

Memo

To: Jim Freeburg, Special Assistant to the Commissioner

rulescoordinator@oic.wa.gov

From: Gail McGaffick for the Washington State Podiatric Medical Association

Re: Prior Authorization

Date: June 14, 2016

The following comments are submitted on behalf of the Washington State Podiatric Medical Association (WSPMA), a statewide organization representing podiatric physicians and surgeons. WSPMA appreciates OIC reaching out to health care providers concerning the important and controversial topic of prior authorization.

In order to prepare the following comments, I asked for input from WSPMA membership, and what I received astonished me. I had no idea of the challenges that providers and patients face every day in dealing with some insurers. Prior authorization was intended to assure that only medically appropriate and necessary care is reimbursed, not block payment of legitimate claims.

The following is a list of problems:

1. The “gotcha” of “no authorization needed.” When providers submit prior authorizations, one would normally expect a response of “approved” or “denied.” But the answer back is often that “no authorization is needed” for this request. Unfortunately, this is often the worst possible response. It may mean that the service is covered without the need for prior authorization. Often, however, it means that this is not a covered service and will not be paid by the plan. The health plan almost always knows which of these is the case, but the provider and patient do not, until it is too late and the service has been provided and the bill submitted.

WSPMA recommends that insurers be required to respond to prior authorization requests with clear language such as: approved, denied, covered benefit without need for prior authorization, or not a covered benefit.

2. Important information not disclosed.
 - a. When a patient or provider calls for prior authorization or to verify coverage and informs the insurer the facility in which the procedures will take place, the insurer should be required to advise if the facility is out of network.
 - b. Foot care, such as custom orthotics, bunions, hammer toes, toe nail debridement, callus debridement, etc., may be covered in some instances and not others. Often, there is some other qualifying criteria, such as diabetes. In requesting a prior authorization for these or any other services, the response of the insurer should clearly include any required qualifying criteria.
3. Insurers withdrawing authorization. Examples were given where prior authorizations were either received, or providers were told no authorization was necessary (see #1 above) and the insurer retroactively reversed their decision after the surgery was performed. Unless there is fraud by the provider, this should not be allowed.

- a. A related concern is what constitutes “proof” of an insurer saying “yes” to a prior authorization request. There should be some form of documentation that providers and patients can rely on. (see #4)
4. Technology – faxing should be obsolete. In the current electronic era, any health plan should have the capability to accept secure electronic transmission of records without requiring the use of faxes. Hard copy faxes are less reliable, more prone to HIPAA breach, and have a less secure audit trail. There needs to be a minimum electronic standard for documentation.
5. Over-specificity. Many plans require CPT and ICD-10 level specificity of requests. A common problem is when a patient is referred for a high-level imaging procedure. Often there are multiple MRI or CT procedures which could be done, and are very similar to each other. The physician will request the one he/she thinks is correct, and will submit the request. When the radiologist reads the request, he/she may suggest a slightly different approach. Often the radiologist will contact the referring physician for clarification, and may do a slightly altered procedure from the one that was submitted. Example: Prior authorization was received for a procedure done with contrast. Upon further review, the physician agreed this was not necessary, and actually did the less expensive version, done without contrast. The claim was denied, because the procedure that was done (even though cheaper and more appropriate) was not EXACTLY what had been pre-authorized.
6. Rigidity of timing.
 - a. As suggested by the OIC, it is a problem that health plans do not operate in the same “real time” space that providers do. Urgent care centers do imaging on Saturdays and Sundays. A patient often needs a procedure on the same day. Health plans authorization processes do not adequately accommodate these realities. In previous years, it was understood that a certain percentage of requests would need to be handled retrospectively. But virtually all plans now unilaterally issue “no retro authorization” policies which trump medical necessity, and they will not overturn this ruling on appeal. The health plan clock should never trump legitimate medical necessity.
 - b. If a surgery is preauthorized with the codes a podiatric physician thinks he/she will be performing, and they turn into different codes during/following surgery because of unforeseen circumstances, some insurers have a very small window in which physicians are allowed to call to have the current codes added to the authorization or they will be denied. Pathology results and wound cultures aren’t back in three days, the timeline required by at least one insurer for making adjustments. Coding cannot accurately be reported until pathology results and wound cultures are returned. Surgeons don’t have a crystal ball. They go into surgery with some suspected problems they might see on an X-ray, or MRI. Sometimes they turn into other things once they are performing the surgery. Pathology results can also change the coding of procedures. There should be a minimum number of days allowed, not less than ten, to update preauthorization surgical codes.