Prior Authorization Promotes Evidence-Based Care That Is Safe and Affordable for Patients

Health insurance providers continue to innovate and collaborate with providers and other stakeholders to implement solutions to promote evidence-based care and improve the prior authorization process.

Streamlining prior authorization for complete courses of treatment for musculoskeletal and other conditions.

Promoting electronic prior authorization requests and decisions.

Providing feedback to health care providers on their performance relative to their peers and professional society guidelines.

Waiving prior authorization for providers with a demonstrated track record in practicing evidence-based care.

Prior authorization is a proven tool to ensure patients get the most up to date evidence-based care. Health insurance providers continue to collaborate with health care providers and other stakeholders to implement innovative solutions to improve the prior authorization process. The examples below demonstrate how health insurance provider and health care provider partnerships and the targeted use of prior authorization can help ensure patients get care that's not only safe and effective, but also affordable.

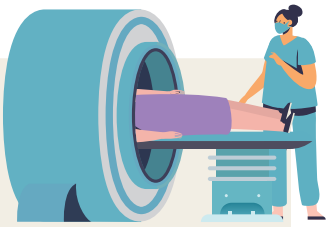
An AHIP clinical appropriateness project with Johns Hopkins found that almost 90% of health care providers in the study practice consistent with evidence-based standards of care.

Thirty percent of all heath care spending in the United States may be unnecessary, and in many cases harmful to patients. Indeed, every year low-value care costs the U.S. health care system $340 billion. Eighty-seven percent of doctors have reported negative impacts from low-value care.

Imaging for Low-Risk Back Pain

Patients with low-risk lower back pain (LBP) frequently receive early imaging studies, which do not improve outcomes and can lead to unnecessary surgery and office visits, undue stress, unnecessary exposure to radiation, lost productivity, potential harms from prescription opioids, and avoidable costs. Prior authorization can be used to ensure that alternatives like physical therapy are used in appropriate cases, consistent with evidence-based guidelines and providers' own recommendations.

Imaging (MRI, CT, X-Ray)



Approximately 20-30% of patients with low back pain have unnecessary imaging ordered early in their course of care.

Early imaging can cost significantly more than recommended alternatives like physical therapy ($2,500 more for MRIs, $19,900 more for CT scans).

Out-of-pocket costs to the patient can average $319 for in-network imaging to $630 for out-of-network imaging.

In addition to greater acute care costs, early imaging is associated with more back surgery, greater use of prescription opioids, and a higher final pain score.

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CT Scan for Abdominal Pain vs. Ultrasound

Evidence-based guidelines suggest an ultrasound should be the first line of testing in diagnosing certain areas of abdominal pain before ordering other types of imaging which could unnecessarily expose a patient to radiation. Prior authorization can be used to ensure that ultrasounds are the first line of diagnosis, consistent with evidence-based guidelines and providers' own recommendations.

CT scan
Median hospital price $1,654

Ultrasound
Median hospital price $455

Lumbar Spinal Fusion Surgery vs. Laminectomy

Spinal Fusion
Average total cost for Medicare $73,453

Laminectomy
Average total cost for Medicare $41,134

Back surgery is typically needed in only a small percentage of back pain cases and is usually considered only when non-surgical treatments have failed to relieve symptoms of stenosis. Surgical options include a laminectomy, which involves removing the bony plate on the back of the vertebra, opening up more space for the spinal nerves, and lumbar spinal fusion surgery, which fuses two adjacent vertebra to stabilize the spine. Despite uncertainty regarding the effectiveness of lumbar spinal fusion surgery for some patients, utilization of the procedure has increased significantly since 1998. Prior authorization can be used to promote evidence-based, appropriate back pain treatment, including surgery if medically indicated.

Hyaluronic Acid Injections for Knee Osteoarthritis

Despite evidence that hyaluronic acid injection offers no meaningful difference in the lives of patients over placebo shots, injections are still widely given to treat knee pain caused by osteoarthritis (OA). Moreover, there is evidence that these injections result in a greater risk of negative side effects, including gastrointestinal inflammation and infections, cardiovascular problems, and blurred vision and dizziness. Prior authorization can help ensure that hyaluronic acid injections are not used as a first line treatment, consistent with providers' own recommendations.

Hyaluronic Acid Injection
Patients receive an average of 3.6 injections at an average cost of $310 per injection, for an average of $1,128 per patient.

Cost to Medicare of over $300 million each year.

Conventional Radiation Treatment vs. Accelerated Radiation Therapy for Breast Cancer

For patients with early-stage breast cancer, a shorter, accelerated course of radiation that delivers more doses of radiation per treatment results in similar outcomes as a longer course, while saving patients from additional radiation exposure, pain, inconvenience, and higher costs. Despite professional society endorsement of accelerated therapy (called hypofractionation), adoption is low. Prior authorization can help ensure eligible patients get hypofractionated radiation therapy when appropriate.

Conventional Radiation Therapy

$1,339.75 total cost per patient

5-7 week treatment course

Hypofractionated Radiation Therapy

$851.77 total cost per patient

3-4 week treatment course

Brand Name Drugs vs. Generic Drugs

One generic competitor
PRICES DROP BY **40%**

Four generic competitors
PRICES DROP BY **80%**

Many brand name drugs have therapeutically equivalent, more affordable generic versions. Even with only one generic competitor, prices drop by 40%; once four generic competitors come to market, prices drop by 80%. Prior authorization can promote the prescribing of generic equivalents where available, and help protect patients from significantly higher costs.

Total Knee Arthroplasty (TKA) in the Inpatient vs. Outpatient Setting

Many joint procedures can be done on an outpatient basis with comparable or improved health outcomes, including lower incidence of opiate use. Recognizing this, Medicare began covering TKA on an outpatient basis in 2018. Prior authorization can help promote appropriate sites of care that can also be more affordable for patients.

Inpatient TKA

$31,573 in total costs over 90 days

Outpatient TKA

$24,749 in total costs over 90 days

Inpatient Total Joint Arthroplasty patients, which includes TKA patients, were significantly more likely to be taking opioids 90-days post surgery than outpatient patients (11.4% vs. 9%)