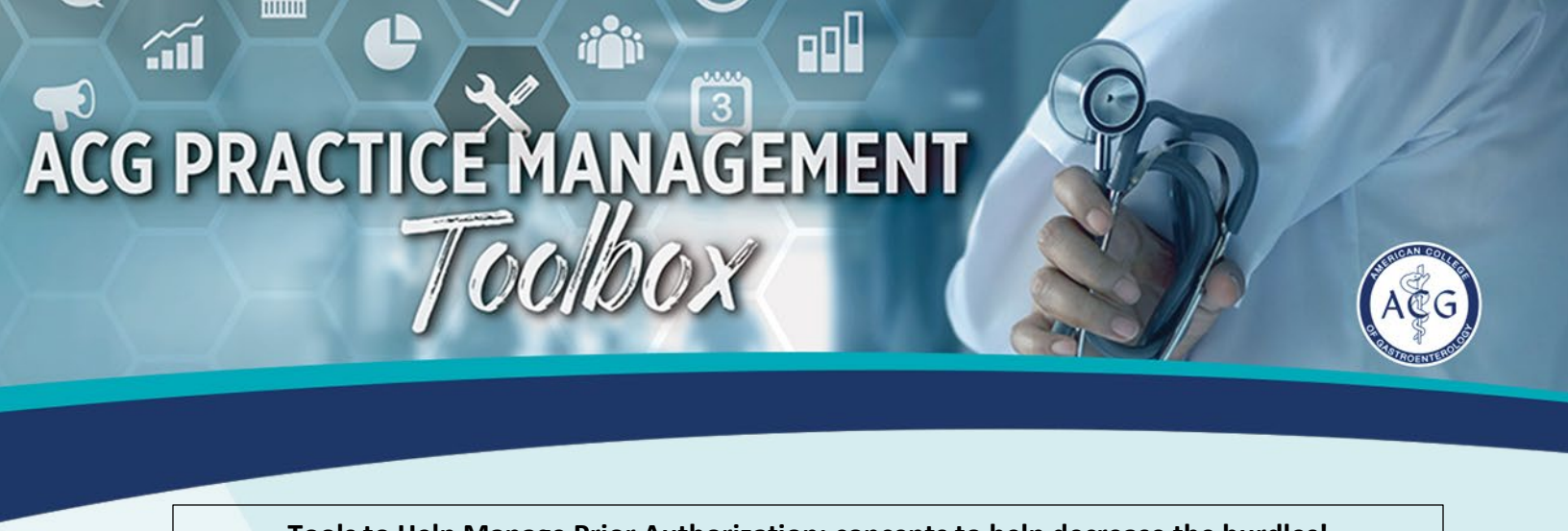

Tools to Help Manage Prior Authorization: concepts to help decrease the hurdles!

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ACG Prior Authorization Task Force

WHY DO WE NEED A PRIOR AUTHORIZATION TOOLBOX?

The prior authorization (PA) quagmire continues to impact our ability to care for our patients, erodes the physician-patient relationship, and has expanded far beyond its original intent. Health plans are likely to continue to use this process to control resource utilization and drug spending. PA has a significant impact on physician practices. More importantly, the delay in care is harmful to our patients.

Based on feedback from the ACG Board of Governors, ACG Practice Management Committee and members across the U.S., the ACG Legislative and Public Policy Council created a survey to gauge the burden of prior authorizations in gastroenterology. [1] Over 150 ACG physicians from 43 states and Puerto Rico highlight the significant problems that PA has on patient care and our practices. For example, the survey found that over 50% of respondents cited at least 1 serious adverse event due to PA delays. The ACG has therefore formed a task force to create resources for members, with the goals of obtaining approval for therapies chosen by ACG members in concert with their patients, as well as easing the significant administrative and practice management burdens during the PA process.

