Prior Authorization
Community Oncology Alliance Position Statement

Community Oncology Alliance Position
The Community Oncology Alliance (COA) opposes the use of prior authorization for certain cancer treatments as it delays important treatment, wastes valuable physician and staff time, and inserts bureaucratic review of treatment decisions by those who are often neither oncologists nor physicians. While prior authorization may have a place for certain non-standard treatments, it should not be required for treatments that follow recognized pathways or clinical care guidelines. COA advocates for a complete reexamination and overhaul of the prior authorization system.

Background
Prior authorization is a cost-control process implemented by health insurance companies that serves to restrict access to a prescribed treatment, test, or medical service until a physician obtains payer approval. Failure to obtain prior approval might mean a procedure does not qualify for payment. Many insurers, if not most, routinely require authorization before treatment, that oncologists and their patients have decided is the optimal therapy, is initiated.

The number of diagnostic and therapeutic procedures requiring prior authorization is increasing every year in staggering numbers. Approximately 86 percent of medical practice leaders reported that prior authorization requirements have increased over the previous year, according to a 2019 Medical Group Management Association survey. The number of payment denials for procedures that had a prior authorization is also growing, an untenable position for providers. The “hassle” factor in time spent and personnel required to adjudicate and be rightly reimbursed for these “authorized” claims is increasingly a financial and staffing drain on practice resources.

The administrative burden of prior authorization is dramatic. Upon denial, physicians begin an appeal process that initially has a treatment plan review performed mostly by non-oncologists. In this time-consuming, multi-step process, there may finally be a peer-to-peer review, also frequently with non-oncologists, where treatments are almost always approved.

Beyond financial motives that dictate a preference for lower-cost clinical and pharmaceutical treatment options, the purpose of prior authorization is unclear. For example, a recent study examined the prior authorization processes and approval patterns within a high-volume breast oncology clinic. Seventeen possible process steps and 10 decision points were required for patients to obtain medications requiring a prior authorization. Of the 324 prior authorizations tracked, 316 (97.5 percent) were approved (or 2.5 percent were denied) on the first prior authorization request after an average time of 0.82 days (range, 0 to 14 days).
For the patients that are denied prior authorization, access to immediate treatment is delayed and/or denied, and the physician typically begins an opaque and cumbersome process that can go on for several weeks as the medication or treatment plan is continually denied. This often leaves patients confused, frustrated, and hopeless at a time when they are particularly vulnerable. Furthermore, it is unclear what purpose prior authorization serves when treatments are prescribed following recognized pathways or clinical-care guidelines.

Physicians are overwhelmingly in agreement on the detrimental effects of prior authorization. In a 2018 survey, the American Medical Association (AMA) determined that more than nine in 10 respondents said prior authorization had a significant or somewhat negative clinical impact, with 28 percent reporting that prior authorization had led to a serious adverse event such as death, hospitalization, disability or permanent bodily damage, or other life-threatening events for a patient in their care. Eighty-six percent reported that the prior authorization administrative burden was high or extremely high, with 88 percent reporting that the burdens of prior authorization had increased over the last five years.

In some cases, the prior authorization process can be extreme. A Texas oncologist reports that the recommended treatment plan for a patient with breast cancer that had metastasized to her brain was to circumvent the fail-first drug and begin treatment with a drug the oncologist knew to be more effective. This decision required a prior authorization and was initially denied. Ultimately, the process to get a prior authorization required two weeks, two letters of medical necessity, 30 emails, an hour every day of physician time, and a call to the vice president of the insurer in question. The treatment plan was ultimately approved. This process delayed treatment and increased costs to the patient by almost $2,000 when certain scans were required but not covered by the patient's insurance policy.

There is a role for prior authorization for treatments and procedures that fall outside of established pathways or guidelines. However, prior authorization for treatments, procedures, and imaging that are part of recognized pathways and guidelines should not be allowed, but unfortunately, it happens increasingly every day.

COA advocates for a complete reexamination and overhaul of the prior authorization system. Meaningful and timely review, such as a 72-hour or less approval or denial mandate, would be more appropriate. Another serious look at the sheer magnitude of its effects on access to care and costs to patients and providers is also clearly needed.

**Summary**
The desire for prior authorization is understandable in light of the increasing costs of health care in the U.S.; however, the practice has grown exponentially and requires too much time, most often at an administrative level, and is a time-consuming waste of resources given the low overall denial rates. More importantly, prior authorization leads to delayed onset of treatment and can impact patient prognosis.
COA advocates for a complete reexamination and overhaul of the prior authorization system. Suggested changes include:

- No prior authorization requirements for treatment that follows a recognized pathway or guideline.
- No “fail-first” step therapy in patients with metastatic cancers, thereby eliminating any need for prior authorization.
- Changes to reduce the administrative burden and wasted time dealing with insurers, such as reducing time on phone calls, use of faxes, and other bureaucratic idiosyncrasies.
- Consideration by insurers to not require prior authorization for physicians that have prior authorization denial rates below a certain threshold.
- A streamlined process for requesting exceptions, rapid reviews, and appeals.

There is ample evidence that the current costly and inefficient prior authorization system needs reform. Providers and insurers must work together to reform the prior authorization program to eliminate its obstruction of patient care. COA strongly supports a complete overhaul of the current prior authorization system.

**Date**
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iv American Medical Association, op. cit.