Standardization of prior authorization process for medical services white paper

Prepared by the American Medical Association
Private Sector Advocacy

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The American Medical Association (AMA) strongly supports the provisions in the Patient Protection and Affordable Care Act (ACA) that are designed to streamline the claims management revenue cycle. The AMA is committed to eliminating administrative waste in the health care delivery system. Cost estimates of inefficient health care claims processing, payment and reconciliation are between $21 and $210 billion. In the physician practice, the claims management revenue cycle consumes an unsustainable 10–14 percent of practice revenue.

The current system is all too often manual. It must be replaced by automated, transparent, unambiguous, real-time health care transactions. **This white paper focuses on the streamlining, standardization and automation of the process for the prior authorization of medical services and does not address or debate the need for prior authorization of medical services. [1]** The prior authorization process for pharmaceuticals will be discussed in a companion white paper expected in the third quarter of 2011.

To automate the prior authorization process and reduce costs, the system needs to:
- Standardize the process across payers and apply it consistently
- Ensure that, as much as possible, the prior authorization process can be programmed into the payer administrative and physician practice systems and their respective work flows
- Ensure that all payers support the Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12N 278 Health Care Services Review—Request for Review and Response standard transaction

We believe these goals can be accomplished while still allowing payers to maintain their own benefit designs and payment levels.

While the AMA believes that prior authorization programs are often overly inclusive and would welcome the opportunity to work with the payer community to find alternatives to these programs when feasible, this paper focuses solely on the prior authorization process. It assumes that prior authorization programs will be used but looks to ways to minimize the associated administrative burden these programs place on payers and physicians alike.

Introduction

Because of their expertise and relationship with their patients, physicians are best suited to educate patients on costs, treatment options and other alternatives. Providing the patient with information on costs, benefits and treatment options for identified services should be an efficient and quick process that is integrated within the clinical work flow of the practice. To enable physicians to conduct this education at the point of care, however, payers need to provide the tools,

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[1] Prior authorization includes any process that requires obtaining approval for performance of a procedure or service from a health insurer. Prior authorization is also commonly referred to as precertification, prior notification, prior approval, prospective review, prior review, certification or precertification.

Visit www.ama-assn.org/go/simplify for more information on the AMA's administrative simplification recommendations.

data, rules and other information historically reserved for their own internal usage to physicians in a fashion that allows the information to be integrated into the continuum of providing care to the patient. Physicians are presumed to be able to combine this information with their personal knowledge of the patient's health and personal issues to arrive at the best recommendation.

This reengineering exercise should extend to the prior authorization process. The current intensely manual process can be improved substantially by making all relevant information available to physicians at the point of care. This would improve the patients' experience while reducing the costs associated with the prior authorization process for both payers and physicians.

To accomplish real-time prior authorization at the point of care, trust will need to be rebuilt between payers and physicians. Both will need to agree to engage in a partnership approach in which it is recognized that the payers know the benefit limits of a particular patient and may also have databases of best practices and other clinical decision support tools of value to physicians and their practice staff. Physicians, in turn, know best the patient and the specifics of the particular situation, are in the ideal position to provide a timely response if given the appropriate resources, and are in the best position to provide alternatives to patients when costs and benefit limits are real considerations. Indeed, as individual physicians demonstrate their ability to arrive at agreed decision/information points based on best practices, it may make sense to consider eliminating prior authorization requirements entirely. In any event, the stronger the foundation of partnership and trust, the more efficient the process may become.

Prior authorization: Current status described

The current prior authorization process is extremely burdensome. According to a recent study, in 2006 **the average physician practice devoted 1 hour of physician time, 13.1 hours of nursing time and 6.3 hours of clerical time to the prior authorization process each week** in 2006.[2]

The administrative burdens experienced by physicians with current practice prior authorization work flows are demonstrated by the following examples:

Example one: The physician practice places a call to the payer to confirm whether prior authorization is necessary. If the answer is yes, the patient's information is then given to a payer representative who enters the information in the payer's computer system. The practice is then transferred to a nurse case manager who verifies the information. The case manager then asks the practice to fax or mail all of the information. The length of time for this process is approximately 50 minutes (20 minutes to reach a payer representative, then up to 30 minutes speaking with a representative and the case manager).

Example two: The physician practice calls the payer to confirm whether prior authorization is necessary. If the procedure or service requires prior authorization, the physician practice is instructed to submit a form. While some payers have their own proprietary forms, some do not, in which case the physician practice submits its own form. For those payers that have a form, the physician practice is often directed to a website that can have many forms to choose from, which requires practice staff to determine which is the appropriate one. In addition to a form, most payers also request a letter of medical necessity, which may require a history of alternatives that have been tried with no success. This very manual process can take from two to four weeks to obtain a response.

The following diagram (Exhibit 1) shows today's prior authorization process, which can take an extended period of time.

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[2] "What Does It Cost Physician Practices To Interact With Health Insurance Plans," Lawrence P. Casalino et al, *Health Affairs* 28.4 (2009): w533–w543 at w537.

Exhibit 1: Current prior authorization processes
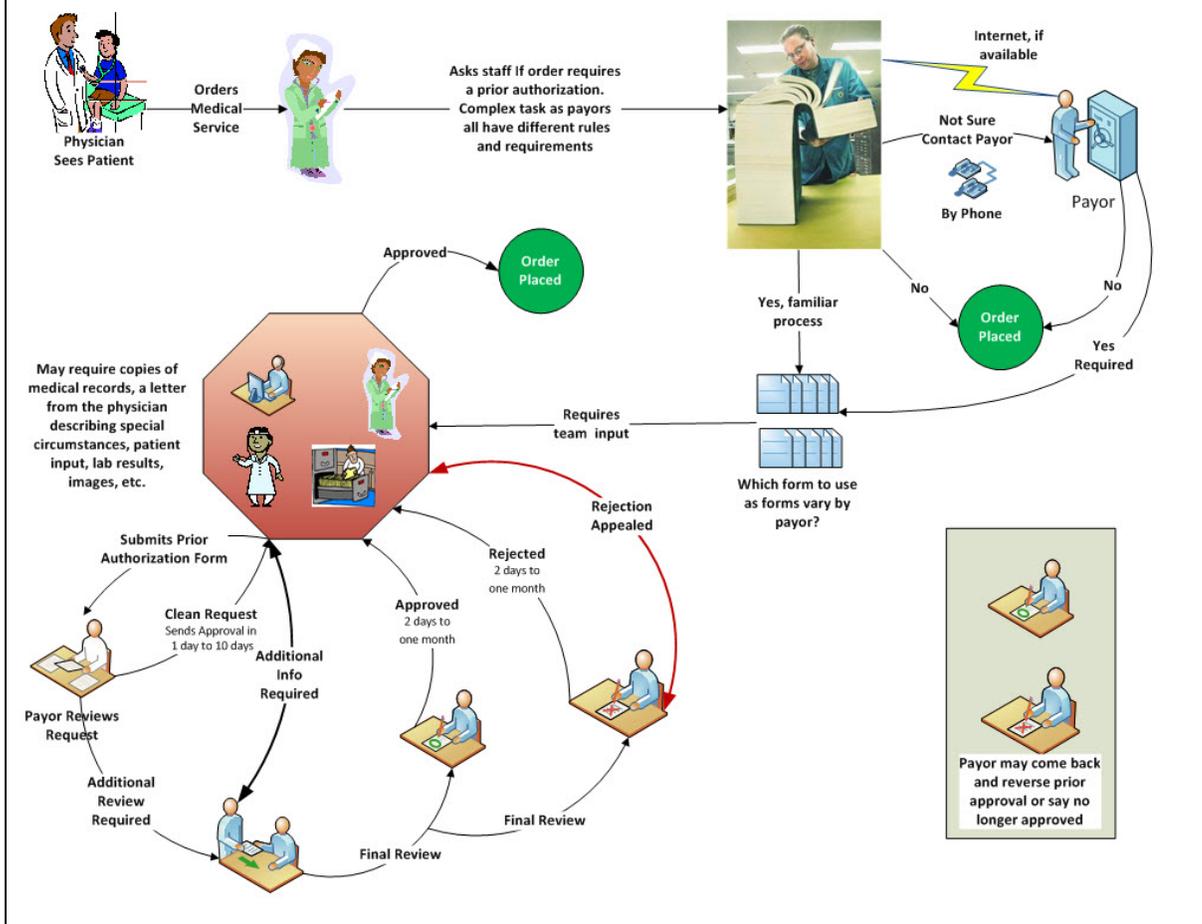
While this effort is extremely burdensome to the physician practice, the payer also expends significant time and resources handling prior authorization requests. A standardized, transparent, automated work flow would benefit all the trading partners: payers, physicians and their patients.

