Improving the Prior Authorization Process

What is Prior Authorization?

For years, utilization management techniques have been used to control the cost of care. Though presented in different forms, utilization management seeks to influence decisions on patient care and as a method to verify that a treatment (e.g., drug, procedure, or service) is medically necessary before it is done.[1]

The Problem

However, the cumulative burden of effort in seeking permission in order to give patients the best care, the time necessary to educate medical reviewers on why the therapies are needed, and sheer amount of paperwork to fight denials is too much; and the burden is only increasing. A recent oncology study found that payer strains with prior authorizations are the most-cited source of stress on the practice.[2]

Seeking Solutions

The Association of Community Cancer Centers (ACCC) held three focus groups to discuss current barriers and challenges, and potential solutions regarding prior authorization practices. Below are some of their recommendations for payers.

- Conduct specialty-to-specialty, peer-to-peer reviews.
- Create universal billing codes and vocabulary for testing and treatment.
- Streamline the prior authorization process to include electronic automation.
- Reduce the number of services and medications that require authorization by performing routine reviews and removing outdated requirements.
- Assign a single point of contact to handle prior authorizations.
- Work with healthcare organizations to streamline processes and improve communication.
- Provide clear and timely communication of up-to-date changes to prior authorization and step therapy requirements, drug tiers, coverage criteria, and other restrictions.
- Establish patient protection for continuity of care during policy change transitions for patients undergoing active treatment to minimize disruptions of active care.
- Minimize repetitive prior authorizations by automating re-approvals for continuation of care for patients on previously approved treatment that is stable and appropriate.
- Communicate proactively by sending status updates and follow up communications to providers electronically, if possible, through the same portal used to submit authorizations.
- Implement a secure online solution to allow providers to upload patient clinical data as requested instead of faxing and/or emailing.
- Create expedited pathways for things that are standard of care (meet NCCN guidelines) – such as auto authorizations through Medicare.
- Eliminate authorization requirements for patients that fall under certain contractual agreements.

Key Takeaways

Throughout each focus group, there were similar major themes:

Empower Patients

Focus group participants identified the following actions that should be used to empower patients:

- Teach patients to advocate on their behalf- it is most impactful when an employee lets their employer know that their health insurer will not cover treatment
- Providers can submit a grievance report on behalf of the patient- results of prior authorizations such as delayed care, non-approvals, etc., so payers can have a stake in accountability
- Improve insurance literacy by educating patients on what insurance coverage means for them.

Advocate at the National Level

Sign-on to, or advocate for legislation that will move the needle on prior authorizations.

- View resources available at ACCC's **Legislative Action Center at accc-cancer.org/Legislative-Action-Center**

Work with Health Insurers

All focus group participants noted an interest in working with health insurers to make a better process. It is now up to insurers to answer the call.

Find additional information and resources at: **accc-cancer.org/prior-authorization**

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References

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Learn more at **accc-cancer.org/prior-authorization**.

The Association of Community Cancer Centers (ACCC) is the leading education and advocacy organization for the cancer care community. For more information, visit **accc-cancer.org**.

Association of Community Cancer Centers