# Maine Medical Association



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TO: Committee on Health Coverage, Insurance and Financial Services

FROM: Dan Morin, Director, Communications and Government Affairs

DATE: May 2, 2023

**RE:** **SUPPORT – LD 796,** An Act Concerning Prior Authorizations for Health Care Provider Services

The Maine Medical Association is Maine's largest professional association representing over 4,300 current and future physicians from all specialties in all practice settings.

Health plans are increasingly requiring physicians to obtain prior authorization before providing medical services and prescription drugs.

Prior authorization not only requires the practice to expend significant clinical and administrative resources, but more importantly can interrupt, delay, and even prevent patient care.

Obtaining prior authorization is often manually completed by the practice using the phone, fax, mail, or via a health plan proprietary web portal.

Further complicating the process, health plans typically have different medical necessity requirements, and the authorization submission and appeals process varies across payers.

According to the Medical Group management Association, 89 percent of practices nationwide report having hired or redistributed staff to work on prior authorizations due to the increased requests. Nearly half have hired full-time staff for prior authorizations, nearly 1 in 3 redistribute existing staff, and 11 percent have hired part-time staff.

- 89 percent report challenges with delays
- 75 percent report inconsistent payer payment policies
- 73 percent report requests for **routinely approved items and services**.

- 95 percent report delays and denials for medically necessary care due to prior authorization

Since prior authorization requirements are disruptive and burdensome for physician practices and their patients, the Maine Medical Association is urging you to vote LD 796 Ought to Pass.

Thank you for considering our comments.

**Attachments:**

- Compilation of MMA member examples
- American Medical Association Issue Brief

# LD 796 – An Act Concerning Prior Authorizations for Health Care Provider Services

## Summary of sponsor's amendment

**Definitions**: Creates definitions of "closely related service", "course of treatment", "prior authorization", and "urgent health care service" would be created. The definition of "emergency services" would be amended to include prehospital care transportation services. The definition of "utilization review" would be amended to include prior authorization, and concurrent review would be amended to include payment will be made for that service.

**Adding 'noncertification'**: A noncertification means that a proposed course of treatment is not medically necessary.

Insurer would have to ensure that a physician issuing a '**noncertification**' is,

- Currently licensed in the State in the same specialty as the doctor providing the health care services in the request and
- Has experience treating patients with the identified medical condition. The noncertification would be issued under the clinical direction of one of the insurer's medical directors. Notice would be required to covered person if an insurer was questioning medical necessity, and the provider would be allowed to speak with the doctor performing the utilization review determination.

**Utilization Review (UR)**: Insurers or utilization review organizations (URO) would be required to evaluate clinical review at least annually, previously was periodically. An insurer's clinical review would have to meet five specified criteria.

**UR list of health care services**: An insurer would maintain a list of health care services for which utilization review is required.

**UR based on type of health care**: Prospective and concurrent utilization review determinations are required to be communicated within three business days after receiving necessary information. Utilization review determination would be made as follows after obtaining all necessary information.

- Within 48 hours for non-urgent health care services,
- Not later than 24 hours for urgent health care services, and
- Within 60 minutes of receiving a request for emergency services that require immediate post-evaluation or post-stabilization services. It would specify further requirements for utilization review of emergency services.

**Additional information request**: Specifies the information an insurer must communicate to a provider when requesting additional information for a utilization review. An insurer would be required to adjudicate any claim subject to a request for additional information to process a claim under prompt pay act.

**UR determination notifications**: An insurer would be required to make a concurrent review determination within 24 hours of obtaining all necessary information. An insurer who fails to make a determination within the applicable time frame would be deemed to have approved the request.

**Retrospective denial**: An insurer could not revoke, limit, condition, or restrict a utilization review determination pursuant to a utilization review within 45 business days from the date the provider received the determination unless any of the exceptions apply.

**Notice of noncertification and appeal**: A written notification of noncertification would be required to include the name and medical specialty of all medical doctors involved in the noncertification. All appeals would be reviewed by a physician who meets specified criteria. The physician must consider all known clinical aspects of the health care service under review.

