

RIMS issues policy statement on prior authorization

Background At its regular February meeting, the RIMS Council approved the statement below as a summary of the Medical Society's position with regard to prior authorization requirements that many, perhaps most, third-party payers in the U.S. now impose upon physicians and their patients for a variety of services. Concern about prior authorization (also known as "prospective utilization review") currently runs high in Rhode Island because of relatively new policies imposed by the state's largest insurer, Blue Cross, with respect to non-emergent, high-end imaging studies. RIMS' statement applies most immediately to imaging, but it is also intended to be generic enough with regard to the spectrum

of pre-authorization requirements that payers commonly impose upon tests, procedures, pharmaceuticals and referrals as a strategy that has proven effective in reducing utilization. RIMS finds that unfocused use of prior authorization requirements imposes wasteful burdens that affect primary care and subspecialty physicians and their patients and unnecessarily introduce inefficiencies into the health care system. RIMS has shared the statement below with all local payers. In addition, RIMS is seeking relief for doctors through legislative channels. These are just the latest efforts by RIMS in more than ten years of work to avert, and more recently to ameliorate, prior authorization requirements in Rhode Island.

Prospective Utilization Review ("Prior Authorization") for advanced medical imaging: A RIMS Policy Statement

The Rhode Island Medical Society (RIMS) opposes the indiscriminate use of prospective utilization review ("prior authorization") by health plans as a technique to control the utilization levels of a growing variety of products and services for patients. Broad imposition of prior authorization requirements by third-party payers impedes optimal patient care and has seriously degraded the efficiency of care delivery in Rhode Island in recent months and years. While blanket prior authorization rules may produce apparent savings for insurers in the short term, these same rules impose insidious burdens throughout the health care delivery system, particularly upon the fragile infrastructure of primary care, which bears the brunt of the prior authorization onus. The false economies of unfocused prior authorization programs inevitably diminish patient access to appropriate care and drive up costs in both the short and long term.

This paper addresses the use of prior authorization requirements in the specific area of advanced medical imaging.

Advanced medical imaging has come to play a critical role in the practice of high quality, cost-effective medicine. There can be no question that judicious use of today's highly sophisticated imaging modalities enhances diagnostic precision and

results in better care for patients, as well as long-term efficiencies and overall savings to the health care system. That said, the rising use and attendant high cost of advanced medical imaging are matters that deserve attention, both nationally and in Rhode Island.

Payers locally and nationally have responded to the rise of utilization and cost by hiring vendors that specialize in reducing the volume of elective, non-emergent, advanced imaging studies. These vendors achieve these reductions primarily by the technique of requiring prior authorization.

The legitimate objective of any imaging management program can only be to achieve consistently optimal efficiency in the provision of consistently optimal patient care. In practice, however, indiscriminately broad implementation has exposed prior authorization to be little more than a crude cost-cutting measure that is insensitive to the needs of patients and unfairly punitive to the great majority of hard-working, competent and conscientious physicians. Prior authorization should be the last tool out of the box, not the first.

RIMS advocates for a high quality, comprehensive, longitudinal and cost conscious health care system with access for all. RIMS supports efforts to contain costs through the coordinated,

patient-centered, evidence-based, and efficient medical practice.

In no case does RIMS condone the imposition of prior authorization requirements purely or primarily as a strategy to reduce costs and utilization. Prior authorization may have limited usefulness in promoting appropriate utilization if implemented with the following attributes:

Collaborative education: Health plans that endeavor to manage imaging utilization have the responsibility to collect accurate and complete data and to provide clinicians with individual imaging profiles that include comparisons with state and national patterns on a twice yearly or other appropriate interval based on volume and performance improvement goals. Outliers may be educated in the appropriate use of advanced medical imaging based on guidelines developed by national medical specialty societies.

