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ACROinsights – Prior Authorizations – A Time for Change

The goal of this series of articles is to ensure that radiation oncologists are aware of and provided with the knowledge to ensure day-to-day processes are being addressed in a compliant manner. This installment will discuss prior authorizations and some processes which may assist radiation oncologists. The information contained within this ACROinsights article is meant as general guidance and is not intended to replace appropriate legal or authoritative guidance.

Prior Authorizations Survey Results

A prior authorization (PA) (also referred to as prior approval, predetermination, precertification) is approval from a health plan or its intermediary, for coverage of services prior to the administration or delivery of the service. Not all services will require prior authorization for coverage, but depending on the insurer, many radiation oncology services do require them, and if not obtained as required, services will likely be denied. While initially the intention for PA for certain services may have seemed justifiable, in practice, the process has often become time-consuming and frustrating for providers and their staff.

The American Medical Association (AMA) conducted a survey of physicians, *2021 AMA Prior Authorization (PA) Physician Survey*. The survey found physicians and their staff complete an average of 41 PAs per week, spend approximately 13 hours, and approximately 2 business days a week, completing them. Forty percent of physicians have dedicated staff dedicated to work on PAs, significantly increasing the cost of practice. The PA process varies by payer or intermediary, which creates additional roadblocks: 93% of physicians report care was delayed and 82% indicated the resultant delays may lead to abandonment of treatment. Some of the most alarming data points of the survey are the estimated impacts to patients, with 34% of physician reporting PA has led to a serious adverse event for a patient in their care.

Delay in initiation of treatment and compliance with radiation treatments has always been something radiation oncologists have had to navigate with patients. A cancer diagnosis is traumatic for any patient: delays in obtaining PAs simply adds to normal delays and timing to get planning and therapy scheduled and treatment started.

Performing a search of "prior authorization for radiation therapy" and numerous payer websites, links to medical forms and clinical and payment guidelines pop ups. Health plans and their intermediaries indicate they have specialized staff (i.e., radiation oncologists and radiation therapy trained nurses) working for them, but when every radiation modality requires PA, these specialized staff are often unavailable. What can radiation oncologists do to make their process as easy as possible and what can they do when denied?

Legislation for Change

Over the last two years legislation has been introduced in both the US House of Representatives and Senate to improve access to care, by changing the ways Medicare Advantage plans and providers use prior authorization. This is predominantly in response to a 2018 report by the Office of Inspector General (OIG), *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*.

The report by the OIG was conducted due to concerns with Medicare Advantage plans inappropriately denying coverage and access to care in an attempt to increase profits under the capitated payment amount model. At the time of the report in 2018, Medicare Advantage plans covered more than 20 million beneficiaries, which statistically would mean even low rates of denials for services or payments would create significant issues for beneficiaries and providers.

The OIG audit found Medicare Advantage Organizations (MAOs) overturned 75% of denials for prior authorization and payment when appealed from 2014-2016, this was approximately 216,000 denials a year! The OIG also found MAOs were specifically denying services and payments which should have been covered and only

1% of providers and beneficiaries submitted a first level of appeal to these decisions. This is in addition to the audit results by Centers for Medicare & Medicaid Services (CMS) which also found high levels of denials. Audit results from 2015 found 56% of audited contracts made inappropriate denials and 45% of contracts sent denial letters with incomplete or inappropriate information, which results in increased difficulty for appeals to be successful. CMS has enacted sanctions and penalties from audits of MAOs, but issues continue.

To respond to this, bipartisan legislation was introduced in 2021 in both the US House of Representatives, *H.R.3173 - Improving Seniors' Timely Access to Care Act of 2021,* and Senate, *S.3018 - Improving Seniors' Timely Access to Care Act of 2021*. Most recently in September 2022 the House passed Bill H.R.3173; however, it is unclear what will happen with the Bill in the Senate. The Bill would require Medicare Advantage plans to implement an electronic prior authorization program under specific standards, including:

- Real-time decisions for routinely approved services
- Annually published specific prior authorization information – including percentage of requests approved and the average response time
- Meet other standards, set by CMS related to quality and timeliness of prior authorization determinations

Key Items for Providers

Until things with prior authorization change because MAOs or other plans are forced to, there are still steps radiation oncologists should continue to do to help their own process.