**Disclosure for review and statistics**: Requires an insurer to post on its website current utilization review requirements in an easily understandable language, and the website must be updated with any changes.

Written notice of the new or amended requirements would be provided to contracted providers no less than 60 days prior to implementation. Insurers would make utilization review statistics regarding approvals and noncertifications available on their website for specified categories.

**Utilization review determination validity**: A utilization review determination would be valid for the entire duration of the approved course of treatment and effectiveness regardless of any changes in dosage for a prescription drug.

**Continuity of care**: The following would apply to ensure continuity of care:

- Requires an insurer to honor a utilization review determination granted to the covered person from a previous insurer with certain parameters,
- A change in coverage or approval criteria for a previously authorized healthcare service will not affect a covered person who received a utilization review determination before the effective date of the change for the remainder of the covered person's health benefit plan year,
- Requires coverage of a service previously granted under a utilization review if a covered person changes under the same insurer, with certain provisions,
- If a provider performs a health care service closely related to the service for which approval has already been granted, an insurer may not deny a claim for the closely related service for failure of the provider to seek or obtain a utilization review if the provider meets notification requirements; and
- Prohibits an insurer from restricting specified benefits related to childbirth.

**Exemptions**: A utilization review is not required if, within the past 12 months, the insurer has issued certifications to the provider for no less than 80% percent of the utilization review requests for that health care service, then an insurer may not require the provider to request a utilization review.

- Once every 12 months, this exemption would be evaluated by the insurer. A provider would not be required to request an exemption, and an insurer may only revoke an exemption under certain circumstances.
- A provider who doesn't receive an exemption would be able to request evidence of why from the insurer.
- A time frame would be specified for how long an exemption remains in place past an insurer's decision to revoke the exemption.
- Decisions on exemptions would be made by providers licensed in the State with the same or similar specialty as the provider being considered for the exemption and with experience in providing the services for which the potential exception applies.
- An insurer who receives an exemption would be provided specified notice. An insurer could not deny or reduce payment for a health care service exempted from utilization review requirement unless certain circumstances occur.

**Deemed approval**: Any failure to comply by an insurer would result in health care services subject to review automatically being deemed authorized by the insurer.

Maine Medical Association

Erik N. Steele, DO, President | Paul R. Cain, MD, President-Elect | R. Scott Hanson, MD, MPH, Chair, Board of Directors
Andrew B. MacLean, JD, CEO | Dan Morin, Director of Communications & Government Affairs

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**RE: LD 796, An Act Concerning Prior Authorizations for Health Care Provider Services**

**Maine Medical Association Examples**

I am writing because as both of you know, prior authorizations are slowly destroying our primary care offices and have gone so far as to cause direct harm to patients. I heard through the weekly email MMA updates that there is a bill, as I understand a concept draft, to help reform the prior authorization process.

I have a patient case that just happened this last week that I think perfectly and emotionally sums up the issues with prior auths in current practice. I am also happy to lend a boots on the ground viewpoint, as everyone in my office literally jumped with joy when they heard someone is trying to work to make this system better.

Here is my patient case:
My patient is a young woman who just delivered a baby. She unfortunately needed an emergency C-section, but this resulted in the delivery of a beautiful healthy baby boy. A week after delivery she then contracted COVID, and subsequently had an acute bilateral pulmonary embolism. She was hospitalized due to the severity of the blood clot, a heartbreaking experience for a brand-new mother to be separated from her newborn.

Luckily things went well and she was discharged home, healthy and reunited with her baby. The hospital and a hematology consult determined that Lovenox, a blood thinner that was FDA approved over 22 years ago, was the first line treatment for her as she is actively breastfeeding. Her insurance gave her difficulty covering her 7 day script to bridge to my office visit. At my office visit I clearly documented her diagnosis and reasons for choosing Lovenox, and sent in the script

for the 6 months of lovenox needed. Of course a prior authorization was requested.

This prior authorization was denied due to "quantity limit." They would only cover 24 syringes out of a 65 day supply, which equates to approximately 15 days of treatment (hematology recommended 180 days of treatment). Over the course of 10 days our office submitted two emergency prior authorization requests, spent hours on the phone with the pharmacy and with her insurance company trying to find a way to appeal their decision.
Ultimately after much contradictory information we were given a new form to override the "quantity limit," a 5 page form that only the physician was allowed to fill out. This was finally accepted today, 10 days after my original prescription, and my patient can finally receive her old, inexpensive, first line, life saving medication.