IMPACT OF PRIOR AUTHORIZATION:

[1] Shah ED, Amann ST, Hobley J, Islam S, Taunk R, Wilson L. 2021 National Survey on Prior Authorization Burden and Its Impact on Gastroenterology Practice: ACG Prior Authorization Survey [published online ahead of print, 2022 Mar 17]. Am J Gastroenterol. 2022;10.14309/ajg.0000000000001728. doi:10.14309/ajg.0000000000001728

Prior authorization is a cost control process by which providers must obtain approval from a health plan before a specific therapy or service will be covered. Other terms for PA include preauthorization, precertification, prior approval, prior notification, prospective review, and prior review. PA was introduced by payers as a strategy to reduce utilization of overused or low value services, reduce costs of healthcare, ensure high quality evidence-based care, and protect patient safety. However, it has evolved into a cumbersome and redundant process that impacts patient care and significantly adds to health care providers' administrative burden.

A recent U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) report found issues the with Medicare Advantage process for prior authorization.[2] Medicare advantage organizations (MAOs) sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules. MAOs also denied payments to providers for some services that met both Medicare coverage and billing rules. The OIG noted that "denying requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers." This recent HHS OIG report echoes a similar HHS OIG report in 2018.[3] Highlights of the 2018 report include:

- When beneficiaries and providers appealed preauthorization and payment denials, insurers overturned 75% of their own denials from 2014-16, overturning approximately 216,000 denials each year.
- This is especially concerning because beneficiaries and providers rarely used the appeals process, which is designed to ensure access to care and payment. During 2014-16, Medicare beneficiaries and providers appealed only 1% of denials to the first level of appeal.

All payers have utilization management programs to help limit drug spending, overutilization of services, under the stated goal of "appropriate care for patients." These determinations are reviewed internally and can be proprietary. However, insurers may have a coverage

[2] Grimm CA. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, OEI-09-18-00260, April 2022. (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp).

[3] Levinson, D. Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials, (OEI-09-16-00410), September 2018. https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp

determination process and explain the rationale for any PA policy. It is important to participate in this process when available.

Gastroenterologists face growing challenges with PA requirements for inflammatory bowel disease (IBD) biologics and other prescription medications, radiologic tests, as well as endoscopic and motility procedures. In addition to the increasing denials raised by ACG members, “step therapy” or fail first policies are also used to require lower cost medications prior to more expensive medications/biologics, often resulting in delayed care and worse outcomes. Lack of a standardized process, different submissions among the different payers only add to this administrative burden and complexity.

This article is designed to offer useful tools and suggestions to facilitate timely approval of therapies for your patients.

TIPS & TRICKS:

1. GET IT RIGHT THE FIRST TIME:
   Take time upfront to submit all requirements. It is much easier to get PA the first time around than go through the appeals process.
2. DOCUMENTATION IS KEY:
   Clearly list the indication, prior failed medication(s) and reasons why medication failed, as well as the clinical rationale for choosing the desired medication/test.
3. PROVIDE SUPPORTING EVIDENCE:
   Make sure to provide the treatment guidelines and references that support your choice of medication/dosing/test. Guidelines are especially important. Then provide other important literature/supporting evidence.
4. TRAIN YOUR PA TEAM:
   It is important to have a pharmacy technician/manager who can initiate the PA process and is familiar with the appeals process among the different payers.
5. AUTOMATE THE PROCESS:
   According to the ACG survey, the average number of PA requests gastroenterologists must deal with on a weekly basis is 14. An automated process will help to save time and effort without reinventing the wheel for each request/appeal.
6. PREPARE FOR PEER-TO-PEER:

Request this as soon as possible but recognize this consultation may be with a non-GI provider. Be well prepared to support your request.

7. MULTIPLE APPEALS CAN WORK:
   Don't give up if it's the right medication/test for your patient! Your patient can participate in the appeals process as well.

STEP BY STEP GUIDE[4] [5]:

- For medical services, check the payer's PA requirements prior to providing the service, if possible. This will help with denials and lost payments.
- Formulate an office protocol to routinely document data and medical necessity requirements for the PA.
  - The PA office team should educate providers on key elements and terms to help in this process. Be sure to use EHR common terminology to make this more efficient. For example, in patients with IBD, note the severity and scale of disease, associated extra-intestinal disease effects and other comorbidities and treatment failures. **See Table 1**.
  - You can use ACG's recent toolbox article on how to create EHR documentation/terminology shortcuts[6]
- If possible, consider an automated process for PAs
  - Electronic PA submissions
  - eRx for use with e-prescribing
    - Do not settle when other drugs are contraindicated in certain situations
  - Use the payer portals
    - There may be limited availability, portals can be payer-specific, and not in the usual office workflow
    - Use multi-payer portals if available
- Typical methods are slow, time consuming, inefficient, and include FAX, PHONE and email