The AMA's Report of the Council of Medical Service (CMS Report 4-I-10)

The AMA's CMS Report 4-I-10, which can be found in Appendix A, confirms the challenges conveyed in the above physician work flows that were raised at the 2010 AMA Annual Meeting of the House of Delegates. The concerns expressed at that meeting highlighted the current plethora of payer-specific prior authorization forms, which creates burdensome hurdles for physicians and adverse health consequences for patients. The lack of standardization makes the prior authorization process difficult and time-consuming. Moreover, the forms often lack clarity and do not contain all of the information required by payers to make a determination regarding the authorization request, potentially necessitating additional time-consuming communication for the physician practice with no additional reimbursement. The prior authorization process can also appear to be a delay tactic used by payers for financial gain and to discourage physicians from advocating for necessary services.
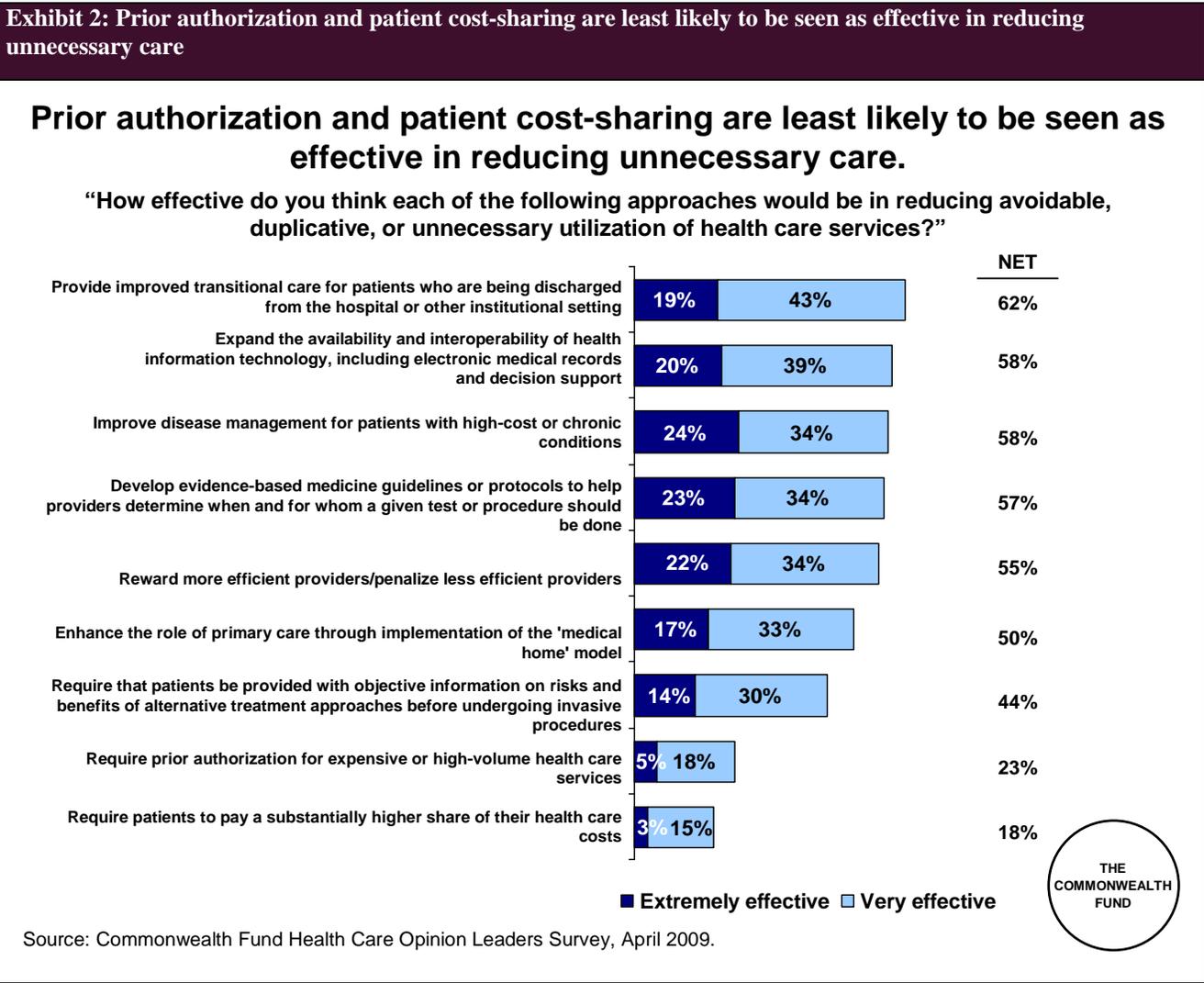
The following Policy H-320.944 was established by the adoption of CMS Report 4-I-10:

> Our AMA: (1) supports the simplification and standardization of the preauthorization process for physicians and patients; (2) supports the adoption of a standardized paper preauthorization form by health plans for those

physicians who choose to submit paper preauthorization forms; (3) will publicize and support the legislatively mandated adoption of HIPAA electronic standard transactions by health plans and encourage adoption of HIPAA electronic standard transactions by physicians; and (4) supports efforts to develop clear and complete requirements for each HIPAA electronic standard transaction.

In addition to such hurdles for physicians, the prior authorization process can have detrimental health consequences for patients. Some payers are requiring prior authorization for an increasing number of routine tests and procedures, resulting in more physician-patient interactions that require payer input and subsequent treatment delays. Lengthy prior authorization processes can interfere with patient follow-through if patients fail to return for needed medication or treatment. In addition, patients can be subjected to redundant tests due to some prior authorization requirements. Ultimately, prior authorization delays can lead to treatment delays or denials, both of which may jeopardize patient welfare.

It is no wonder that when physicians were asked which strategies would have the most impact on reducing the soaring costs of health care, increasing prior authorization requirements and patient cost share were the bottom two results of the 2009 Commonwealth Fund Health Care Opinion Leaders survey as shown in Exhibit 2.

Exhibit 2: Prior authorization and patient cost-sharing are least likely to be seen as effective in reducing unnecessary care

Prior authorization and patient cost-sharing are least likely to be seen as effective in reducing unnecessary care.

"How effective do you think each of the following approaches would be in reducing avoidable, duplicative, or unnecessary utilization of health care services?"

Approach	Extremely effective	Very effective	NET
Provide improved transitional care for patients who are being discharged from the hospital or other institutional setting	19%	43%	62%
Expand the availability and interoperability of health information technology, including electronic medical records and decision support	20%	39%	58%
Improve disease management for patients with high-cost or chronic conditions	24%	34%	58%
Develop evidence-based medicine guidelines or protocols to help providers determine when and for whom a given test or procedure should be done	23%	34%	57%
Reward more efficient providers/penalize less efficient providers	22%	34%	55%
Enhance the role of primary care through implementation of the 'medical home' model	17%	33%	50%
Require that patients be provided with objective information on risks and benefits of alternative treatment approaches before undergoing invasive procedures	14%	30%	44%
Require prior authorization for expensive or high-volume health care services	5%	18%	23%
Require patients to pay a substantially higher share of their health care costs	3%	15%	18%

■ Extremely effective □ Very effective

THE COMMONWEALTH FUND

Source: Commonwealth Fund Health Care Opinion Leaders Survey, April 2009.

May 2010 AMA national prior authorization study

The issues outlined above were confirmed by an AMA survey of physicians regarding their experience with prior authorization. Questions covered topics such as administrative hassles surrounding prior authorization and the effect on patient outcomes.
This national online survey of 2,400 physicians, which was done in conjunction with the Federation of Medicine, was conducted in May 2010. The survey asked a representative sample of physicians about their experiences with health insurers' prior authorization and prior notification programs. Highlights of the survey, which can be found in Appendix B, show an in-depth and creditable assessment of the range of problems physicians are presently experiencing. Some key findings include:

- Hassle factors related to prior authorization requirements need to be eliminated
- Preference for an automated prior authorization process
- Vague prior authorization requirements
- Long wait times with prior authorization requests
- Difficulty obtaining approval of prior authorization requests
- Health insurer review of first-time prior authorization requests by a health insurer representative without medical training
- 20 percent of first-time prior authorization requests rejected by the payers
- Physician practices need to appeal 80 percent of payer rejections of first-time prior authorization requests

April 2009 Medical Association of Georgia prior authorization study

As further evidence of the recognition of how disruptive the prior authorization process is to physicians, the Medical Association of Georgia (MAG) in an Apr. 16, 2009 news release highlighted "the 'clear and considerable' burden that the 'prior authorization' process places on physicians in Georgia. Physicians must obtain prior authorization from health insurance providers before they can treat their patients for certain procedures—essentially dictating patient care. MAG's study placed the number of services requiring prior authorizations at 880 or more."

