Alliance of Specialty Medicine

Sound Policy. Quality Care.

May 23, 2023

The Honorable Richard Blumenthal
Chairman
Permanent Subcommittee on Investigations
Senate Homeland Security & Governmental Affairs Committee
Washington, DC 20510

The Honorable Ron Johnson
Ranking Member
Permanent Subcommittee on Investigations
Senate Homeland Security & Governmental Affairs Committee
Washington, DC 20510

The Honorable Gary Peters
Chair
Senate Homeland Security & Governmental Affairs Committee
Washington, DC 20510

The Honorable Rand Paul
Ranking Member
Senate Homeland Security & Governmental Affairs Committee
Washington, DC 20510

Subject: Delays and Denials in Medicare Advantage Plans

Dear Chairs Blumenthal and Peters and Ranking Members Johnson and Paul:

As the Alliance of Specialty Medicine (Alliance), a coalition of 16 medical specialty societies representing more than 100,000 physicians and surgeons, our mission is to advocate for sound federal health care policy that fosters patient access to the highest quality specialty care. We write to thank you for examining Medicare Advantage plans during the hearing "**Examining Health Care Denials and Delays in Medicare Advantage**."

Prior authorization is a cumbersome process that requires physicians to obtain pre-approval for medical treatments or tests before rendering care to their patients. The process for obtaining this approval is lengthy and typically requires physicians or their staff to spend the equivalent of two or more days each week negotiating with insurance companies — time that would better be spent taking care of patients. Patients are now experiencing significant barriers to medically necessary care due to prior authorization requirements for items and services that are eventually routinely approved.

Specialty physicians and their patients are often subject to prior authorizations and other utilization management tactics in the Medicare Advantage program. Generally, utilization management processes delay enrollee access to medically necessary care and treatments and create considerable, unnecessary administrative burdens for specialty physicians. Equally concerning, these tactics are a leading cause of physician burnout, forcing many to retire early or leave the practice of medicine. While utilization management processes, such as prior authorization, may be appropriate in some situations, the Office of Inspector General has found that Medicare Advantage plans use prior authorizations to deny *medically*

necessary care, that is, care that meets coverage requirements under traditional Medicare and is supported by the enrollee's medical records.

In the fall of 2022, the Alliance of Specialty Medicine surveyed over 800 specialty physicians on the topic of utilization management. The findings underscore the burden of utilization management protocols on the practice of medicine, both in terms of the negative impact on patient care, as well as the increased administrative onus on medical practices. Respondents overwhelmingly indicated that the use of prior authorization has increased in the last five years across all categories of services and treatments:

- Over 93% of respondents answered that prior authorization has increased for procedures;
- More than 83% answered that prior authorization has increased for diagnostic tools, such as labs and even basic imaging; and
- Two-thirds (66%) responded that prior authorization has increased for prescription drugs, with physicians noting that even many generic medications now require pre-approvals.

Other key findings can be found in the attached survey results.

The Alliance supports opportunities to meaningfully improve utilization management in the Medicare Advantage program, reduce administrative burdens, and ensure safe, timely, and affordable access to care for patients. In the 117th Congress, we endorsed S. 3018, the *Improving Seniors' Timely Access to Care*, which garnered significant bipartisan support. The solutions included in this legislation, along with new regulations issued by the Centers for Medicare & Medicaid Services, will go a long way to ensuring that our nation's seniors get the care they need when they need it.

Thank you for holding this important hearing. If you have any questions or want to meet with the Alliance to discuss these issues further, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American College of Osteopathic Surgeons
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
National Association of Spine Specialists
Society of Interventional Radiology

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Nationwide Survey of Practicing Specialists:
Utilization Management Negatively Affects Clinical Care

Physicians Report Cases of Patients Blinded, Paralyzed Due to Care Delays by Insurers

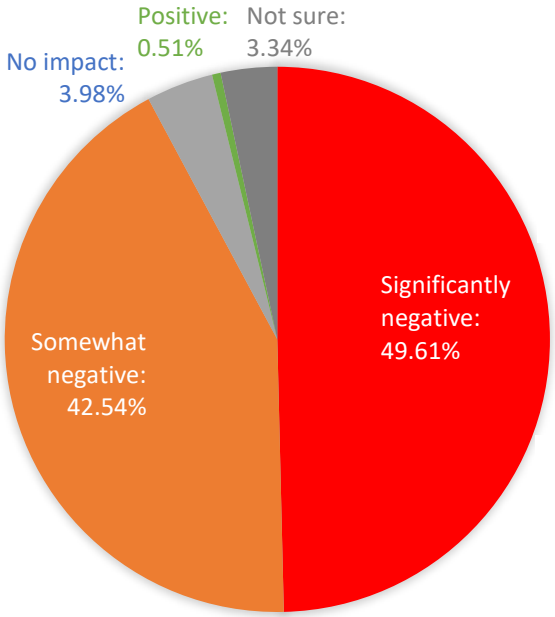
In the fall of 2022, the Alliance of Specialty Medicine conducted a survey of over 800 specialty physicians on the topic of utilization management. The findings underscore the burden of utilization management protocols on the practice of medicine, both in terms of the negative impact on patient care, as well as the increased administrative onus on medical practices.

Respondents overwhelmingly indicated that the use of prior authorization (PA) has increased in the last five years across all categories of services and treatments: over 93% of respondents answered that PA has increased for procedures; over 83% answered that PA has increased for diagnostic tools, such as labs and even basic imaging; and over 66% answered that PA has increased for prescription drugs, with physicians noting that even many generic medications now require pre-approvals. Other key findings are below.

