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Did Prior Authorization Refusals Lead to This Patient's Death?

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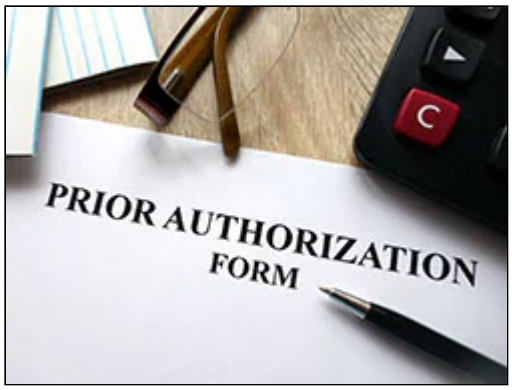
Ramy Sedhom, MD, a medical oncologist and a palliative care physician at Penn Medicine Princeton Health in Plainsboro, New Jersey, will always wonder if prior authorization refusals led to his patient's death.

The patient had advanced gastric cancer and the insurer initially denied a PET scan to rule out metastatic disease. When the scan was eventually allowed, it revealed that the cancer had spread.

Standard treatment would have been difficult for the patient, an older individual with comorbidities. But Sedhom knew that a European study had reported equal efficacy and fewer side effects with a reduced chemotherapy regimen, and he thought that was the best approach in this situation.



The insurer disagreed with Sedhom's decision and, while the two argued, the patient's symptoms worsened. He was admitted to the hospital, where he experienced a decline in function, common for older patients. "Long story short, he was never able to seek treatment and then transitioned to hospice," Sedhom said. "It was one of those situations where there was a 3- to 4-week delay in what should have been standard care."

That course of events is not an outlier but everyday life for physicians trying to navigate insurers' prior authorization rules before they can treat their patients. Nearly 4 years after major organizations — American Hospital Association, America's Health Insurance Plans, American Medical Association, Blue Cross Blue Shield Association, and others — signed a consensus statement agreeing to improve the prior authorization process, physicians say little progress has been made.

Indeed, 83% of physicians say that the number of prior authorizations required for prescription medications and medical services has increased over the last 5 years, according to survey results released earlier this year.

"It's decidedly worse — there's no question about it," said Andrew R. Spector, MD, a neurologist and sleep medicine specialist at Duke Health in Durham, North Carolina. "Drugs that I used to get without prior authorizations now require them."

When Vignesh I. Doraiswamy, MD, an internal medicine hospitalist at The Ohio State University Wexner Medical Center in Columbus, discharged a patient with *Clostridioides difficile* infection, he followed clinical guidelines to prescribe vancomycin for 10 to 14 days. "And the insurance company said, "Well, yeah, we only authorize about 5 days," which just makes no sense,'" Doraiswamy said. "There's nowhere in any literature that says 5 days is sufficient. What worries me is that is the standard of care we are supposed to give and yet we are unable to."

Yash B. Jobanputra, MD, a cardiology fellow at Saint Vincent Hospital in Worcester, Massachusetts, laments that prior authorization is used in situations that simply do not make common sense. During his residency, a woman who had tested positive for the *BRCA* gene mutation with a strong family history of breast cancer needed a breast ultrasound and an MRI scan every 6 months to 1 year. Despite the documentation that she was at extremely high risk for developing breast cancer, he had to go through prior authorization every time she was due for new images.

"I had to call the insurance company, they would put me on hold, I would wait to speak to a physician — and the end response would be, 'Yeah, this is what needs to be done,'" he said. "But having established her positive status once should be enough really. I shouldn't have to go through the circus all over again."

Prior authorization is also being used for routine diagnostics, such as a Holter monitor for patients complaining of heart palpitations. "Depending on the insurance, for some patients we can give it to them in the clinic right away," Jobanputra said. "Whereas some others we have to wait until we get prior authorization from the insurance company and the patient has to come back again to the hospital to get the monitor. That is a delay in patient care."

The delays also extend to emergency care, Doraiswamy said. He cites the example of a heart attack patient who needed an emergency heart catheterization but ran into a prior authorization delay. "I just said, 'Try your best not to get stressed' which is not easy for a patient finding out their stay wasn't covered when they had just been through a heart attack," he said. "Then I spent 20 to 30 minutes — most of it on hold — to answer the question 'Why did this patient need to get admitted?' "

Physicians feel disrespected because that type of prior authorization hassle is just busywork. "Rarely is a valid stay that was initially denied, not eventually accepted," Doraiswamy said. "But why couldn't they have just seen that the guy had a heart attack and he obviously needed to be in the hospital?"