Transparency of prior authorization information study

In addition to the above mentioned survey efforts, the AMA conducted a Web search of prior authorization information made available by national payers. The websites of national payers were visited to determine how transparent each payer was in posting their prior authorization and/or notification requirements on their respective websites. In some cases, the information was readily available. But the scope of information covering the process of submitting, obtaining and/or appealing prior authorizations is arguably overwhelming when one considers the impact of the lack of industry standards.

Even when the information is readily available, physician and their practice staff have to take their best guess as to the meaning of the terms used to describe prior authorization because there are no standard definitions across the health care industry.

The following three terms: (1) pre-authorization, (2) pre-certification and (3) pre-determination, while used interchangeably, can have different meanings and impacts on the practice.

Exhibit 3: Common definitions of three terms often used interchangeably

Pre-authorization: A prospective process to verify coverage of proposed care and establish covered length of stay.

Pre-certification: A utilization management program that requires the member or the physician to notify the health insurer prior to a hospitalization, diagnostic test or surgical procedure. The notification allows the health insurer to provide an authorization number.

Pre-determination: A health insurer requirement that the physician practice request confirmation from the health insurer. In some cases, this confirmation must be in writing, ensuring that a service or procedure the physician or health care provider will perform is contained in the patient's benefit coverage.

*Definitions from "Prepare that Claim," a resource of the American Medical Association's Practice Management Center, 2008–2009. Access "Prepare that Claim" at www.ama-assn.org/go/pmc under "Claims Management Revenue Cycle" to learn more about this part of the claims process in the physician practice.

The practical cost implications of our failed current processes

As noted above, physician practice staff report spending 20 hours per week on average just dealing with prior authorizations (Casalino 2009). The same study estimated that physician practices spent an average of $68,274 per physician annually for all types of interactions with health insurance companies. These costs are not included in any payment system and are akin to "unfunded mandates."

Payers and physicians should come together to determine how this process can be automated to reduce the costs for both parties. That approach, in turn, may require the capture of additional data to be submitted in the HIPAA ASC X12N 278 Health Care Services Review—Request for Review and Response standard transaction so that both the payer and physician can automate their processes.

Potential solutions

There are several ongoing initiatives that give reason to be optimistic that the prior authorization process can be substantially streamlined and significant savings can be achieved. Current initiatives include:

1. **Development of standard paper forms**
2. **Enhancement of the 5010 ASC X12278 standard transaction**
3. **Multi-stakeholder efforts moving toward standardizing data capture and promoting transparency**
4. **Federal and state initiatives and legal requirements:** The ACA provides opportunities to bring about increased efficiencies in the prior authorization process.
5. **State initiatives, laws and legislation:** Certain state laws have mandated additional effort to streamline the prior authorization process. See Appendix C for a listing of states with existing state law.
6. **Best practices:** Adherence to best practices can lessen ambiguity, increase quality and lower costs.

Development of standard paper form coupled with the enhancement of the 5010 ASC X12 278 standard transaction

Creating both a standardized paper form and electronic transaction that require a physician to submit common data elements that meet the industry requirements for beginning the prior authorization process would be a significant first step to addressing the unnecessary complexity of knowing whether prior authorization is required, which form to use and what data is required. The 5010 version of the electronic standard transactions is mandated on Jan. 1, 2012. The 5010 version enhances the ASC X12 278 Health Care Services Review transaction, which will allow payers and physicians to more

easily embrace this standard transaction. The 5010 instructions are also clearer, which should reduce the variability of interpretation concerning how to implement the standard.

Additionally, a number of new functions were added to 5010 version of the X12 278 standard transaction, including:[3]

- Ability to report procedure modifiers
- Ability to report revenue codes and rates
- Ability to request procedure ranges
- Ability to reserve a limited number of occurrences of a service within a defined time frame
- Ability to send and received ICD 10-CM codes
- Support for "reconsideration requests" prior to filing a formal appeal
- Clarified patient condition segment, which creates separate implementation segments and rules for the following information:
    - Ambulance certification
    - Durable medical equipment
    - Oxygen therapy certification
    - Functional limitation
    - Chiropractic certification
    - Activities permitted
    - Mental status

The enhanced transaction also provides the ability to support the upcoming ICD-10-CM coding requirements. The timing is right for expanding the intended administrative benefits from this HIPAA mandated transaction building on the improvements of the 5010 version of the X12 278 standard transaction.

The national efforts described above to standardize the prior authorization form and process is a natural extension of other national standardization initiatives, state and regional initiatives, and those championed by health care associations like the AMA.

Multi-stakeholder efforts moving toward standardizing data capture show promise.

The AMA Multi-stakeholder Prior Authorization Workgroup (Workgroup) is looking at ways to enhance and increase the use of the ASC X12 278 Health Care Services Review standard transaction in order to automate the prior authorization process. This workgroup is comprised of AMA staff, the AMA-Federation Payment Policy Workgroup, which includes staff specializing in third-party payer issues from state medical associations and national medical specialty societies, and several national payers.

The AMA has advocated for the development and adoption of robust operating rules requirements for each HIPAA electronic standard transaction, including the standard transaction for prior authorization. The workgroup was formed to explore the feasibility of creating a universal prior authorization form for medical services and streamlining the process. The recent effort has focused on how to increase the value of the current 5010 HIPAA ASC X12 278 Health Care Services Review—Request for Review and Response electronic standard transaction that is intended to automate the sending or receiving of referral or authorization requests and responses. This transaction holds the potential to reduce the current manual effort and hassle incurred by physicians and their practice staff in handling prior authorization and prior notification requirements on behalf of their patients. Currently, many payers respond to the 4010 version of this transaction with minimal specificity, if they respond at all. By increasing the value of the information contained in the

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[3] "ASC X12 Version 5010 Upgrade" presentation to NCVHS Subcommittee on Standards and Security, Don Bechtel, co-chair of ASC X12N Health Care Task Group, July 30, 2007.

electronic prior authorization standard transaction and the use of this transaction by payers, the manual process currently incurred by the practice and the payer could be dramatically reduced.

As a start to creating that robust transaction, the workgroup reached agreement on the top 10 questions/common data elements that should initially be provided by a physician when seeking prior authorization for medical services. This core set of common data requirements for prior authorization requests and placement within ASC X12 278 standard transaction can be found in Appendix D. The workgroup agreed that the payer's response to such a robust request would be either: (1) approval, (2) request for specific additional information required to make the decision or (3) link to a specific online form for the authorization request.

Exhibit 4: Core set of common data requirements for prior authorization requests
1. Patient Demographics (required)
Name of patient (customer/member)
Patient (customer/member) ID number
Date of birth
2. Ordering Physician Demographics (required)
Ordering physician or health care professional name
Ordering physician or health care professional Type 1 National Provider Identification (NPI)
Ordering physician or health care professional contact telephone number
3. Rendering Physician Demographics (required)
Rendering physician, group or facility professional name and TIN or NPI
Rendering physician or health care professional Type 1 or Type 2 NPI
4. Rendering Facility Demographics if different than 3
If different than 3, report Facility name where service will be performed (when applicable)
If different than 3, report Type 2 NPI where service will be performed (when applicable)
5. Type of procedure/service/device being requested (CPT/HCPCS code(s)) (required)
6. Unit/volume of procedure/service/device being requested (when applicable), default is 1 unit
7. Whether the request is Emergency, Urgent or Elective (default is Elective)
8. ICD-9-CM (or its successor) primary diagnosis code(s) (required)
9. Planned date(s) of service (Patient event date or start/end date for every procedure code) (required)
10. Site of service (11-Office, 22-Outpatient Hospital, 24-Amb Surg Center, 12-Home, 21-Inpatient) (required)
7. Whether request is emergency, urgent or elective (default is elective)
8. ICD-9-CM (or its successor) primary diagnosis code(s) (required)
9. Planned date(s) of service (patient event date or start/end date for every procedure code) (required)
10. Site of service (11-Office, 22-Outpatient Hospital, 24-Amb Surg Center, 12-Home, 21-Inpatient) (required)

The next steps of the workgroup are to explore the following:
- Can the vast majority of prior authorizations be evaluated by payers using a rules engine?
- If yes, what are the clinical data elements necessary to be sent for leveraging a rules-driven assessment with the objective that a request for additional information is not required?
- Will the HIPAA ASC X12 278 Health Care Services Review—Request for Review and Response standard transaction need to be modified to send those data elements?
- What electronic medical record or practice management system changes would enhance this process for physicians with the end objective that prior authorizations flow naturally from clinical activity?
- For automated transactions, should the standard response time be real time (20 seconds or less per the CAQH CORE standard)?[4]
- For the remaining manual review processes, should the standard response time be 48 hours or less?
- In the spirit of administrative simplification, can there be a waiver process for prior authorizations on those services, prescriptions or items for which a physician demonstrates a high approval rate?
- Finally, once payers are comfortable with the rules engines for evaluating prior authorizations, can they be integrated into the clinical workflows by enhancing EHRs and practice management systems to apply these rules concurrent with care delivery as the epitome of administrative simplification?