Of note, at one point she was quoted a $300 out of pocket price from the pharmacist, which she would have been forced to pay for her health should we not have gotten this covered today, as the emergency scripts the pharmacist kept authorizing had just run out. We do not understand why prior auths, a concept originally designed to control costs and help doctors choose cheaper safer alternatives, is now being used to avoid paying for even inexpensive life saving medication.

I would also like to note that my patient is a social worker, and has a passing interest in healthcare advocacy. She gave me permission to share her story today, and if it would help she is willing to bring her story public and testify, especially if it has a chance of stopping insurance companies from hurting other patients in this manner. She and I acknowledge that she had the financial means to pay $300 out of pocket if worse came to worse, but many patients do not have the means or the knowledge to navigate a system like the one above, and likely would not have been able to get this medication covered.

Thank you for your time, and let me and my patient know if we can help change the prior authorization crisis in the state of Maine.

A patient of mine had unexplained neck / back pains that persisted and worsened over several months. An MRI was ordered, as she had failed to improve with PT and had a history of cancer >15 years ago.

After 2 weeks of waiting the MRI was ultimately denied with the option of a peer to peer appeal. Due to staffing issues and an incredibly busy office this then delayed the MRI another month, as it is very difficult to find the time for a peer to peer, especially for an MRI that should have been approved in the first place.
Two months after the original MRI order and continued refusals from her insurance company, she finally presented to the ED recently and was found to have metastatic cancer to multiple bones, which was the cause of her pain.

This is an insurance company delaying the diagnosis of cancer by over 2 months, which could make the difference between life and death for this patient.

I really do feel we need to dismantle the whole prior authorization structure. Simply enforcing new guidelines to follow, like easier documentation or transparent reasons, will not actually stop the for-profit systems trying to deny claims to make a profit.

Mass automatic denials will continue to happen as long as we permit a system that allows an insurance company to unilaterally deny the decision made by a physician and a patient. The proof of denial should be on the insurance company, not on the provider or the patient.

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I am a medical assistant. I once had an older patient who needed a new oxygen supply. In order to accommodate the PA, she needed to have an oxygen reading below 90%.

She had to take her oxygen tank off and walk in circles around the clinic with an ox meter on her finger until we got the reading we needed. It was hanging at 90% and I just wouldn't go down

that 1% we needed. We walked and walked until she was gasping for air and could not go one more step. It was right at that point of giving up that the meter finally read 89% and I could document that it was under 90%.

I feel like the PA process led me to do harm, which none of us should have to do.

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I am emailing in response to the request for prior authorization request stories.

I recently shared this with our office manager and thought that it may be helpful to this situation as well.

I originally sent this to her last week and today when I came in there was a 4th denial reviewed by the same physician at NIA that denied a request for testing.

The most frustrating thing for me is the fact that the wording of the denial letter makes it sound like they did not receive clinical information to review in order to make an educated well informed decision which is very much so not the case as you can see by the attached examples.
The denial letters are mailed out to the patients in a deceiving way to take away confidence in their physician and staff, it is very sad. I hope that this is useful.

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I will preface this by saying that I have watched insurance companies steadily engage in more and more denials but it has become absolutely unbelievable over the past 12 months.

The most challenging offenders definitely seem to be the Medicare Advantage plans for some reason.

A few recent examples from my own patient panel:

1. I had a patient recently present with a 50 pound weight loss over the past year. He was quite weak and sick. Subsequent work-up with xray and chest CT revealed a mass in his lung that is almost certainly lung cancer. I ordered a PET scan to better characterize and stage the suspected cancer which is absolutely the standard of care. His insurance company denied the PET scan and we are currently engaging in an appeal process. We cannot get a biopsy to define the cancer or start treating the cancer until the PET scan is done.
His care and his treatment for his cancer is absolutely being delayed which could result in shortening his life span.

