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We Take Care

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VIA EMAIL to rulesc@oic.wa.gov

Mr. Jim Freeburg
Washington State Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255

RE: Prior authorization processes and transparency (R2016-19)

Dear Mr. Freeburg:

On behalf of the 70 physicians in Family Care Network, an independent family medicine practice in Whatcom and Skagit Counties, I would like to thank the OIC for allowing comments on the Prior authorization processes rule (R2016-19).

We agree with the comments made by the Washington State Medical Association that the prior authorization process consumes a very large, disproportionate amount of time in our primary care offices. We appreciate all efforts both to streamline the process for all concerned, and to minimize the circumstances in which prior authorization is required.

Specific features important to us in our daily practice of medicine include the following issues.

Availability of Criteria: Issuers should be required to make easily available to all providers the standards, criteria and information the issuer uses for medical necessity decisions and the specific documentation that must be submitted in a prior authorization request.

Availability of Peer-to-peer Contact: We have been informed that in Washington State issuers must make available a peer-to-peer physician with whom the requesting provider can discuss the particular issues of a request. In our experience, it can be very difficult to make this happen, often taking a fair degree of assertiveness on the phone to non-MD staff, and then finally getting a physician on the line who is unfamiliar with the case under consideration. Also in our experience, once a requesting provider does succeed in getting to a peer physician, the request for prior authorization is rarely denied, indicating that in fact most of these are medically indicated, simply falling out in structured screening programs for prior authorization. The practice of medicine, even in relatively straightforward circumstances is rarely as simplistic or "cookbook" as it may seem, especially due to the multiple co-morbidities and psycho-social issues of a patient that may not be apparent to the reviewers.

Limitation of Number of Prior Authorizations Required: Because of the undocumented costs and delays inherent in the prior authorization process, major attempts should be made to limit the circumstances in which this process is used to those areas that will have a clear benefit in assuring improved value and cost-savings to health care. For this reason, services for which appropriate use criteria exist should be exempt from prior authorization requirements if the provision of the services is within the applicable criteria.

For example, an abdominal/pelvic CT scan is the diagnostic procedure of choice for an adult with clinical findings suspicious for appendicitis or acute diverticulitis. Nevertheless, we are required by almost all of our contracted carriers to obtain prior authorization before getting this procedure for these diagnoses. This leads to fairly absurd escalations in the cost of healthcare. The following is a not infrequent occurrence, given as an example.

If a patient is seen in one of our offices for an acute visit for abdominal pain, and the clinical findings are suspicious for acute diverticulitis but the patient is not ill enough to require hospitalization if the CT were negative, generally we cannot get a prior authorization from many insurance carriers in a timely enough manner to get the CT scan done as an outpatient that day. Since it is too risky to let a patient go untreated overnight with a possible serious intra-abdominal infection, the only alternative is to send the patient to the emergency room. A CT scan done through the emergency room (ordered by the emergency physician per hospital policy) requires no prior authorization. Thus, instead of the total health care cost to the patient/insurer being one medical office visit + 1 outpatient CT scan, the costs escalate to include one medical office visit, 1 high-level emergency room visit (rarely under $1000) plus a hospital based CT scan, which is generally priced higher than the outpatient version for the identical test. Interestingly, insurance plans generally consider all of that a covered service without question.

Expedited Prior Authorization Requests: The current proposed rules allow 24 hours for a decision. As one can see in the above example, 24 hours is frequently too long. If a physician sees a patient with a head injury, mild concussion and needs a CT scan of the brain to rule out bleeding, waiting 24 hours is unacceptable. Again, most insurers require prior authorization for this, often then leading to an unnecessary emergency room visit and costs in order to accomplish the CT scan.

Timeline for Requested Additional Information: We agree with the principle expressed in the proposed rules that if more information is needed, the issuer should notify the provider exactly what information is needed and give a deadline for submission. The proposed deadline is 72 hours. This is not an unreasonable length of time once the provider is aware of the request. However we have examples of receipt of such a request by US mail after the deadline has passed. If a faxed message is used, it is important for the OIG to understand that our offices literally receive hundreds of faxes/day, so that it is not at all a guarantee that the request will be seen on the day of arrival.

Due to this overload of information and the importance of timely decisions on prior authorizations, we recommend that any letter or faxed request from the issuer for additional information be accompanied by a phone call to the provider's office to alert the staff of the incoming request.

The current practice of insurance plans hoping to decrease costs by "micro-managing" the provision of health care through the prior authorization process is detrimental to the development of comprehensive primary care offices staffed to provide true patient-centered population management. We find it highly frustrating that our clinical staff is busy with these types of activities, when we could be training them to help assure that our patients receive their needed preventive care and chronic illness management in a timely efficient manner.

Respectfully,

Family Care Network

Bertha Safford, MD
Vice President, Medical Director of Quality Improvement