Selective focus: Any program of prior authorization should focus first on identifying and working with those individual professionals whose ordering and prescribing patterns appear to depart from community norms and from guidelines developed and promulgated by national medical specialty societies. Prior authorization mechanics should leverage the capacity of electronic records, predictive

algorithms and other technical advances. Only persistent outliers who fail to respond to education should be required to seek prior authorization for advanced medical imaging, and then only as long as they remain outliers in their ordering patterns.

Administrative efficiency:

Streamlined processes should guide the ordering physician to the best test or, as the case may be, to no test, for the patient's clinical condition. As currently implemented by some payers in Rhode Island, prior authorizations are excessively time-consuming and approvals generally entail delays of one to two business days. Such delays are disruptive to patient care. Ordering physicians should have the option to obtain prior authorization themselves or delegate the task to imaging centers. Prior authorizations for all health plans should follow standard processes and use the same format to capture all necessary information for a particular imaging test. Demographic information required from ordering physicians should be limited to the patient's name and policy number.

Transparency in recognizing costs:

Prior authorizations entail substantial administrative cost both to insurers and to medical offices. Physicians' time spent securing prior authorizations for particular services is not recognized in the "work" component of the RBRVS system and is therefore wholly uncompensated. This is unacceptable and must be addressed to make medical offices whole for performing the extra work imposed by insurers. Moreover, any valid measure of the cost-effectiveness of a prior authorization program must include the full continuum of costs, including physicians' incurred costs and fair compensation.

Scientific integrity: Criteria for approval must be based upon the best scientific evidence as developed and validated by national medical specialty societies.

"Prior Authorization" controversy sparks a U.S. Senate investigation of MedSolutions; process is found "burdensome and confusing"

Investigative reporting by the Wilmington, Delaware, *News Journal* a year ago touched off parallel investigations by the U.S. Senate Commerce Committee and the Delaware Insurance Commission. The story eventually got national exposure on NBC news, and the flood of negative publicity prompted Blue Cross of Delaware to terminate MedSolutions of Tennessee as the Blues' vendor for prospective utilization review ("prior authorization") for high-end imaging studies.

Both the Senate Committee and the state Commission issued reports on their findings on April 15, 2011.

The case that attracted public, regulatory and Senatorial attention to health plans' prior authorization requirements was the experience of one forty-five year-old man who came close to dying in February 2010 after MedSolutions had repeatedly rejected his nuclear stress test as medically unnecessary.

Noteworthy is the fact that the Rhode Island Chapter of the American College of Cardiology proactively succeeded in getting MedSolutions and BCBSRI to modify their protocols, specifically in the area of nuclear cardiac imaging. Perhaps the Delaware incident would have been prevented in Rhode Island, thanks to the vigilance and activism of the local ACC.

In any case, after months of study, the U.S. Senate Commerce Committee, chaired by Senator Jay Rockefeller, found that the "pre-authorization process is burdensome and confusing for consumers and health care providers" and that "many medically appropriate test requests were likely denied on 'administrative' [i.e., essentially clerical rather than clinical] grounds."

The Senate investigators also found that MedSolutions' "Cardiac Imaging Guidelines" "diverge in key ways from the 'appropriate use criteria' established by the American College of Cardiology. This conflict created situations in which MedSolutions denied requests for tests that the cardiologists' professional guidelines deemed appropriate.

"Moreover, MedSolutions' failure to develop its 'evidence-based' guidelines through a transparent process leaves it vulnerable to criticisms that the purpose of MedSolutions' guidelines is to deny test requests, rather than reflect the strongest available scientific evidence."

However, the Senators also found that doctors themselves do not always comply with professional guidelines in ordering tests and that MedSolutions properly denied requests for inappropriate tests in some cases. ❖

Risk-adjustment: Any valid comparison of clinicians based on their utilization rates must systematically take into account differences in patient populations and adjust for such differences.

In sum, the Medical Society opposes the current overuse of prior authorization for imaging studies and recommends a carefully targeted

educational and collaborative approach to resolving questions of appropriateness in utilization. Insurers have an obligation to collect, manage and share complete and accurate data and to use such data to focus their utilization review activity, always with the goal of optimal patient care provided with optimal efficiency. ❖