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FROM: Sandy Ganak, Practice Manager

RE: Comments on OIC Proposed Rule Making and PA Processes Rule

I support the OIC's efforts to establish rules regulating prior authorization processes used by insurers. My experience mainly comes from PBM processes and I'd like offer some possible solutions for the OIC to consider to improve the administrative burden put on physicians and staff. I hope these suggestions will also apply to other services requiring prior authorizations.

My tenure as a practice manager has spanned over 25 years and the last 14 years have been with Interlake Psychiatric Associates, PLLC. Up until the last several years, prior authorizations for medications were minimal. Now, insurance companies request PA's for quantity limits, step-therapy, continuation of therapy, etc. For the sake of providing feedback, I've kept track of the time I've spent over a period of one month processing prior authorizations. Astoundingly, I've spent 322 minutes both by phone and online completing medication PA's. And the reasons why some medications need prior authorization range from quantity limits such as #45 for 30 days to step-therapy. I've done PA's where the only clinical criteria question was, "how old is the patient?" which is ridiculous for 2 reasons: 1. The insurer already has the patient's date of birth; 2. I've given the date of birth when verifying the patient to the customer service rep. If the medication is only indicated for certain ages, then there should be appropriate questions asked that pertain to the clinical reasoning for prescribing to someone outside of the approved age limits.

I have several suggestions for consideration to add to the proposed rule making agenda that could improve the administrative burden to the current system:

- Given that submission by electronic means is already established:
    - ALL providers, non-contracted and contracted, should be able to electronically access the insurer's benefit/formulary criteria for services/medications requiring prior authorization. Specific criteria to meet approval should be clearly stated.
    - ALL providers, non-contracted and contracted, should be able to submit prior authorizations via the insurer's website or other electronic delivery system.
    - Insurers should provide a link to 3rd party benefit administrators, i.e. PBM
    - Each PA submitted should be assigned a case # and a "confirmation received" email be sent to the person requesting PA
    - Every PA form should have a Comments area where additional supportive statements can be manually entered for consideration.

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- NCPDP Reject Error Code system needs to be revamped with a universal coding system used by all insurers. Particularly with medications, insurers should send reject codes with detailed explanations to the pharmacy who then notifies the provider. Example, Error code 75 "Prior Authorization Required" isn't sufficient. NCPDP Code 75 including a sub-code detailing the reason for the PA, i.e. daily quantity limits exceeded, step-therapy required, etc. Going one step further would be for insurer to list the medications the patient needs to try and fail. If the insurer fails to send specific rejection reasons, the pharmacy should be required to obtain the information from the insurer to pass along to the provider. Pharmacies, in my experience, can be too quick to send a notice to start a PA to the provider without proper vetting. Sometimes the insurer is only requesting actions from the pharmacy and not the provider.
- Proposed rule says prior authorizations expire no less than 45 days. For medications, the approval should be indefinite unless the dosing changes ESPECIALLY if the approval was done via appeal. I have one situation where a PA-Appeal for quantity limits (2 capsules daily) is needed every year. I complete the PA which is then denied and then submit an appeal.
- Most importantly, insurance companies must clearly identify and provide direct contact information to providers who receive a PA denial and want to appeal the decision - phone number (not plural), fax number, address, and/or website information as well as clearly identify steps to appeal. The denial should always include the specific criteria that was not met.

Please feel free to contact me anytime.

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