The Washington State Podiatric Medical Association (WSPMA) is a statewide organization representing podiatric physicians and surgeons. WSPMA members report growing problems with the current use of prior authorizations by health insurers. While once seen as a tool to prevent over-utilization, prior authorization has morphed into an obstacle course that often delays as well as prevents patients from receiving the right care at the right time, and creates an administrative nightmare for healthcare providers.

A key change in recent years is that prior authorization is now applied to an ever-growing array of healthcare services, as well as prescription drugs. At the same time, health insurers’ technology and systems have not kept pace, leaving many providers and their patients to depend on fax machines and 1-800 numbers while navigating a maze of ever-changing criteria and requirements.

The following are some examples of the challenges faced by providers in assuring their insured patients receive medically necessary health care.

**Important information not disclosed.** When providers submit requests for prior authorizations, the normal response is “approved” or “denied.” But there’s a third response: “No authorization is needed.” Often, this means that this is not a covered service and will not be paid by the plan.

When a provider calls for prior authorization or to verify coverage and informs the insurer the facility in which the procedures will take place, the insurer may not say if the facility is out of network.

Foot care, such as custom orthotics, bunions, hammer toes, toe nail debridement, callus debridement, etc., may be covered in some instances and not others. Often, there is some other qualifying criteria, such as diabetes. In requesting a prior authorization for these or any other services, the response of the insurer does not always include required qualifying criteria.

**Retroactive denial of claims.** Once a prior authorization has been secured, an insurer should not be able to retroactively deny coverage for the service. The presumed availability of coverage for a particular service, based on that prior authorization, directly influences the course of treatment agreed upon by the patient and the provider. When insurers retroactively rescind a prior authorization, patients can be left bearing the financial responsibility for services provided to them that were understood to be approved and should otherwise be covered under the health plan.

**Over-specificity.** Many insurers require CPT and ICD-10 level specificity of requests. A common problem is when a patient is referred for a high-level imaging procedure. Often there are multiple MRI or CT procedures which could be done, and are very similar to each other. The provider will request the one he/she thinks is correct, and will submit the request. When the radiologist receives the request, he/she may suggest a slightly different approach. When this occurs a claim may be denied, because the procedure that was done was not exactly what had been pre-authorized.

**Lack of 24/7 access.** Insurer prior authorization processes do not adequately accommodate that health care delivery is 24/7. In previous years, it was understood that a certain percentage of requests would need to be handled retrospectively. But now many plans unilaterally issue “no retro authorization” policies which result in non-payment for medically necessary health care.

**Office of the Insurance Commissioner (OIC).** The OIC is in the process of collecting information concerning prior authorization from provider and patient groups, in an effort to determine how to streamline and improve the process. While that’s a very positive step, if the OIC is not successful in writing meaningful rules, provider groups will continue to ask the Legislature for help to assure that insured patients receive medically necessary health care.