

From: [Vantage Physicians, Christine](#)
To: [OIC Rules Coordinator](#)
Cc: jeb@wsma.org
Subject: Prior Authorization Feedback
Date: Friday, June 10, 2016 4:24:59 PM

I am writing to comment on the proposal to streamline the insurer prior authorization process in Washington. I manage a small concierge family practice in Olympia, Washington. Vantage Physicians has been a direct Medical Practice for 10 ½ years and I have been here for 8 years. As a concierge practice, we do not bill insurances. Our patients pay a monthly membership fee so our doctors can spend more time actually practicing medicine instead of doing insurance required paperwork. For the first 8 ½ years of our practice, the doctors authorized the occasional medication for our patients. Unfortunately with the changes in medication prior authorization requirements, we have had to hire a full time Medical Assistant to take over this duty. Each insurance company has a different form they require that needs to be filled out for medication prior authorizations and some companies even have different forms for individual medications. We need to gather information not only about the medication we are prescribing, but also about the pharmacy the patient will go to, the pharmacy provider ID number and tax ID number, we also need to get a signature from the patient who may live as far as a 2 hour drive away from our clinic. Most of the prior authorizations we do are urgent as if the patient would go without their medication, their life would be severely impacted. Urgent prior authorizations can take 48-72 hours. If the patient requests a refill on a Friday afternoon, they may not get their prior authorization approved until the following Wednesday, meaning they will either need to purchase the medication out of pocket or if they have state insurance, they are not allowed to purchase the medication so they must go without.

Our Medical Assistant was out last Friday so the doctor completed a prior authorization form she received via fax and faxed it in herself. All of the information the insurance company requested was on the form, however, she placed the diagnosis code on the wrong line, so the prior authorization was denied for lack of information. I received the denial later in the day, faxed in a new prior authorization containing all of the same information, just placing the code on the line below and Monday the prior authorization was approved. I wish I could tell you this was an exception to how our requests for prior authorization are routinely handled.

Another patient had a prior authorization for the name brand of the medication Avinza. However, it became increasingly difficult for her to obtain 30 mg Avinza so she decided to try the generic form. She was unable to fill the prescription without a new approval for the generic although it was 400% less expensive for the insurer than the brand name and chemically the same thing. This requirement for prior authorization meant she had to wait an additional 7 days for the insurance to pay for her prescription, so she paid out of pocket.

We had another urgent prior authorization we sent to an insurance company on a Friday morning. They sent us a request for more information at 4 pm that day stating that we had 24 hours to respond or they would deny the prior authorization and any future authorization for this medication would need to go through appeals which would take up to 4 weeks. We responded Monday morning at 11 am and were told the 24 hour window had already run out. (They count weekends not business hours). The patient had to pay in full for a month of her medication.

I wish I could say the problem is with only one insurer, however we run into this problem with many major carriers including: Regence, Premera, and United Health.

If you need additional information I would be happy to share it with you.

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