1. Determine what tools they and their staff have in place or need to assist with and work through the different prior authorization applications.
    a. Develop a health plan "workbook" with a section, tab, or page dedicated to each payer and, if applicable, the benefit management company they use. Information such as weblinks, forms, contact information, clinical and billing guidelines, timelines for applying and appealing should all be outlined and routinely updated.
    b. Develop a clinical modality "workbook" created by the radiation oncologist and clinical staff for use by any staff applying for prior authorizations. This would provide an outline of the services, codes, and quantities to be requested for the specific patient treatment course.
        i. Individual tables or interactive-based forms separated by modality of 2D, 3D, IMRT, SRS/SBRT, systemic radionuclides, and brachytherapy with associated procedure codes, diagnosis codes, quantities, if a boost is needed, fractions of treatment, type of IGRT, use of mixed modalities etc.
    c. Develop a process to communicate if the application is to be expedited or standard timing and how this may impact the care to the patient.
    d. Develop an internal process for communicating if comparative dosimetry plans are required by health plan (e.g., 3D vs. IMRT). These plans can create burdens to staff and potential delays to other services, are not compensated, but necessary to the PA process.
    e. Schedule regular feedback and meetings between the physician and staff regarding common issues, denials, or updates to clinical modalities.
2. Document everything. Every contact with payer or intermediaries should be documented in the permanent record, including date, time, individual contacted, and their response.
3. Appeal, appeal, appeal! The Affordable Care Act requires health plans to have a process for appealing a denied prior authorization, but appeals can take time and the process can vary. Due to the findings of the OIG report, it is important if a denial for care is received an appeal is submitted. Health plans may be banking on providers not appealing.
    a. Create templates with standard language pertinent to necessary appeal information for responding to the denial in addition to any templates by the health plan that must be completed.

   b. Create phone transcripts for staff to ensure all pertinent data is ready and presented because calling the health plan sometimes will result in a faster response for some denials.
4. Understand the legal aspects for prior authorizations for your state. The AMA website has the 2021 Prior Authorization State Law Chart which outlines each state's legal requirements of health plans. Some of the statutes or requirements apply to limited items such as drugs or particular services, while other states do not define any limitation.
5. Understand how payers and intermediaries may define emergent care: a prior authorization is not required in order to provide the emergency services, but the situation will need to meet the criteria for an emergency and the potential for serious implications and/or death if no intervention. Understand ahead of time what this may mean for patients needing emergent radiation treatments.
6. Understand that just because a prior authorization was obtained, this does not guarantee payment, or it will be covered. This may mean the patient is now responsible for payment.
   a. Do you have or provide resources through your organization or practice to assist patients when insurance will not cover, and they cannot afford treatment?
   b. Do you have a financial counselor or billing representative to review with the patient options for payment or financial responsibility?
   c. What other treatment options that are covered by the health plan would still be medically and clinically appropriate for treating the patient?
7. Support from societies like ACRO and AMA. Utilize the AMA grassroots campaign, #FixPriorAuth, to share stories about the prior authorization process for physicians, patients, and employers. Stay engaged with ACRO for updates, resources, and support for physicians.

The Take Home Message

The prior authorization process is imperfect and requires fixing. It is important for radiation oncologists to continue to work closely with staff to ensure tools are available which can streamline the prior authorization process as much as possible. This includes regular conversations about issues and changes from health plans and intermediaries as well as clinical updates and implementation of new technology. It is also critical for radiation oncologists to engage with ACRO about concerns with health plans and their decisions which are impacting patient care, and the physician's ability to prescribe clinically appropriate radiation treatments.