

## THE OFFICE

## Dealing With Prior Authorization

Since passage of the health care reform bill in March, there has been considerable discussion in medical periodicals, forums, and blogs about the dramatic changes that will be taking place.

At least one thing—prior authorizations—will not change, because the legislation did not address it.

Lawmakers have offered no public explanation for ignoring such a glaring problem. It should have been obvious, even to them, that requiring physicians to ask permission, over and over, for necessary tests and treatments is senseless and inefficient.

Common sense dictates fixing something so universally hated by doctors and patients alike. One can speculate that the third party in the physician-patient equation—insurers—had a lot to do with this oversight.

Insurers love prior authorization because it saves them money. In fact, it's one of the most effective cost-cutting tools in their box: rationing through inconvenience. So it's logical to speculate that they probably used their considerable input into the reform law's content, via their army of lobbyists, to discourage action.

So, prior authorization will remain a problem for the foreseeable future, and we need to deal with it as best we can.

First and foremost, minimize the wasted time prior authorizations cause you and your staff. My office took a major step toward this goal by banning all submissions by telephone.



BY JOSEPH S. EASTERN, M.D.

A single prior-authorization phone call can easily take 30 minutes of staffers' time as they fight through the automated greetings and category selections, and wait on hold before finally speaking to somebody with a pulse. At that point, since the person is hardly ever authorized to give approval, they get another department's number or a faxed form. It's an inexcusable and outrageously expensive waste of time.

When a request for preauthorization comes in, we call the patient and ask that he or she make the call to the insurance company to request the form.

I have mixed feelings about passing along the automated phone-hoop hassle to patients, but it is their insurance, after all, and this is one area where I simply can't afford the luxury of providing a time-consuming service for free. Plus, it gives patients some understanding of

the absurdity of the whole prior-authorization game.

When possible, we enlist the help of any other parties at our disposal. Some insurers will accept prior-authorization requests from pharmacies, which makes a lot of sense. They typically have a complete record of all medications tried and failed, as well as the necessary diagnosis codes.

Unfortunately, many insurers inexplicably insist that only the physician's office submit the request, but it's worth your time to ask if the company in question accepts pharmacy filings, rather than assuming it doesn't.

Also, don't forget that manufacturers of some medications (biologics, for example) will help with some, or all, of the prior-authorization burden. Sometimes they have an auxiliary company set up just for that purpose.

If not, a representative or district manager may be able to help or point you toward someone who can. It never hurts to ask.

Also, most pharmaceutical companies have a "compassion" program that provides medications free when the insurer will not pay and the patient can't afford it.

Other potential allies are the big-box chains that offer selected medications at \$4 (or less) per prescription. Sometimes,

the most efficient solution is to point the patient toward Walmart, Costco, Target, or another chain in your area, and forget the preauthorization altogether.

The key is to get the insurance company's form. Not only do you avoid the phone runaround, but the form tells exactly what that particular company wants, so your staff won't waste time finding and supplying information that is not needed.

What about patients who request prior authorization for medically unnecessary medications?

In my office, that's usually a retinoid prescription for wrinkles. I tell them it's against the law to say a treatment is necessary when it is not, and that there is zero chance their insurer will pay. (As a diplomatic friend of mine puts it, "Your insurance company barely cares if you are dying, let alone how you look!") I tell them I will not be able to go to bat for older patients with recalcitrant acne who really need retinoids, if I try to slip cosmetic prescriptions past insurers. Most understand. ■

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## New Health Plans to Offer Free Preventive Services by Law

BY MARY ELLEN SCHNEIDER

New health plans will soon be required to offer a range of recommended preventive health services to patients free of charge under the Affordable Care Act.

The requirements will affect new private health plans in the individual and group markets starting with plan years that begin on or after Sept. 23.

The Health and Human Services department estimates that in 2011, the rules will impact about 30 million people in group health plans and another 10 million in individual market plans. The rules do not apply to grandfathered plans.

The administration released an interim final regulation detailing the new requirements on July 14.

Under the final rule, health plans may not collect copayments, coinsurance, or deductibles for a number of recommended preventive services. However, they may collect fees for the associated office visit if the preventive service wasn't the primary purpose of the visit.

Patients may also incur cost sharing if they go out of network for the recommended screenings.

**Covered services include screenings for breast and colon cancer, diabetes, blood pressure and cholesterol, and vitamin deficiencies during pregnancy.**

The covered services include those given an evidence rating of "A" or "B" from the U.S. Preventive Services Task Force. Those services include breast and colon cancer screenings, diabetes screenings, blood pressure and cholesterol testing, and screening for vitamin deficiencies during pregnancy.

Tobacco cessation counseling is also given a high evidence rating by the U.S. Preventive Services Task Force and would be covered under the new rule.

Health plans will have some extra time to begin

covering newly recommended services. For recommendations that have been in effect for less than a year, plans will have 1 year to comply after the effective date, according to the interim final rule.

Health plans will also be required to cover the list of adult and childhood vaccines recommended by the Advisory Committee on Immunization Practices.

For children, the rule also requires health plans to cover all preventive care recommended under the Bright Futures guidelines. The guidelines include

screenings, developmental assessments, immunizations, and regular well-child visits from birth to age 21 years. These guidelines were developed jointly by the Health Resources and Services Administration and the American Academy of Pediatrics.

The rule calls for coverage of additional preventive services for women, which will be developed by an independent group of experts. The recommendations from that group are expected by Aug. 1, 2011.

There was no word from the HHS on whether those recommendations are likely to include coverage for contraceptives, something many reproductive health advocates

have been lobbying for in recent months.

HHS officials expect that the move to expand coverage and eliminate out-of-pocket costs for these services will decrease costs for many Americans, especially those at high risk for certain health conditions. At the same time, the change is expected to increase premiums for enrollees in non-grandfathered plans. The federal government estimates that premiums in the affected plans could increase about 1.5% on average.

A list of the recommended preventive services is available online at [www.healthcare.gov/center/regulations/prevention/recommendations.html](http://www.healthcare.gov/center/regulations/prevention/recommendations.html). ■

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