AMA's "Heal the Claims Process™" campaign

The increasing commitment of national payers to the AMA's "Heal the Claims Process"™ campaign has already been demonstrated in the prior authorization arena. It appears that a consensus will be achieved on an initial 5010 implementation strategy and on the additional work necessary to enhance future versions of the HIPAA ASC X12 278 Health Care Services Review—Request for Review and Response electronic standard transaction. Such enhancements should enable a complete, one-step automated solution for all prior authorization requests. Visit www.ama-assn.org/go/healthatclaim for more information regarding the AMA's "Heal the Claims Process"™ campaign.

The AMA's National Health Insurer Report Card initiative is an effort to improve transparency, and the AMA has requested and received links from participating payers to their prior authorization and/or prior notification information. These links are posted on the AMA website. Visit www.ama-assn.org/go/payerpolicies to access them. The intent of this Web page is to raise awareness of the information available on payer websites and help physicians and their practice staff to easily access their respective health insurers' websites for information. In addition, we believe this effort will increase payers' disclosure of this information on their respective websites.

Federal requirements: HIPAA standardization mandates, code set standards and operating rules

There is a plethora of examples of national and international standards in force in the United States that have demonstrated administrative simplification value. The HIPAA Transaction and Code Set rules mandate standard electronic transactions formats and code sets. Similarly, the Current Procedural Terminology (CPT®) and International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) codes are mandated code sets for use in standard electronic transactions.

The underutilized HIPAA electronic transaction for prior authorization, referred to as the "referral certification and authorization" transaction, or HIPAA ASC X12 278 Health Care Services Review—Request for Review and Response, has not yet demonstrated similar value.

According to section 1104 of the ACA, operating rules that contain the necessary business rules and guidelines for the electronic exchange of information are to be mandated. These operating rules are not to be defined by the standard or its implementation specifications. A set of operating rules for each transaction, including prior authorization, is to be adopted with the goal of creating as much uniformity in the implementation of the electronic standard transactions as possible.

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[4] Visit www.caqh.org for more information about the operating rules of the Council for Affordable Quality Healthcare (CAQH) Committee for Operating Rules on Information Exchange (CORE).

The AMA has been actively participating in the X12 standard setting process and the CAQH CORE operating rule effort to increase the value of this transaction, including evaluating whether it meets the current data reporting needs of payers. As noted above, the National Council for Prescription Drug Programs (NCPDP) prior authorization standard for prescription drug transactions will be discussed in a companion white paper.

The operating rules for the ASC X12 278 prior authorization standard transaction are to be adopted by the Centers for Medicare and Medicaid Services no later than July 1, 2014, and will take effect by Jan. 1, 2016. In addition to consideration of the workgroup effort described above, the AMA suggests that a review of the many state laws which have already been passed to regulate the prior authorization process be considered. These rules express solutions that various legislative and regulatory bodies have found valuable, and they will need to be complied with in the states that have passed them in any event. See Appendix C for the AMA's National Managed Care Contract provision governing the prior authorization process and its citations to the most stringent prior authorization laws in the country. Visit www.ama-assn.org/go/nationalcontract to access the entire National Managed Care Contract database.

State initiatives, laws and legislation

There are numerous state laws and regulations that address challenges with obtaining timely prior authorization. Massachusetts went one step further and enacted Section 57 of Chapter 288 of the Acts of 2010, "An Act to Promote Cost Containment, Transparency and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses." This act seeks to promote administrative simplification in the processing of claims for health care services by carriers. The act directs the Division of Insurance to consult with a statewide advisory commission charged with investigating and studying the relative value of a uniform claims administration system for all payers in the commonwealth. This act requires Massachusetts to "establish a **standard authorization form** to be submitted by health care providers to obtain authorization to provide health care services to a member." Currently, the Massachusetts Authorizations and Referrals Workgroup is working toward defining the scope of standardization: deciding whether to create standard forms for all services requiring prior authorization or a subset, identifying barriers to standardization and wading through more than 150 authorization forms to assist in determining its next steps.

Best practices in the marketplace

The AMA calls for best practices currently in the marketplace to be brought forward. These best practices, once identified, can assist in creating operating rules and enhancements to the standard transactions to address payer/reviewer efficiencies. Operating rules should require that payers/reviewers disclose the data elements they use to make a prior authorization determination so that the HIPAA X12 278 Health Care Services Review—Request for Review and Response standard transaction will contain those data elements, thereby permitting the payer to automate its review process. Even where complete automation is not possible, operating rules should encourage the sender to include as much codified information as possible to expedite the review process. If capturing that additional codified information requires changes to the existing 278 standard, then our recommendations below are augmented by a request to make those changes in future iterations of that standard.

Recommendations

1. The development of a standard uniform prior authorization form that can be submitted to and accepted by all payers in a paper or online format or in the preferred electronic standard transaction is needed.

There should be one standard paper form for submitting a prior authorization request agreed upon by the industry:

> This form should be accessible via a payer's website or designated portal, and it should also be satisfied by a physician's submission of the standard 278 transaction directly from the practice management system. Payers are

encouraged to create the standard form and other prior authorization solutions that do not require extra manual tasks (such as phone calls and website searches) and fit within the physician practice work flow.

The industry should use the ASC X12 278 transaction as the preferred method for submitting and responding to an industry standard electronic prior authorization request.

This standard form, whether on paper or created electronically, should reflect the needs of the health care industry with every effort made to minimize unnecessary, extraneous requests. The form may reflect the needs of a group of services or items for review, or it may be focused on a single procedure or service, with the caveat that every effort should be made to create as few forms as practical.

A single prior authorization set of requirements can potentially yield $6.7 billion per year in savings.[5]

2. Transparency, accessibility and consistent application of prior authorization requirements and restrictions, including a standard definition, are needed.

An entity performing utilization review (utilization review entity), such as a payer, carved out benefit manager or other entity should make any current prior authorization requirements and restrictions readily accessible on its website to subscribers, physicians and the general public. This includes the written clinical criteria.

Requirements should be described in detail but also in easily understandable language. If a utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity should provide contracted physicians written notice of the new or amended requirement or amendment no less than sixty (60) days before the requirement or restriction is implemented.[6]

3. Transparency, accessibility and consistent application of utilization review criteria and clinical expectations are needed

In order to automate prior authorization review, the rules should be uniform across payers for a given medical condition and treatment option so that physicians are not being asked to have varying best practices by payer rather than those made in the best interest of the patient within the realities of benefit limits.

All prior authorization restrictions and adverse determinations and final adverse determinations should be based on clearly accessible, consistently applied and written clinical criteria that are based on the medical necessity or the appropriateness of those services.

4. There should be practical limits on medical record requests, which should in any event be reserved to those cases when there is difficulty determining medical necessity.

In order to reduce excessive manual processes by both the payer and the physician practice, medical record requests should be limited to when difficulty develops in determining the medical necessity or appropriateness of a health care service. In such cases, the utilization review agent should only request the necessary and relevant sections of the medical record, consistent with the privacy limits placed on physicians by HIPAA.

5. Consistent response times and processes with respect to prior authorizations or adverse determinations in non-urgent circumstances are needed to achieve administrative simplification.

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[5] "What Does it Cost Physician Practices to Interact with Health Insurance Plans?," Lawrence P. Casalino et al, *Health Affairs* Web Exclusive, May 2009; w533-543.
[6] *National Managed Care Contract Database*, American Medical Association, accessed July 2011, www.ama-assn.org/go/nationalcontract.

Requirements should be described in detail but also in easily understandable language. If a utilization review entity intends either to (1) implement a new prior authorization requirement or restriction or (2) amend an existing requirement or restriction, the utilization review entity should provide contracted physicians written notice of the new requirement or amendment no less than ninety (90) days before the requirement or restriction is implemented.[7]

If a health insurer requires prior authorization of a health care item, service, test or imaging procedure, the utilization review entity should make a prior authorization or adverse determination, and notify the subscriber and the subscriber's physician or other health care professional under non-urgent circumstances within two (2) working days.[8]

For urgent circumstances, if the determination concerns the extension of an ongoing course of treatment, the utilization review entity should make a prior authorization or adverse determination and notify the subscriber and the subscriber's physician or other health care professional within 24 hours of receiving a preauthorization request from the physician or other qualified health care professional concerning such health care service.[9] If the determination concerns other urgent care services, the prior authorization or adverse determination and notification must occur with 72 hours of receiving a preauthorization request from a physician or other qualified health care professional.[10]

6. Industry consensus efforts should be aggressively pursued to automate the prior authorization processes on behalf of patients and physicians to reduce unnecessary costs.