2. I had a patient present with a cough ongoing for several months, chest x-ray was negative. I ordered blood work and a CAT scan of his chest. When the blood work came back it showed that he had abnormalities in his liver function tests and abnormalities indicating potential inflammation/infection.

In order to expedite the work-up I ordered a CAT scan of his abdomen and pelvis to be done along with a CAT scan of his chest. His chest CAT scan was approved but the CAT scan of his abdomen and pelvis was denied because I was told to get an ultrasound first as this is a less expensive test.

I ordered the requested liver ultrasound and the patient's liver function tests continue to increase making me quite concerned that there was an abdominal issue ongoing.
When the ultrasound came back negative, I then ordered the CAT scan of his abdomen and pelvis but it was denied because there had been a denial within the past 60 days, even though the test was totally indicated at this point.

I ended up having to order an MRI of his liver because that was the only test I could order without waiting 2 months.

In this case the denial resulted in more expensive care and a big delay in care.

3. I recently had a patient who had a subcutaneous mass on his shoulder. Ultrasound was

ordered which is entirely appropriate. The ultrasound showed either a cyst versus possible malignancy and the radiologist recommended a CAT scan or MRI. I ordered a CAT scan but it was denied stating that I needed to get an x-ray first.

There is absolutely no way an x-ray is indicated in this situation, the mass was subcutaneous and not in the joint space or in the bone. I called to do a "peer to peer" and discussed the situation with a physician representative at the patient's insurance company. The physician refused to approve a CT scan or MRI stating that the x-ray was the best test, flagrantly untrue. I have since ordered the x-ray which did not show any new findings and has recommended getting a CAT scan or MRI which we are in the process of obtaining. Again this patient could very well have a malignancy and his care has been delayed by weeks through this process. Plus he had the unnecessary expense and time of getting an x-ray that was not indicated.

The amount of time that both my staff and I have spent on these issues alone adds up to hours and hours. Every single provider has multiple examples just like this. It is a giant waste of medical resources as well as an enormous contributor to provider burnout having to do all of this.

Happy to provide more information if needed.

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I manage our Endocrinology & Diabetes and Rheumatology practices, both spend significant amount time managing medication prior authorizations.

**Example 1 –**

The RN spent over 5.5 hours last week submitting prior auths and filing appeals for biologics to manage patients with a wide array of connective tissue/rheumatoid diseases. She started to build a spreadsheet (see attached) listing by drug class, and the step therapy required by various insurance company. Her initial thought was to gather all this information in one spreadsheet so the provider could easily choose the right medication for their patient's treatment plan. It would

also streamline the process for the RN and MA to submit the prior auth. What our RN discovered is that the insurance companies change their criteria and formularies throughout the year and it's difficult to keep up with the changes.

We have a patient with severe Systemic sclerosis who needs a lifesaving infusion drug. It took 13 business days to get an approval, from the initial submission to the appeal and finally a peer to peer. Fortunately the patient reports less pain after starting the infusions. Unfortunately this is not the only patient in our practice on a similar path.

**Example 2 –**

On 3/2/2023 an MA started a medication prior auth for a patient with polycystic ovarian syndrome. The prior auth was denied with formulary alternatives. The MA started the new prior auth for the alternative and that was denied. The provider decided to put the patient back on a medication that was working but has to be injected daily, which was the reason for choosing one of the previous medications. Again the MA put in a prior auth for the medication that the patient has been on and now we have to do an appeal. It's now 4/25/23 and the patient has not started her treatment and continues to experience severe symptoms due to her POCS. I've attached snips from the denial letters showing where the insurance directs the provider to order a different drug and then denies that one too.

One MA in endocrinology spends 40% of her time processing medication prior auths and paperwork needed to approve insulin pumps and continuous glucose monitoring devices.

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I have spent over 23 years serving patients in Maine and have many examples of increased administrative burden directly impacting physician wellness and patient care.

