

## **Frequently Asked Questions: Medical Management and Prior Authorization**

### **What is prior authorization?**

- Prior authorization is a process whereby a provider, on behalf of a patient, requests approval or authorization from the health plan before delivering a treatment or service in order for the treatment or service to be covered by the health plan.
- Prior authorization is one example of a range of evidence-based medical management tools adopted by health plans and government-sponsored health care programs to help ensure patients receive optimal care based on well-established evidence of efficacy and safety, while providing benefit to the individual patient.

### **How is prior authorization used and for what purposes?**

- Prior authorization is used to address the significant gaps that continue to exist between evidence-based practice and care actually being delivered to patients. Prior authorization is most effective in addressing overuse and misuse of treatments and services. For example, prior authorization can be used to:
  - Ensure that providers adhere to nationally-recognized care criteria (e.g., ensure opioid prescribing consistent with federal guidelines).
  - Promote appropriate use of medications and services to ensure that they do not interfere with other types of medications or potentially worsen existing conditions.
  - Make sure that medications are not co-prescribed with other drugs that could have dangerous, even potentially fatal, interactions.
  - Ensure that medications are safe, effective, and provide value for specific populations or subpopulations who may be affected differently by a medication (e.g., antipsychotic medications in children and adolescents).
  - Make sure that drugs and devices are not used for clinical indications other than those approved by the FDA or supported by medical evidence.
  - Ensure that the administering clinician has the appropriate training to do so (e.g., limiting prescribing of chemotherapy medications to oncologists).
  - Promote dialogue with clinicians to ensure tailored, patient-focused treatment programs to promote adherence and improve outcomes.
  - Ensure that for members newly prescribed a medication, that the medication is accompanied by services such as counseling, peer support, or community-based support if appropriate (e.g., medication-assisted treatment).

### **How do plans generally determine what services necessitate a prior authorization?**

- Health plans look at data on variation, adherence to evidence-based medicine, safety concerns, and other relevant factors to determine what services should be subject to prior authorization.
- Additionally, health plans regularly review the list of medical services and prescription drugs that are subject to prior authorization. This is done to identify therapies that no

longer warrant prior authorization due to low variation in utilization or updates to standards of care, for example. Regular review can also help identify services – including new and emerging therapies – where the evidence base on effectiveness is incomplete or where there are safety concerns.

### **What are the guardrails CMS imposes on plans when it comes to prior authorization?**

- Plans are required to include prior authorization and other utilization management requirements in their plan benefit packages and formularies, which are submitted to, reviewed, and approved by CMS.
- CMS imposes time limits on pre-service requests. For Medicare Advantage requests, plans must respond 14 days (standard request) or 72 hours (expedited request) from receipt of the request. For Part D requests, plans must respond 72 hours (standard request) or 24 hours (expedited request) from receipt of the request. Generally, the receipt of the request is generally logged in both plan and provider systems. If a timeline is missed, then the prior authorization request must auto-forwarded to Maximus, which is an independent review entity who then makes the determination on granting the prior authorization or not.

### **What does the submission process for a prior authorization request look like?**

- In general, each health plan market maintains their own process for processing prior authorization/medical necessity requests subject to state and federal law and regulation and private accreditation standards.
- However, a typical process generally is as follows:
  - The treating physician, on behalf of patient, requests prior authorization of coverage of a service or treatment from the health plan. With the request, the treating physician provides documentation supporting the request, including a letter of medical necessity and medical records. The prior authorization request is often submitted via fax.
  - A physician or nurse reviewer reviews the request for the plan and can make a positive determination (approval) regarding coverage, in which case the approval is communicated to the treating provider and patient within the applicable timeframes. There are different timeframes for urgent and non-urgent, pre-service and post-service determinations. Timeframes are dictated by state and federal law and private accreditation.
  - The criteria for determining medical necessity/coverage may vary by plan. Generally, to be medically necessary and therefore covered by a plan, a service must be one that a provider, exercising clinical judgement, would provide to a patient to prevent, evaluate, diagnose, or treat an illness, injury, or disease. The service must be consistent with generally accepted standards of medical practice, which are based on credible, scientific evidence published in peer-reviewed medical literature or other nationally accepted evidence-based standards, and be clinically appropriate in type, frequency, extent, site and duration, and be considered effective for the patient's condition. The service must also not be

primarily for the convenience of the patient or provider, and not be more costly than a treatment likely to result in a comparable health outcome.