Building on the workgroup effort described above, this effort must include the development of a health care industry consensus on operating rules and standard transactions, payer and physician workflow expectations, product capabilities, and their associated policies and procedures based on where the health care industry needs to be, independent of legacy system limitations, to reduce prior authorization administrative burdens.

Our first two historical barriers for administrative simplification are quickly unearthed here: the limitations of payer "legacy systems" and the shortcomings of physician practice management systems (PMS). The AMA recommends that both the payer and physician communities need to raise their commitment to adopt the automated solutions necessary to allow true automation of the complete claims revenue cycle, including the prior authorization process.

Many PMSs, and EHRs with integrated PMSs, do not provide the software features and functionalities that are essential to the physician practice to ensure automated claims revenue cycle management. These limitations may become barriers to effective implementation of the enhanced prior authorization processes recommended by this white paper. Therefore, the AMA encourages vendors of PMSs and EHR systems with an integrated PMS to provide the automated solutions necessary to automate prior authorization and the additional critical functionality as more fully described in the AMA and Medical Group Management Association "Selecting a Practice Management System Toolkit."[11]

If the recommendations listed above are implemented by the industry, we will have a prior authorization process approaching what is depicted in Exhibit 5 below. Most of the process in Exhibit 5 is automated starting with the determination of whether or not a prior authorization is required for a particular patient and condition using the ASC X12N 270/271 process and a PMS/EHR value-added rules engine that is built on prior authorization approval rules that

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[7] Tex. Ins. Code Ann. § 843.321; Tex. Ins. Code Ann. § 1301.136; 28 Tex. Admin. Code § 11.901; 28 Tex. Admin. Code § 3.3703; Colo. Rev. Stat. § 25-37-104

[8] Mo. Rev. Stat. § 376.1363(2)

[9] Ky. Rev. Stat. Ann § 304.17A-607(1)(i); NH. Rev. Stat 420-E:4(IV)(b); 28 Rex. Admin. Code § 19.1723(d)(2)

[10] R.I Gen. Laws § 23-17.12-9(a)(1)(ii); see also 29 C.F.R. § 2560.503–1(f)(2)(i)

[11] **AMA practice tip: Toolkit helps maximize practice efficiency in rapidly changing health care environment.** The upcoming transition to the government's modified electronic transaction standards, coupled with the Medicare and Medicaid electronic health record incentive program, will require physician practices to upgrade or replace their current practice management software. To help you select and purchase the most appropriate software for your practice, the American Medical Association (AMA) and the Medical Group Management Association (MGMA) collaborated to develop an online toolkit. Free to members of the AMA and the MGMA, the new "Selecting a Practice Management SystemToolkit" provides a roadmap to make this process easier for your practice. Visit www.ama-assn.org/go/pmsoftware to start taking advantage of this valuable toolkit today.

the payers have fully disclosed (transparency). When "clean" prior authorizations are submitted with all the information necessary to make the determination, it is expected that payers will be able to develop real-time processes to approve or deny the prior authorization request. The occasional manual reviews that may occur are not shown.

Exhibit 5: Next generation prior authorization processes
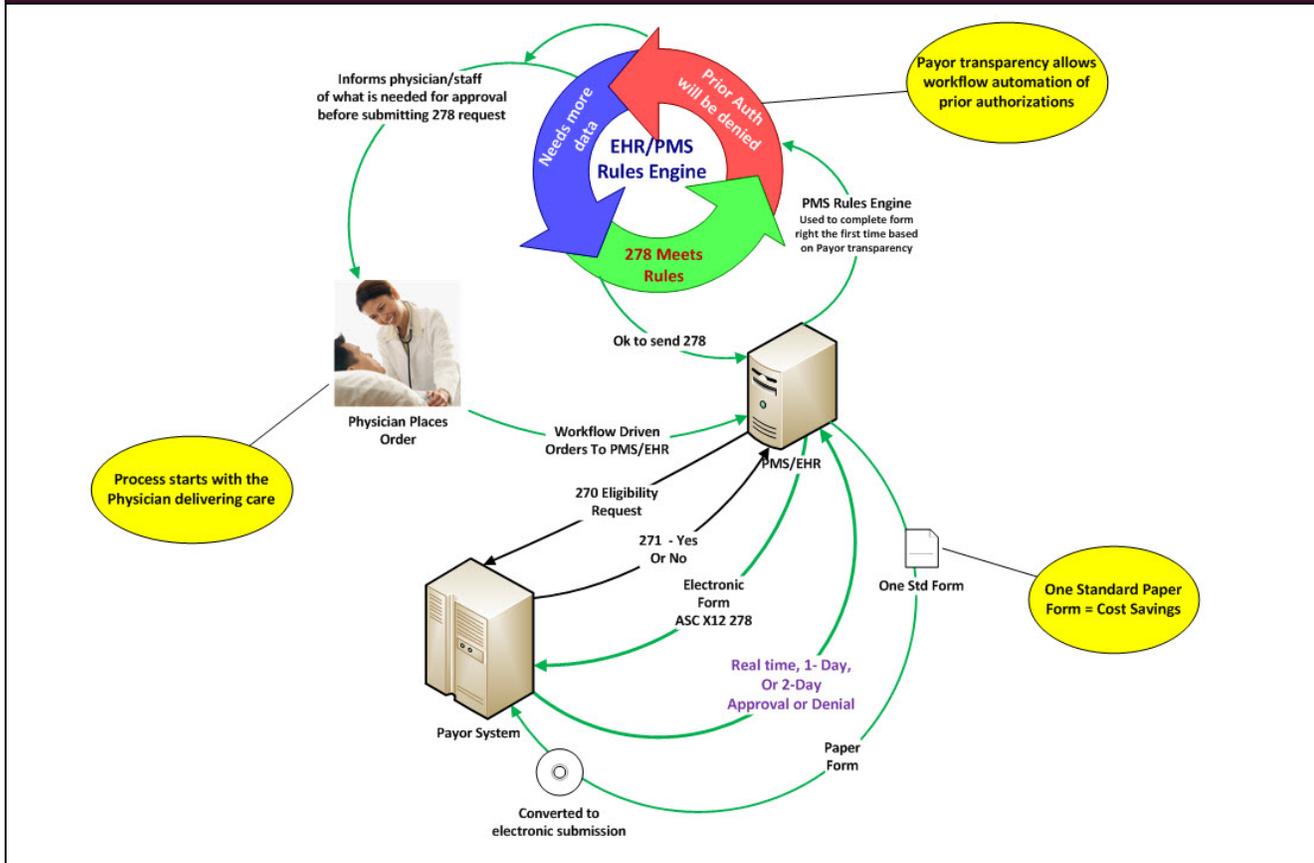
Summary and insights

The process to request prior authorization for procedures and services from payers and/or their agents is disruptive and costly for physicians and their patients. **Prior authorizations cost physicians approximately \$23 billion to \$31 billion each year**.[12] The AMA continues to push for the elimination of significant administrative waste from the health care system by simplifying and standardizing the current health care billing and payment process.

We are assessing why the current prior authorization process is disruptive to the clinical work flows and is so expensive for physicians to perform. As part of this assessment, and in our recommendations for improvement, we will look at past health care reforms for general lessons learned that we can apply to other administrative simplification efforts by the AMA and the industry.

What clearly works is the trust and partnership in care that is seen in the physician-patient relationship. That same approach for establishing a solid foundation of trust, when applied to payers and physicians, is critical for the success of our recommended solutions for prior authorizations. All partners in this process—payers, physicians, vendors,

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[12] "What Does It Cost Physician Practices To Interact With Health Insurance Plans," Lawrence P. Casalino et al, *Health Affairs* 28.4 (2009): w533–w543 at w537.

governmental entities and patients—need to work together in a collaborative, not adversarial way, if we ever want to reduce costs and further improve the quality of our health care delivery system.

For more information on the AMA's administrative simplification agenda, as well as other associated AMA efforts, visit www.ama-assn.org/go/simplify to access the AMA's "Administrative Simplification White Paper" and "Standardization of the Claims Process: Administrative Simplification White Paper."