Recently a patient was seen in my office for cervical and facial pain with a reported history of Migraine Headache. She, on exam, was noted to have exquisite tenderness and Tinel's signs directly over the greater occipital nerves and the left lesser occipital nerve. This responded

100% to nerve block. She is diagnosed with Occipital neuralgia (traumatic since a remote MVA) without mention of her migraine history in her assessment, which may or may not be related to the ON.
Anthem BC/BS chose information recounted by the patient in the HPI which was her migraine history rather than her assessed diagnosis of Occipital neuralgia to deny her claim.

In addition to ignoring the diagnosis provided, they required me twice to be ready for a peer to peer review with a family practitioner who is NOT a peer to a peripheral nerve surgeon or a plastic surgeon. I helped train the chairman of Harvard Plastic surgery at Mass General, Dr. William Austen, in the surgery for Occipital Neuralgia, and sit with him on the board and executive committee for the Migraine Surgery Society. He has no issues with denials for this service.

I would at least expect a real peer if I am to set aside unremunerated time in my day to advocate for their insured. Also, I expect them to vet my diagnosis rather than information the patient provided in the history before denying a claim with no basis for the denial. It was a worthless hurdle for me to jump over for the patient's sake and a delay in her care, despite Anthem's efforts to avoid paying for it. This "non peer to peer" review process should be eliminated. It is a part of what is driving physician suicide since 2019 to be the highest of any profession in the nation - even higher than the military. This specific example is just one of many.

My staff spends hours on the phone obtaining prior authorizations only to get incorrect information. We have had to implement a second check on prior authorizations to insure we are receiving correct information from the insurance companies. This process alone adds a significant financial burden to my private practice. However, if this is not done, it creates countless staff hours appealing denials and often months of delay in payment.

Acquiring pre-determinations on surgery is the only way to ensure coverage of CPT codes prior to surgery, but this process can takes weeks which, again, significantly delays patient care. Anthem, particularly, but many insurance companies go out of their way to make out-of-network physicians struggle with communications as there is no line for OON physicians to use.

Anthem, particularly, will send the physician payment to the patient, creating hardship and confusion for both patient and physician.

The absolute worst problem that has led to the near extinction of private medicine and to physicians leading the nation for the last 5 years in suicide (the hospitals and the media like to avoid that term and just say "burnout") is , I'm afraid, not fixable on the state level.

Anthem, Cigna and United all prefer their networks to utilize the big hospital setting and whatever physician might have arrived there, rather than realize significant savings and better outcomes by admitting lower cost, higher quality-of-care physicians to their network. This is because of the MLR provision in the ACA which assures insurance companies will choose higher cost over better quality, since they ultimately get 20%, no more, of the total premiums collected.

> The proof of this practice lies in this negotiation anecdote: When negotiating with a private insurance company, I presented paid EOBs from patients showing the tremendous cost of their in-network care at Northern Light compared to the costs for me to provide the same care in a different setting. They did not dispute the savings of $20 to $30K per surgery, nor did they dispute the significantly lower infection, overall complication, and lower re-admission rates where I operate. When asked why they declined to admit me to their network for a relatively small increase in professional fees, they stated REPETITIVELY AS IF ONLY PERMITTED TO SAY ONE THING, "We're sorry but we cannot pay one physician more than another." It was so maddening that I eventually threatened to tell large local self-insured companies what this company was doing – negotiating for the highest cost of care, regardless of higher complication rates. This created a tremendous uproar from them over the conference call, but ultimately resulted in this company giving into our every demand. I had pointed a finger directly at their ACA-legislated business model which they preferred to keep under wraps.

Broadly speaking, this most critical issue facing physicians is, essentially, the discreditation of our expertise, the devaluation of our services and the commoditization of our profession in order

to escalate the costs, of which they are assured to get 20%.

The way things are now, it doesn't matter to them whether a surgeon has 23 years' experience, a low complication rate, or a high patient satisfaction rate – we are all to be paid the same – even if the surgeon is just starting or already has an abysmal record. This favoring of costs over quality is what is contributing to the tolerance of maddening inefficiencies for employed physicians whose complaints are most often ignored.

I am happy to speak about this and would welcome the opportunity to provide my insight in Augusta.

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I hope this is helpful. Please let me know if you want to speak more and I would be happy to connect.

