MASSACHUSETTS MEDICAL SOCIETY

Summary

PRINCIPLES FOR THE USE OF PRIOR AUTHORIZATION PROGRAMS

January 2006

Background Information

The Massachusetts Medical Society (Society) acknowledges that the cost of care is rising rapidly and the current rate of health care inflation may not be sustainable. The Society very much wants to work with the health care community to address this critical issue and the implementation of cost-effective evidence-based guidelines to optimize resource utilization.

Many issues in the complex world of medicine require a genuine partnership among stakeholders to ensure the community reaches the mutual goal of expanded access to affordable quality medical care. However, in light of increasing health care costs, many health plans are exploring reinstitution of some elements of managed care that were prominent in the 1980s and had fallen on disfavor in recent years.[1]

Health plans have recently implemented unduly, burdensome requirements for pre-certification/pre-authorization processes with potentially serious effects on the management of physician practices, physicians' relationships with patients, and physician morale. The Society cannot support pre-certification programs that interfere with the physician-patient relationship. Physicians want their patients to be informed, and welcome their partnership in making the best health care decisions.

These circumstances presented an appropriate opportunity for the Massachusetts Medical Society, through their Task Force on Medical Cost Control, to develop and promulgate Principles for the Use of Prior Authorization Programs.

[1]James C. Robinson and Jill M. Yegian, Medical Management After Managed Care, Health Affairs Web Exclusive, May 19, 2004.

Principles for the Use of Prior Authorization Programs

These principles for the use of prior authorization programs should apply whether the program is administered by a health plan, third party vendor, or provider organization.

1. Prior authorization programs should be implemented only upon a showing of substantial variation in the targeted practice and good evidence of overutilization among those providers the proposed prior authorization program would affect. Such data should be shared with the physician community well before any action is taken regarding new prior authorization programs in order to allow for appropriate improvement.
   a. Prior authorization requirements should never apply in a medical emergency, or when a patient could be harmed by the delay caused by such programs. If care is required on an urgent basis during non-business hours, prior authorization requirements should be suspended.
   b. The party running a prior authorization program should actively seek input from practicing physicians in development and maintenance of the program.
2. All prior authorization programs should be entirely transparent to patients and physicians. This includes the provision of:
   a. A complete list of all procedures subject to any prior authorization, including all relevant codes for providers.
   b. Comprehensive clinical criteria and algorithms, as updated based on current medical literature.
3. Prior authorization programs should be operated in a manner that avoids administrative burdens for physicians and their office staff and incremental costs to physicians, other providers, and patients. Data should be reviewed frequently, and physicians who are meeting criteria should be excluded from the program.

   Proper notice of any change in prior authorization process or criteria should be communicated in a timely fashion.
   a. Data collected for prior authorization programs should include a minimum number of necessary data elements.
   b. Providers should be allowed to transmit required data in a number of different ways, including telephonic, fax, U.S. Postal Service, and electronic, in a Health Insurance Portability and Accountability Act (HIPAA)-compliant manner.
   c. Prior authorization programs should have adequate capacity such that there are no busy signals or delays in transmitting data.

d. Providers should receive immediate proof of submission of prior authorization data.

e. Turnaround time for prior authorization should be less than one business day for non-urgent cases.

f. Appeals rights for patients, families, and providers should be clearly spelled out, and appeals should be readily accessible.

g. Appeals should require the minimum incremental information.

h. Patients, families, or providers should have the right to present appeals information in person at a time and place that is reasonably convenient.

i. Providers should be paid for incremental work effort of prior authorization programs.

j. Providers should receive timely, clear, and actionable reporting on their performance in a prior authorization program.

k. Providers who consistently meet clinical criteria should be exempted from all elements of prior authorization programs.

4. Prior authorization programs should be conducted using up-to-date clinical criteria and appropriate clinical experts.

   a. All clinical coverage criteria should be reviewed and updated regularly with evidence-based protocols.

   b. Any proposed denials should be issued by a licensed, actively practicing physician who regularly treats patients in a clinical setting and who would typically manage the medical condition under review. Such a physician should be available on a 24 hour basis.

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