Appendices
Appendix A: AMA's CMS Report 4-I-10
Appendix B: May 2010 AMA National Prior Authorization Study
Appendix C: States with laws related to prior authorization
Appendix D: Core set of common data requirements for prior authorization requests and placement within ASC X12 278 standard transaction

Appendix A: AMA's CMS Report 4-I-10

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-10

Subject: Standardized Preauthorization Forms
         (Resolution 729-A-10)

Presented by: William E. Kobler, MD, Chair

Referred to: Reference Committee J
           (Kathleen Blake, MD, Chair)

1	At the 2010 Annual Meeting, the House of Delegates referred Resolution 729 to the Board of
2	Trustees. Resolution 729-A-10, introduced by the Organized Medical Staff Section (OMSS), asked
3	that the American Medical Association (AMA) "seek a governmental mandate that requires: 1) All
4	insurance companies to utilize a universal preauthorization form," and "2) A decision on
5	preauthorization that must be received by the provider within 48 hours." The Board of Trustees
6	assigned this item to the Council on Medical Service for a report back to the House of Delegates at
7	the 2010 Interim Meeting.
8	
9	This report outlines physician concerns with the current preauthorization process; identifies efforts
10	to standardize and improve both the electronic and paper preauthorization processes; highlights
11	related AMA activity and policy; reviews potential avenues for additional AMA advocacy; and
12	presents policy recommendations.
13	
14	BACKGROUND
15	
16	Resolution 729-A-10 presented concerns that current preauthorization forms lack standardization
17	among insurance companies resulting in burdensome hurdles for physicians and health
18	consequences for patients. The lack of standardization makes the preauthorization process difficult
19	and time-consuming. The forms can lack clarity and not contain all of the information required by
20	health insurers to fulfill the requested preauthorization, potentially necessitating time-consuming
21	communication for the physician practice with no additional reimbursement. The preauthorization
22	process can also appear to be a delay tactic used by health insurers for financial gain and to
23	discourage physicians from advocating for necessary services.
24	
25	In addition to such hurdles, the preauthorization process can have detrimental health consequences
26	for patients. Some health insurers are requiring preauthorization for an increasing number of
27	routine tests and procedures, resulting in more patient-physician interactions that have health
28	insurer input and subsequent treatment delays. Delays in treatment and interruptions of the patient
29	physician relationship due to the preauthorization process can result in adverse effects on the
30	patient's health. Lengthy preauthorizations can interfere with patient follow-through if patients fail
31	to return for needed medication or treatment. In addition, patients can be subjected to redundant
32	tests due to some preauthorization requirements. Ultimately, the delay of preauthorization can lead
33	to treatment denial, which negatively impacts the patient's care.
34	
35	A study of the time physicians spend interacting with health insurance companies found that
36	physician practice staff reported spending 20 hours per week on average just dealing with

1   preauthorizations (Casalino, 2009). The same study estimated that physician practices spent an
2   average of $68,274 per physician annually for all types of interactions with health insurance
3   companies. The lack of standardized paper forms among health plans and the inconsistent use of
4   the electronic standard transaction for preauthorizations have been the focus of various efforts to
5   improve and streamline both the paper and electronic preauthorization process.
6
7   STANDARDIZING THE PREAUTHORIZATION PROCESS
8
9   The Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) Transaction
10   and Code Set rule mandates standard electronic transaction formats, including preauthorizations,
11   and their implementation guides. The latest completed version of the HIPAA electronic standard
12   transactions, version 5010, was recommended to the Department of Health and Human Services
13   (HHS) for adoption under HIPAA and has been adopted for implementation in January 2012.
14   Although the administrative simplification provisions in HIPAA required the HHS to establish
15   national standards for electronic health care transactions, including preauthorizations, uniformity
16   has been elusive, with individual health insurers creating their own companion guides containing
17   payer-specific transaction rules.
18
19   The Patient Protection and Affordable Care Act of 2010 (PPACA, Public Law 111-148) contained
20   administrative simplification provisions requiring HHS to develop a complete set of requirements,
21   processes and operating rules necessary to electronically submit and receive each HIPAA standard
22   transaction, including preauthorizations. PPACA requires that the operating rules contain the
23   necessary business rules and guidelines for the electronic exchange of information, which are not
24   defined by the standard or its implementation specifications. A set of operating rules for each
25   transaction, including preauthorizations, is to be adopted with the goal of creating as much
26   uniformity in the implementation of the electronic standard as possible.
27
28   The HIPAA electronic transaction for preauthorizations is referred to as the "referral certification
29   and authorization" transaction, or HIPAA ASC X12 278. Under PPACA, health plans must adopt
30   and implement operating rules for referral certification and authorization transactions to be adopted
31   no later than July 1, 2014, to take effect by January 1, 2016. PPACA has mandated that health
32   plans must file a certification statement with the Secretary that their data and information systems
33   comply with the most current published standards, including the operating rules for certain
34   transactions. In addition, penalties will be imposed against health plans for non-compliance with
35   the administrative simplification standards determined by HHS.
36
37   There has been some activity to collaboratively standardize a paper preauthorization form. To
38   date, wide-spread adoption has not occurred. Examples are highlighted in the section entitled
39   "AMA Collaboration with External Organizations" in this report.
40
41   RELATED AMA ACTIVITY AND POLICY
42
43   The AMA has long been committed to supporting administrative simplification efforts specific to
44   the preauthorization process through various avenues, such as the legislative process, collaborating
45   with the federation and external organizations, and developing resources and policy.
46
47   *AMA Advocacy*
48
49   With the passage of PPACA in 2010, the AMA is actively monitoring through the regulatory
50   process the implementation of provisions related to developing uniform guidelines for HIPAA
51   electronic standard transactions, including preauthorizations. The AMA is advocating for uniform

1   standardized rules that do not permit variation between different payers or undermine the goal of
2   administrative simplification. The AMA is advocating for these standardized rules to be developed
3   in a timely manner; in coordination with all the bodies involved in managing and updating the
4   transactions, code sets and standard identifiers; in consultation with representatives of all industry
5   segments; and pursuant to a standards process that engages in total quality management.
6
7   *AMA Collaboration with the Federation*
8
9   The AMA's Private Sector Advocacy (PSA) group is working with the Federation Staff Payment
10 Policy Workgroup, which is part of the Practice Management Federation Staff Advisory Steering
11 Committee. The workgroup is comprised of key staff from state medical associations and national
12 medical specialty societies that have been active throughout the years in raising private payer
13 issues to the attention of the AMA PSA unit. Improving the preauthorization process is part of the
14 workgroup's 2010 objectives.
15
16 Specifically, the Federation Staff Payment Policy Workgroup is seeking to: 1) identify specific
17 physician challenges with health insurers' preauthorization and prior notification requirements; 2)
18 identify the impact these requirements have on patients; 3) reduce administrative burdens
19 associated with preauthorization; and 4) increase health insurers' disclosure of preauthorization and
20 prior notification requirements. The workgroup has surveyed physicians regarding their experience
21 with preauthorization. The survey results revealed that over half of the respondents indicated that
22 it takes several days to receive preauthorization for services and procedures. Eliminating
23 preauthorization hassles and streamlining the process was very important to the majority of
24 respondents. Additional details from this survey will be forthcoming.
25
26 *AMA Collaboration with External Organizations*
27
28 In 2006 the AMA worked with America's Health Insurance Plans (AHIP) to develop and publicize
29 a standardized form for physicians to use to request preauthorization and coverage for non
30 formulary drugs in the Medicare Part D program. The AMA has continued to work with AHIP and
31 the Center for Medicare and Medicaid Services (CMS) to roll-out widespread use of the form.
32
33 In other efforts, the American College of Rheumatology (ACR) developed a preauthorization form
34 that is available on its website. The one-page form was sent to more than 200 insurers for
35 consideration of adoption. Physicians were also encouraged to add the form to their electronic
36 medical records as a print-out option. ACR is a member of the Payment Policy Workgroup and the
37 AMA is hopeful that the Workgroup can expand on such efforts to establish similar uniformity that
38 can be established throughout all specialties.
39
40 As a participating organization of the Council on Affordable Quality Healthcare (CAQH), the
41 AMA strongly supports the efforts of CAQH's Committee on Operating Rules for Information
42 Exchange to develop standard operating rules for electronic transactions. The AMA supports
43 efforts to create a single, binding companion guide for each HIPAA standard transaction, so that all
44 trading partners would be required to implement and interpret all HIPAA electronic transactions in
45 a universal manner, consistent with the administrative simplification provisions in PPACA.
46
47 The AMA is a member organization of X12N-Insurance, which is a group comprised of technical
48 experts from payer, provider and vendor organizations. This group contains workgroups, including
49 a workgroup entitled WG10-Health Care Services Review (278), which was created to determine
50 how to increase the value of the current standard transaction for preauthorizations. Currently,
51 many health insurers respond to this transaction with minimum specificity, if they respond at all.