- I had a patient who was experiencing severe debilitating migraines but had a history of ischemic strokes. They found some improvement with sumatriptan, but this cannot be used as a long-term med in patients who have a history of stroke. I attempted to order an alternative, but it required prior authorization. It took >30 days for me to get notification that another medication was a preferred agent and that their prior authorization as not approved. Meanwhile they were experiencing multiple episodes of severe migraine symptoms.

- I had a patient who has been experiencing external ear symptoms related to otitis externa. It did not respond to the first line therapy, and I sent a second line therapy, but this required a prior authorization. I completed the prior authorization, but it took over a week and still was not approved.

I tried sending multiple alternatives without success. We decided to try the first line treatment in the interim as some treatment was felt better than none. This same patient needed a new glucometer for poorly controlled diabetes and injected insulin. Their glucometer was broken. I sent a new prescription for the preferred glucometer, but it was no longer available and was on

back order. I ordered an alternative glucometer system and submitted a prior authorization, but they still had not received their glucometer for over 65 days despite active discussion with their insurance company.

This is particularly dangerous as they need to inject insulin and is therefore at risk of fatal complications if they cannot get his glucometer. Given the limitations of supply chains, insurance companies should adjust their policies to improve access.

Thank you for your help!

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Last week, I received a 4th denial reviewed by the same physician that denied a request for testing.

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I'm very unhappy with a client's health plan...I don't know if it's other HPs as well....or indication of the future for all insurances.

The RX part was contracted with Point32. No person-person contact, even when I pressed the representative---was put on hold for 40mins....I gave up...also thinking that maybe that way to get rid of me.

I rx'd Vyvanse (new for the client). Was denied, required PA, denied the PA, never notified my office, requires office notes. It's now been 2 weeks since I rx'd it!

AMA AMERICAN MEDICAL ASSOCIATION

# Advocacy Resource Center

**Advocating on behalf of physicians and patients at the state level**

# It is time to fix prior authorization

## Prior authorization is hurting patients

- 93% of physicians report **care delays** as a result of prior authorizations.
- 82% of physicians report that prior authorization can lead to **treatment abandonment.**
- 34% of physician reported that prior authorization has led to a **serious adverse event** for their patients.
- 24% of physicians reported that prior authorization has led to a patient's **hospitalization.**
- 18% of physicians reported **life-threatening event or intervention to prevent permanent impairment or damage.**
- 51% of physicians treating patients in the workforce report that prior authorization has **interfered with a patient's ability to perform their job responsibilities.**

## Prior authorization is costly

- Physicians and their staff spend more than 13 hours/week (nearly two business days) on prior authorizations.
- Physicians complete an average of 41 prior authorizations per week.
- 40% of physicians have staff who work exclusively on prior authorizations.
- 88% of physicians describe the prior authorization burden as high or extremely high.

## What can be done?

As a start to fixing prior authorization, policymakers and other stakeholders should consider how the volume of prior authorization is impacting patients, physicians and the health care system. While these programs may reduce the amount health insurers are paying on care in the short-term, delaying or denying medically necessary care is not an appropriate or effective long-term solution to reducing costs. **Prior authorization, if used at all, must be used judiciously, efficiently, and in a manner that prevents cost-shifting onto patients, physicians and other providers.**

Policymakers should consider the following **prior authorization reforms**:

- Establish quick response times (24 hours for urgent, 48 hours for non-urgent care).
- Adverse determinations should be made only by a physician licensed in the state and of the same specialty that typically manages the patient's condition.
- Prohibit retroactive denials if care is preauthorized.
- Authorization should be valid for at least 1 year, regardless of dose changes, and for those with chronic conditions, the prior authorization should be valid for the length of treatment.
- Require public release of insurers' prior authorization data by drug and service as it relates to approvals, denials, appeals, wait times and more.
- A new plan should honor the patient's prior authorization for at least 60 days.
- Volume reduction through the use of solutions like prior authorization exemptions or gold-carding programs.

For more info contact Emily Carroll at emily.carroll@ama-assn.org.

*Data comes from the 2021 AMA Prior Authorization Physician Survey. For more information on the survey, to access prior authorization resources, and to join our grassroots campaign, visit fixpriorauth.org.