Alliance of Specialty Medicine

Sound Policy. Quality Care.

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

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

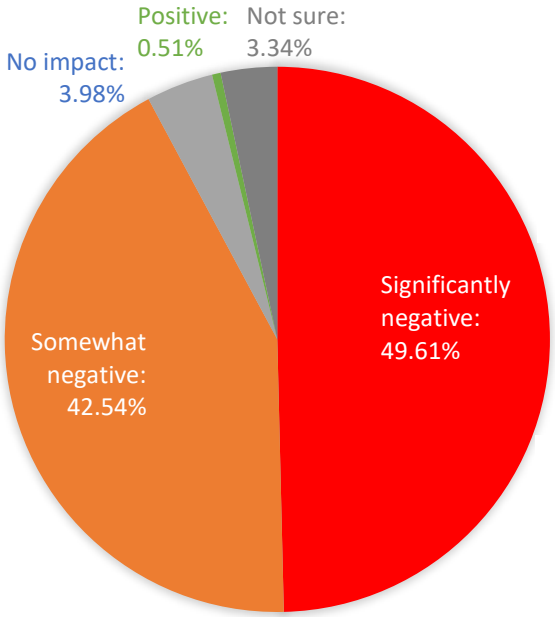
In the fall of 2022, the Alliance of Specialty Medicine conducted a survey of over 800 specialty physicians on the topic of utilization management. The findings underscore the burden of utilization management protocols on the practice of medicine, both in terms of the negative impact on patient care,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

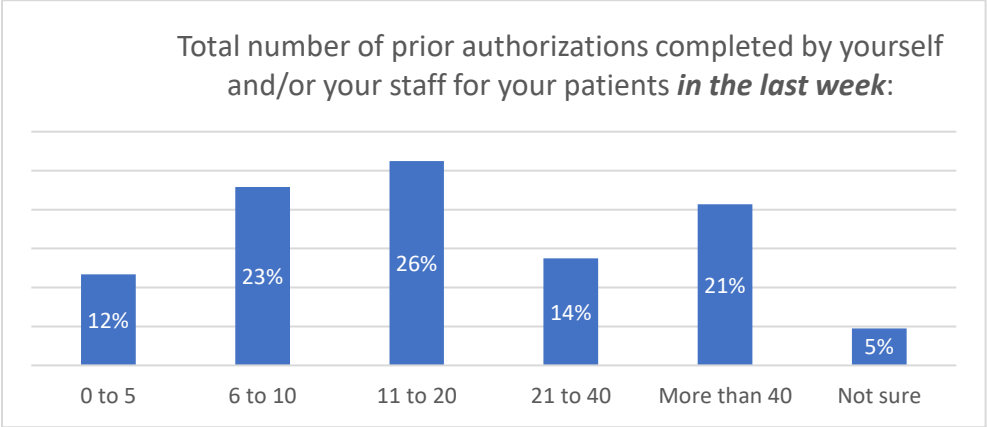
*"It delays care and sometimes means that I have to use different medications or different procedures than what I think is most appropriate because the insurance company says so."*

*"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."*



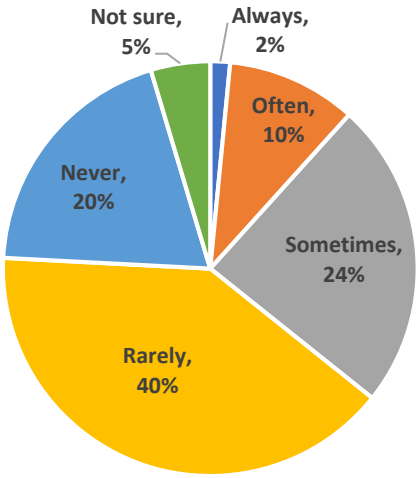

*"Prior auth has resulted in some of my patients being blinded by various eye conditions over the years."*

*"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."*