1   Increasing the value of the information on the electronic preauthorization standard transaction and
2   the use by payers can dramatically reduce the manual effort currently incurred by the practice and
3   the payer.
4
5   The AMA and the Medical Group Management Association (MGMA) collaborated to develop an
6   online toolkit, available at www.ama-assn.org/go/pmsoftware, to help physicians select and
7   purchase the most appropriate practice management system software for their practices. The
8   upcoming transition to the 5010 version of the HIPAA electronic standard transactions, coupled
9   with the Medicare and Medicaid electronic health record incentive program, will require physician
10 practices to upgrade or replace their current practice management software. Free to members of the
11 AMA and the MGMA, the new "Selecting a Practice Management System" toolkit provides a
12 roadmap to make this process easier for the physician practice. This resource can be used to
13 establish a practice's needs and take advantage of recent improvements in automation.
14
15 *AMA Resources*
16
17 The AMA developed the "Health Insurer Code of Conduct: Standards for health insurers'
18 administrative and clinical processes," which sets forth clear and concise principles addressing
19 medical care policies and payment issues. The Code includes two principles related to
20 preauthorization. The administrative simplification principle states that requirements imposed on
21 patients, physicians and other health care providers to obtain approvals and respond to information
22 requests must be minimized and streamlined, and health insurers must maintain sufficient staff and
23 infrastructure to respond promptly. The medical necessity principle addresses urgent care and
24 states that all emergency screening and treatment services (as defined by the prudent layperson
25 standard) provided by physicians and hospitals must be covered without regard to preauthorization
26 or the treating physician's or other health care provider's contractual relationship with the payer.
27
28 A valuable tool aimed at minimizing insurance-related administrative activities is the AMA's
29 "National Health Insurer Report Card" (NHIRC), which is available online at www.ama-assn.org/go/reportcard
30 assn.org/go/reportcard. The NHIRC provides physicians with a reliable source of critical metrics,
31 including one for preauthorization, for seven commercial health insurers and Medicare.
32
33 Another resource, the National Managed Care Contract (NMCC), is a comprehensive contracting
34 tool that offers model contract provisions based on the most physician-favorable managed care
35 statutes and regulations from all 50 states and the District of Columbia. Initially released in 2009,
36 the NMCC was developed by the AMA in consultation with state medical association attorneys
37 with extensive expertise in managed care contracting laws and regulations. The NMCC contains
38 highly-detailed provisions that address many of the concerns physicians face when analyzing and
39 negotiating managed care contracts, and during the subsequent business relationship, including
40 provisions regarding the preauthorization process. Associated with the NMCC is the NMCC
41 Database, which contains the full text of the thousands of state managed care statutes and
42 regulations that were used to develop the NMCC. The contents of the NMCC database are easily
43 accessible through varying search functions (e.g., keyword searches), and searches can be restricted
44 to focus on the applicable laws and regulations of multiple states or even a single state. The
45 NMCC database contains relevant AMA policies and includes issue briefs that provide in-depth
46 discussions of some of the most important physician concerns associated with manage care
47 contracting.
48
49 Although the NMCC contains provisions specifically discussing preauthorization, those provisions
50 do not address all aspects of preauthorization. The AMA is in the process of adding a section to
51 the NMCC that will comprehensively address utilization review, which will include, but not be

1   limited to, preauthorization. The section will be based on all state and federal laws and regulations
2   governing managed care organizations' and health benefit plans' use of utilization review. These
3   laws and regulations will be added to the NMCC database.
4
5   *AMA Policy*
6
7   The AMA has a strong foundation of policies pertaining to preauthorization, utilization
8   management and medical necessity. The AMA advocates that utilization review efforts should
9   focus on outliers rather than on all physicians or all instances of particular services (Policy H-
10 320.950 [1,2], AMA Policy Database). In addition, the AMA strongly supports fair compensation
11 for administrative costs when providing services to managed care patients (Policy H-385.948).
12 Specific to standardized preauthorization forms, Policy H-320.968 [1b] supports the development
13 of model draft state and federal legislation to require disclosure in a clear and concise standard
14 format by health benefit plans to prospective enrollees of information on preauthorization or other
15 review requirements. In addition, Policy H-320.968 [2e] supports the development of draft state
16 and federal legislation to require that review entities respond within two business days to patient or
17 physician requests for preauthorization.
18
19 DISCUSSION
20
21 Through the AMA's PSA group and its work with the Federation Staff Payment Policy
22 Workgroup, the AMA is gaining a comprehensive perspective on the issues facing physicians
23 during the preauthorization process. Results of the Federation Staff Payment Policy Workgroup
24 survey indicate that physicians desire to eliminate the hassles associated with preauthorization and
25 to streamline the process. The Council believes that these results will help guide the AMA's
26 advocacy efforts to simplify and standardize the preauthorization process for physicians and
27 patients.
28
29 While the AMA supports greater adoption of electronic preauthorizations, the Council understands
30 that the adoption of electronic transactions is not realistic for all physicians. Given physician
31 concerns and preliminary efforts to standardize a paper preauthorization form, the Council believes
32 that supporting widespread adoption by health insurance companies of a standardized paper
33 preauthorization form would alleviate some of the burdens physicians face with obtaining
34 preauthorizations.
35
36 While Resolution 729-A-10 refers to a universal preauthorization "form," focusing solely on
37 standardizing paper preauthorization forms independent of the HIPAA standard electronic
38 transaction would impede the automation process. Physicians who submit paper claims are not
39 required by HIPAA to implement electronic standard transactions, although health insurers are
40 mandated to do so. HIPAA does require any physician who chooses to transmit these transactions
41 electronically to comply with the HIPAA standards. Some health insurers still have not adopted all
42 of the standard transactions, although the AMA strongly encourages the use of standard electronic
43 transactions by both physicians and health insurers. Accordingly, the Council believes that the
44 AMA should publicize and support the PPACA mandated adoption of HIPAA electronic standard
45 transactions by health plans and encourage adoption of HIPAA electronic standard transactions by
46 physicians.
47
48 The AMA will continue to work through the regulatory process to include physician concerns
49 regarding HIPAA electronic standard transactions as the relevant administrative simplification
50 provisions in PPACA are implemented. Specifically, the Council believes it is important for the

1   AMA to actively support efforts to develop clear and complete requirements for each HIPAA
2   electronic standard transaction.
3
4   Policy H-320.968 [2e] supports the development of draft state and federal legislation to require that
5   review entities respond within two business days to patient or physician requests for
6   preauthorization. The Council believes that this policy addresses the request in Resolution 729-A-
7   10 for the provider to receive a decision on a preauthorization within 48 hours and therefore
8   suggests that it be reaffirmed. AMA policy is routinely reviewed for relevant implementation
9   opportunities in the context of AMA advocacy efforts. With respect to preauthorization policies,
10   the AMA's Advocacy Resource Center is developing model legislation regarding the appropriate
11   use of preauthorization that includes language pertaining to providers receiving a decision on a
12   preauthorization request within 48 hours.
13
14   Policy H-385.948 supports fair compensation for a physician's administrative costs when providing
15   service to managed care patients. The Council believes that this policy should be reaffirmed to
16   highlight and direct the AMA's focus on ensuring fair compensation for administrative costs.
17
18   RECOMMENDATIONS
19
20   The Council on Medical Service recommends that the following be adopted in lieu of Resolution
21   729-A-10 and that the remainder of the report be filed:
22
23   1.   That our American Medical Association support the simplification and standardization of
24   the preauthorization process for physicians and patients. (New HOD Policy)
25
26   2.   That our AMA support the adoption of a standardized paper preauthorization form by
27   health plans for those physicians who choose to submit paper preauthorization forms.
28   (New HOD Policy)
29
30   3.   That our AMA publicize and support the legislatively mandated adoption of HIPAA
31   electronic standard transactions by health plans and encourage adoption of HIPAA
32   electronic standard transactions by physicians. (New HOD Policy)
33
34   4.   That our AMA support efforts to develop clear and complete requirements for each HIPAA
35   electronic standard transaction. (New HOD Policy)
36
37   5.   That our AMA amend Policy H-320.968[2e], which supports the development of draft
38   state and federal legislation to require that review entities respond within ~~two business days~~
39   48 hours to patient or physician requests for preauthorization. (Amend HOD Policy)
40
41   6.   That our AMA reaffirm Policy H-385.948, which supports fair compensation for a
42   physician's administrative costs when providing service to managed care patients.
43   (Reaffirm HOD Policy)

Fiscal Note: Staff cost estimated to be less than $500 to implement.
References are available from the AMA Division of Socioeconomic Policy Development.

Appendix B: Federation Survey of Prior Authorization Experiences Summary

AMA survey of physicians on prior authorization requirements
May 2010

Hassle factor related to prior authorization requirements
Nearly all physicians report that eliminating hassles caused by insurer prior authorization requirements is very important (78%) or important (17%).

Preference for an automated prior authorization process
Three-quarters (75%) of physicians said an automated prior authorization process would help them manage patients' care more efficiently.

Vague prior authorization requirements
Nearly two-thirds (64%) of physicians report it is difficult to determine which test and procedures require prior authorization by insurers. More than two-thirds (67%) of physicians report it is difficult to determine which drugs require prior authorization by insurers.

Wait times with prior authorization requests
Nearly two-thirds (63%) of physicians typically wait several days to receive prior authorization from an insurer for tests and procedures, while one in eight (13%) wait more than a week. More than two-thirds (69%) of physicians typically wait several days to receive prior authorization from an insurer for drugs, while one in ten (10%) wait more than a week.