- If more information is needed to make a determination, the plan communicates to the treating provider what additional information is needed within the applicable timeframes.
- Only a physician reviewer can issue a coverage denial based on medical necessity whereas other clinical reviewers may grant prior authorization. If the requested treatment is denied, the denial is communicated to the treating physician and the patient, along with the clinical rationale for the denial and instructions on how to file an appeal.

### **If a prior authorization is denied, what is the process for appealing the denial?**

- Each health plan in the commercial market maintains their own process for addressing appeals subject to state and federal law and regulation and private accreditation standards.
- However, a typical process generally is as follows:
  - Depending on the plan and state/federal law, there may be one or two levels of internal appeal.
  - An appeal is reviewed by a physician who was not involved in the initial determination. The appeal is subject to the applicable timeframes for urgent and non-urgent appeals.
  - A denial of an appeal (or a request for additional information) is communicated to the treating physician and patient within the applicable timeframes along with the clinical rationale and instructions for any next steps (i.e., another internal appeal or appeal to an independent, external review entity).
  - Once the internal appeals process is exhausted, there is typically an opportunity for independent medical review for denials based on medical necessity or experimental treatment. Depending on the applicable law, the review may be conducted by a single reviewer or a panel of reviewers. The composition and qualifications of the reviewers are specified in applicable law and regulation.
- Under the Medicare Advantage and Part D programs, there are multiple levels of appeal prior to Judicial Review. After the first level of appeal, CMS requires the plan to forward the case to an Independent Review Entity (IRE).

### **What educational resources are available to physicians and beneficiaries to help them understand what services/drugs plans require prior authorization for?**

- Health plans make their medical coverage policies, including the documents needed to accompany requests for coverage, available and transparent to their network physicians and enrollees. The medical coverage policies indicate which therapies are subject to prior approval or other medical management techniques, including step therapy or quantity limits.

- In addition, in our recent collaboration with the AMA and other provider groups, AHIP endorsed working with other stakeholders to encourage the communication of up-to-date prior authorization and step therapy requirements, coverage criteria and restrictions, drug tiers, relative costs, and covered alternatives (1) to EHR, pharmacy system, and other vendors to promote the accessibility of this information to health care providers at the point-of-care via integration into ordering and dispensing technology interfaces; and (2) via websites easily accessible to contracted health care providers

### **Why do plans have prior authorization for services that result in 100% approval rates?**

- The use of prior authorization and other medical management techniques serves as a deterrent in some cases to inappropriate care. The existence of a process to make sure care is consistent with evidence-based practice encourages evidence-based practice. The elimination of such a process risks regression to care inconsistent with best practices. Plans must maintain the ability to remain flexible and responsive to changes in evidence of safety, effectiveness, and value. The need for such flexibility can clearly be seen in our efforts to combat the opioid epidemic where many plans have increased utilization management techniques for opioid prescription to ensure providers are adhering to CDC guidelines.
- Plans also use prior authorization to help trigger care coordination and management, including activating plan case managers and ensuring that follow on providers are in-network for the patient and appointments are made. This not only improves care and outcomes, but it increases affordability for the patient and reduces stress. For example, prior authorization for planned surgeries can trigger these types of services.

### **Why isn't there a standardized process for submitting a prior authorization across all plans?**

- While health plans need flexibility to develop utilization review criteria that address the issues specific to variation in practice patterns in their geographic region, and to address the needs of their enrolled population, the process for submitting a prior authorization has room for improvement and the potential to be significantly streamlined.
- Many plans are working with providers and investing resources to leverage technology to streamline the process. Technology limitations prevent this from being the norm at this time. However, the industry strongly supports the goal of electronic prior authorization to reduce administrative burden on both plans and providers. In fact, AHIP has endorsed moving toward industry-wide adoption of electronic prior authorization transactions based on existing national standards. We are currently exploring the potential to set up pilot projects with member plans to test out various ways to speed up this adoption and improve the process.