant patient groups, create a set of best practices for PA and possible alternative approaches to utilization control; advocate that accreditation organizations include these concepts in their program criteria; and urge health plans to abide by these best practices in their PA programs and to pilot PA alternative programs. (Directive to Take Action)

7. That our AMA explore and report on potential funding sources and mechanisms to pay for time and expertise expended pursuing prior authorization procedures. (Directive to Take Action)

Fiscal Note: $3000.

REFERENCES

[1] Casalino LP, Nicholson S, Gans DN, et al. What does it cost physician practices to interact with health insurance plans? *Health Aff* (Millwood). 2009;28:w533-w543.

[2] Morley CP, Badolato DJ, Hickner J, Epling JW. The impact of prior authorization requirements on primary care physicians' offices: report of two parallel network studies. *J Am Board Fam Med*. 2013;26:93-95.

[3] Morra D, Nicholson S, Levinson W, Gans DN, Hammons T, Casalino LP. US physician practices versus Canadians: spending nearly four times as much money interacting with payers. *Health Aff* (Millwood). 2011;30:1443-1450.