For Spector, the Duke Health sleep medicine specialist, prior authorization is not just a speed bump, it's a full stop. Insurers have started mandating a multiple sleep latency test (MSLT) to confirm narcolepsy before covering medication to treat the condition. "We know that the MSLT is very often wrong," he said. "There are a lot of times we're dealing with patients with narcolepsy who simply don't meet the testing criteria that the insurance requires, and payers will not accept our clinical judgment."

In his view, the prior authorization landscape is worsening — and not only because a "faulty test" is being used to deny treatment. "The appeal process is worse," Spector said. "I used to be able to get on the phone and do a peer-to-peer review with a physician who I could reason with… but that doesn't happen anymore. There is virtually no way to bypass these blanket rules."

Other survey findings also stand in direct contradiction of the 2018 consensus agreement:

- A large majority (87%) of physicians report that prior authorization interferes with continuity of care, even though the industry groups agreed that patients should be protected from treatment disruption when there is a formulary or treatment-coverage change.
- Despite a consensus to encourage transparency and easy accessibility of prior authorization requirements, 68% of physicians reported that it is difficult to determine whether a prescription medication requires prior authorization, and 58% report that it's difficult for medical services.
- Phone and fax are the most commonly used methods for completing prior authorizations, despite agreement that electronic prior authorization, using existing national standard transactions, should be accelerated. Fewer than one quarter of physicians said that their electronic health record system supports electronic prior authorization for prescription medications.

Spector wants to see legislation that forces insurers to live up to some of the tenets of the 2018 consensus statement. In September, a new Texas law went into effect, exempting physicians from prior authorization if, during the previous six months, 90% of their treatments met an insurer's medical necessity criteria. In January, the recently approved Prior Authorization Reform Act in Illinois will reduce the number of services subject to prior authorization, mandate a prior authorization decision within 5 days, and set disciplinary measures for health plans that do not comply, among other things.

"What gives me hope is that at least somewhere in the country, somebody is doing something," Spector said. "And if it goes well, maybe other insurers will adopt it. I'm really hoping they demonstrate that the money they can save on the administration of all the appeals and prior authorization paperwork can actually go into caring for patients."

In addition to state-level action, reform may also be advancing at the federal level. In October, a bill was introduced in the US Senate that mirrors a prior authorization reform bill introduced in the House of Representatives last May. Both bills have broad bipartisan support; the House bill has more than 235 co-sponsors.

In an interview with Medscape, Rep. Ami Bera, MD, (D-CA) said it is "very realistic" that the bill will become law during this session of Congress. "We do think this bill will get marked up in committee and hopefully we can get it to the floor either as a stand-alone bill where we know we have the votes to pass it or as part of a larger legislative package," he said.

If approved, the Improving Seniors' Timely Access to Care Act of 2021 would require that Medicare Advantage plans minimize the use of prior authorization for routinely approved services; require real-time decisions for certain requests; report the extent of their use of prior authorization and their rate of approvals or denials, among other things; and establish an electronic prior authorization system.

Medicare Advantage plans are private insurers that are regulated by the Centers for Medicare & Medicaid Services (CMS), which will create the specific rules and penalties associated with the reforms, if they become law. "One would presume that a condition of being a Medicare Advantage plan is that you're going to have to comply with these new regulations," said Katie

Orrico, senior vice president of health policy and advocacy for the American Association of Neurological Surgeons and Congress of Neurological Surgeons (AANS/CNS). "So they will have some amount of teeth in the form of a mandate."

The AANS and CNS are part of the Regulatory Relief Coalition, a group of 14 national physician specialty organizations. Winning prior authorization reform in the Medicare Advantage plans is part of its bigger strategy. "If those commercial plans have to follow a set of rules and processes for Medicare, then why not just expand those same processes to all other parts of their business?" Orrico said.

Despite his frustration with their prior authorization processes, Doraiswamy, the Ohio State hospitalist, agrees that working to improve insurers' practices is the best way forward. "It's so easy to make them look like these evil, giant conglomerations that exist solely to suck money and not care about anyone's health, but I don't know if that's necessarily the case," he said. "We really have to figure out how best to work with insurance companies to make sure that, while they are profit-generating institutions, that [profit] shouldn't come at the cost of patient care."

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