Obtaining approval on prior authorization requests
Nearly half (46%) of physicians experience difficulty obtaining approval from insurers on 25 percent or more of prior authorization requests for tests and procedures. More than half (58%) of physicians experience difficulty obtaining approval from insurers on 25 percent or more of prior authorization requests for drugs.

Insurer review of first-time prior authorization requests
Nearly half of physicians (43%) report that first-time prior authorization requests are "often" reviewed by an insurer representative without medical training.

Insurer rejections of first-time prior authorization requests
More than one-third (37%) of physicians experience a 20 percent rejection rate from insurers on first-time prior authorization requests for tests and procedures. More than half (57%) of physicians experience a 20 percent rejection rate from insurers on first-time prior authorization requests for drugs.

Appealing insurer rejections of first-time prior authorization requests
More than half (52%) of physicians report appealing 80% or more of insurer rejections on first-time prior authorization requests for tests and procedures. Nearly two-fifths (39%) of physicians report appealing 80% or more of insurer rejections on first-time prior authorization requests for drugs.

The national online survey of 2,400 physicians was conducted in May 2010. The survey asked a representative sample of physicians about their experiences with prior authorization and prior notification programs of health insurers.

Appendix C: States with laws related to prior authorization

There are more than 100 laws related to utilization review and prior authorization that are in effect in the following 31 states:

1. Alabama	17. Nebraska
2. Arizona	18. New Hampshire
3. California	19. New Jersey
4. Colorado	20. New Mexico
5. Connecticut	21. New York
6. Florida	22. North Carolina
7. Illinois	23. North Dakota
8. Kentucky	24. Ohio
9. Louisiana	25. Oklahoma
10. Maine	26. Oregon
11. Maryland	27. Pennsylvania
12. Massachusetts	28. Rhode Island
13. Minnesota	29. Texas
14. Mississippi	30. Virginia
15. Missouri	31. Washington
16. Montana	

AMA members and Federation staff can visit www.ama-assn.org/go/nationalcontract to access the state laws in the AMA's National Managed Care Contract (NMCC) Database. Please note that this resource is only available to AMA members and Federation staff.

The NMCC database contains model contract language, issue briefs on important managed care topics, AMA policy and the full text of all individual managed care state and federal laws, including those related to prior authorization.

Prior authorization contract terms in the NMCC are outlined in Article 13: Utilization Review. To access this section, navigate to the table of contents located on the left-hand side of the database and select "II. National Managed Care Contract" → "B. Articles" → "Article X111 Utilization Review." When you select any section in the table of contents, it will expand to display the complete content of that section, enabling you to hyperlink directly to the section you are interested in.

To look up individual state laws on prior authorization, go to the search function and select "State Law Text – Incorporated and Related." You can search by state, keyword or citation.

You can also perform searches of state statutes and regulations for one state, all states or multiple states of your choice—as many as five states at once.

Access the NMCC's user guide for more information on how to conduct searches and use the NMCC database.

Appendix D: Core set of common data requirements for prior authorization requests

	Core set of common data requirements for prior authorization requests	Required or Situational	Included in HIPAA 4010 278 standard transaction	Included in HIPAA 5010 278 standard transaction	Included in HIPAA 6020 278 standard transaction	HIPAA 5010 standard transaction field
1	Patient demographics	R	Yes	Yes	Yes	Loop 2000C/Loop 2000D Member identification is always required. Loop 2000C is always required. Loop 2000D is only required for dependent requests.
1A	Is this request for a subscriber or dependent?	R	Yes	Yes	Yes	2000C/D NM101/102
1B	Patient name (customer/member)	S	Yes	Yes	Yes	2000C/D NM103/04 Only required when needed by the UMO to identify the member.
1C	Patient ID number (customer/member)	R	Yes	Yes	Yes	2000C NM108/109
1D	Patient date of birth (customer/member)	S	Yes	Yes	Yes	2000C/D DMG02 Only required when needed by the UMO to identify the member.
2	Requesting provider demographics	R	Yes	Yes	Yes	Loop 2000B Identification of who is making the request is always required.
2A	Is this request from a provider or facility?	R	Yes	Yes	Yes	2000B NM101/102 Qualifier needed to determine if the requestor is a Provider (Person), or Facility (Non-Person Entity). In most cases, this is not entered by the requester submitting the request but hard coded behind the scenes.
2B	Requesting physician or health care professional name	S	Yes	Yes	Yes	2010B: NM103-NM107 Only required when needed by the UMO to identify the requester.
2C	Requesting physician or health care professional ID number	R	Yes	Yes	Yes	2010B: NM108-NM109 **NPI** should only be utilized unless the submitter is considered a non-healthcare entity.
2D	Requesting physician or health care professional contact telephone number	S	Yes	Yes	Yes	2010B: PER01-PER05 Required when the UMO must direct requests for additional information.
3	Service provider demographics *This information can be repeated multiple times for identification of all*	R	Yes	Yes	Yes	Service providers can be identified in either Loop 2000E or Loop F Identification of who is completing the services and their specific role in the care is always required by either method:

	the rendering provider roles.					• Identification by using the Provider/Facility ID number • Identification of a Specialty (taxonomy code) [see 3D] *Example: Some payers offer the option to allow a referral to a specific specialty versus identifying a specific provider. In these instances, instead of requiring the NPI of a provider, the request would be populated with a taxonomy code (207RC0000X =Cardiology). Meaning the request would be valid to any participating Cardiologist.*
3A	What is the role of the rendering provider or facility?	R	Yes	Yes	Yes	2010E/F: NM101/102 Qualifier needed to determine the role of the Service Provider (Attending, Admitting, Facility, or Service Provider etc.) and if they are a (Person), or Facility (Non-Person Entity). In most cases this information is already provided by an input screen. *Example: An input screen would have a section named Attending Provider ID# and the provider would just enter the ID# of the rendering provider.*
3B	Rendering physician or health care professional name	S	Yes	Yes	Yes	2010E/F: NM103-107 Only required when needed by the UMO to identify the Rendering Provider. *Not used if the request is to a specialty [see 3D]*
3C	Rendering physician or healthcare ID number	S	Yes	Yes	Yes	2010 E/F: NM108-NM109 **NPI** should only be utilized unless the rendering provider is considered a non-healthcare entity. *Not used if the request is to a Specialty [see 3D]*
3D	Type of specialty being requested	S	Yes	Yes	Yes	2010 E/F: PRV01-03 Only required when a service provider has not been identified by using an ID #. In most instances these are referral requests to a specialty versus an individual provider. Most payers will require the ID# of the provider completing the services.
4-10	Service demographics	R	Yes	Yes	Yes	Loop 2000E and/or 2000F Identification of what services are being requested to include when and where they are being performed is always required.
4	Type of request	R	Yes	Yes	Yes	2000 E/F UM01/UM02 Required to identify if the request is for an admission, health services, or for a referral. It is also required to indicate if it is an initial request, an update to a previous request, appeal, etc.
5	Site of service	R	Yes	Yes	Yes	2000 E/F UM04 Utilize the industry Place of Service options: 11-Office, 22-Outpatient Hospital, 24-Ambulatory Surgical Center, 12-Home, 21-Inpatient, etc.

6	Level of service	S	Yes	Yes	Yes	2000 E/F UM06 Only required when the level of service is not considered "Routine". In most cases preauthorization requests are not routine. Values include: Emergency, Elective, or Urgent
7	Admission Date	S	Yes	Yes	Yes	2000E: DTP01/02 Required for all admission requests.
7A	Service dates	S	Yes	Yes	Yes	2000E/F : DTP01/02 *Procedure Dates are captured within the HI segment in Loop 2000F in the 4010 version.* The Patient Event Date or the Service Date (if different than the Patient Event Date) is required if known. In most instances the payers will require a date when the services will be completed for all non-admission requests.
8	Patient diagnosis	S	Yes	Yes	Yes	2000E: HI01-2 to HI12-2 Required when known. Up to 12 different diagnosis codes can be submitted. ICD-9 will be allowed until ICD-10 is required. In most instances the payers will require a diagnosis code for all preauthorization requests.
9	Type of procedure, or service being requested	S	Yes	Yes	Yes	2000F: SV1 Or 2000E/F UM03 Required when specific services are being requested. Requesting professional services can be captured using a specific procedure code (HCPCS) at the 2000F loop. The standard also allows the ability to request specific Service Types using the UM03 when a procedure code is not valued. *Example: A request may be submitted using an actual procedure code for a specific diagnostic X-Ray, or the same request may come in with a UM03 value= 4 (Diagnostic X-Ray). In most instances the payers will require a specific procedure code for all non-admission requests.*
10	Unit/volume of procedure, or service being requested	S	Yes	Yes	Yes	Required when requesting services with a specific delivery pattern. In most instances the payers will require a need to know how many visits are being requested, or how many days are expected for the admission requests.