For patients whose treatment requires prior authorization,
what is the impact of this process on patient clinical outcomes?

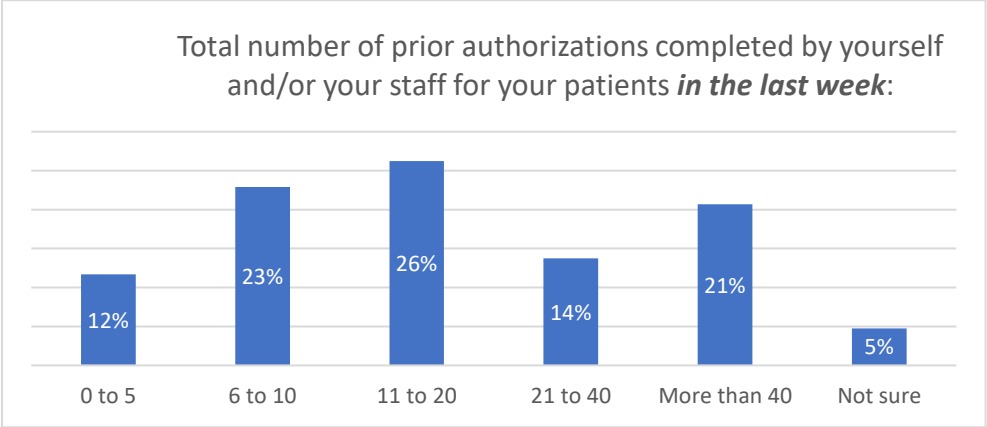
"It delays care and sometimes means that I have to use different medications or different procedures than what I think is most appropriate because the insurance company says so."

"I had a patient with an undiagnosed epidural abscess. I was suspicious of this diagnosis and ordered a stat MRI. The Hospitalist delayed it because her Blue Cross insurance doesn't recognize outpatient stat MRI orders. The patient is now paralyzed."



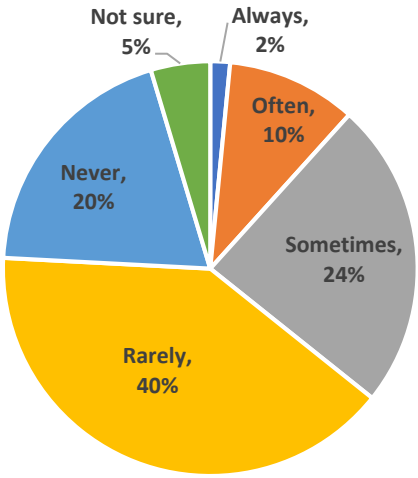
"Prior auth has resulted in some of my patients being blinded by various eye conditions over the years."

"Have seen permanent neurologic deficit, permanent pain syndromes secondary to delayed or denied care."



PA is leveraged to delay coverage of necessary care: over 87% of respondents reported that requests were eventually approved in the majority of cases.

When a peer-to-peer consultation is required, how often is the insurers' representative in the same/similar specialty or have experience with your specialty?



"Many can't even pronounce the words they are reading to me, let alone know what they mean or why they are significant."

"If we request a same specialty reviewer, it often will not happen prior to having to give up the scheduled surgical date."

"The Family Practice Physician [reviewer] will recommend [to the neurosurgeon] a lesser surgery that will not fix the problem, causing the patient to have a second surgery a few months later."

Have increased administrative burdens by insurers influenced your ability to practice medicine?

"I have seen this specifically contribute to physicians leaving the field and retiring earlier."

"Administrative burdens by insurers is the number one reason I consider leaving the field of medicine on a weekly basis. It's killing rheumatology!"

"I am at the mercy of prior auth in order to provide care for my patients."

A great source of frustration among respondents is the fact that insurers often deny payment after the fact for services they pre-authorized:

"This is a daily occurrence! United Medicare and Humana are notorious for authorizing after all requirements are met, then denying for not medically necessary. I've asked them countless times, why they approved the surgery based on clinical documentation IF it was not medically necessary. This is extremely frustrating."

"Payment has been denied months after the procedure was approved and conducted. In some instances, a refund of payment has been requested."

"Sometimes they tell us authorization isn't required then say later it was required so they won't pay."

"This is happening nearly 80% of the time for at least part of a claim submission."

"A recent denial was reported to me six months after surgery. I had just seen the patient who was happy, reported zero pain and shook my hand in thanks! I was then told the insurer asked for the money back!"

Over 60% of respondents were denied payment for pre-authorized services at least twice in the preceding year, with almost 20% of those having experienced this at least *twenty times* in just one year.

"They look for small variations in coding and deny the whole claim including the codes they pre-approved. It requires a huge amount of manpower to fight back so we always lose money."

"After re-submitting over and over, we just stop sending and take the loss."

"This is happening more and more. We provide a necessary service that was authorized then we do not get paid."

"Pre-approval obtained, only to have payment subsequently denied. Patient is incredibly frustrated and blames us, we have no understanding of why this occurs, no real explanation offered and have no recourse but to apologize to patient."

"Most recent was for a single level, unilateral microdiscectomy which occurred more than a year prior! They sent patient bill for full charge, which created significant stress. We had full documentation of the authorization, they kept up the harassment for no explainable reason until patient retained attorney."

"We have certainly been told pre-op that no auth was needed. Then, after the procedure is performed, been sent a denial for not obtaining a pre-op auth. This has happened many times. We always get it straightened out eventually, but as usual this wastes lots of time and manpower."

"This happens daily. […] We receive medical necessity denials even when a P2P or appeal was performed during the auth process to provide medical necessity for procedures."