[4] American Medical Association (AMA) Prior Authorization Tip Guide. www.ama-assn.org. Accessed 4/2022.
[5] Turner A, Miller G, Clark S. Impacts of prior authorization on health care costs and quality: A review of the evidence. National Institutes of Health Care Reform Nov 2019
[6] Mehta, Manoj K, Nemec, Richard L, Leveraging the EHR to Your Advantage: Make the electronic beast work for you!. ACG Practice Management Toolbox.
https://webfiles.gi.org/links/pm/LeveragingTheEHRToYourAdvantagePMCommitteeToolbox.pdf

- Keep and record all phone calls and faxed PA documents, with date and time stamps
- Record full name of payer-personnel with whom you met, as well as the date and time

- Follow-up regularly on process and document this follow-up
  - Encourage staff to use EHR reminders
- Inappropriate denials
  - Submit a concise appeal with supporting clinical information (see below)
  - If denied the first time, resubmit the appeal
- Peer-to-Peer
  - This remains the most contentious issue. These calls are often not set up based on your availability, but instead, require you to wait until the “reviewer” is available. The reviewer may not have the myriad of documents you have already submitted as part of your review. In addition, they are not likely to be in the same specialty as you.
  - Ensure you are familiar with patient chart and case.
  - Make sure to use the clinical guidelines to support your request. Know the guidelines and quote the relevant recommendations/references during this call.
  - However, if the guidelines are not applicable, state the specific reasons why your patient's condition does not strictly fit the guidelines, such as comorbidities or overlap diseases. Be prepared to support this course of treatment.
  - You can ask for a specialty review by a gastroenterologist in your appeals, but please note, this may further delay treatment. Thus, plan ahead.
  - Request the reviewer’s name and document every conversation in the patient chart/notes.
  - Be firm but cordial.
  - Request the medical literature and /or guidelines the reviewer used in any denial.
  - Your letters can ask for a timeframe or date by which you/your patient needs this decision.

TABLE 1

Typical information for EMR documentation
Date and method of diagnosis
Disease severity and use accepted descriptors, severity or stage from accepted guidelines
Treatment failures or side effects of prior treatments if known in brief narrative
Document good outcome on current therapies or treatment

For PA denials and requests for letters/further documentation

In addition to the information included in Table 1, also consider:

- Keep the narrative brief and be concise
- Cite clinical practice guidelines to support the treatment plan whenever possible. Conversely, be prepared to discuss why guidelines are inapplicable in this case.
- Detail why the patient should be on the specific agent/drug or test
- Describe why the specific therapy is the preferred therapy and why other agents are not helpful, contraindicated, or have side-effects
- If you are looking for approval of off-label use, you must describe why and provide supporting evidence.
- Detail the contraindications when switching a current therapy, as well as the risks associated in any with a switch in therapy.
- Use peer-reviewed articles as support (use more than 1 article)

Conclusion

Please encourage your patients to get involved in the process, have them engage their primary care or any other providers, ask them to engage their employer's human resources (HR) departments, contact your state insurance commissioner, as well as federal/state representatives. The PA process is not likely to go away. It is paramount that we, as physicians, continue to be staunch advocates for our patients' needs.

Additional Guidance

The list of ACG guidelines can be found here: https://gi.org/guidelines/

In addition to the ACG guidelines, other guidelines and medical literature:

- American Association for the Study of Liver Disease (AASLD) guidelines: https://www.aasld.org/publications/practice-guidelines
- American Gastroenterological Association (AGA) guidelines: https://gastro.org/clinical-guidance/
- American Society for Gastrointestinal Endoscopy (ASGE) guidelines: https://www.asge.org/home/resources/key-resources/guidelines
- National Institutes of Health (NIH) PubMed: https://pubmed.ncbi.nlm.nih.gov/
- World Gastroenterology Organisation (WGO) guidelines: https://www.worldgastroenterology.org/guidelines