Department of HUMAN SERVICES

Prior Authorization Listening Session

February 10, 2022

Agenda

- Introduction and purpose of listening session
- Requesting feedback on the following:
  - Are there services where PA requirement does not feel aligned with intent of service
  - Are there areas where PA process/timeline unreasonably delays care
  - Are rationales for decisions clear enough for follow up/action
  - Recommendations for process improvement
- Next Steps

Are there services where PA requirement does not feel aligned with intent of service

- Challenge in determining medical necessity for rare pediatric diseases
- 98% of above (hematology and oncology) are approved so feels unnecessary delays to care
- Practice standards in the field do not feel aligned with prior authorization and clinical guidelines
- On with Life – PT/OT/ST is limited and only one guideline for therapy – individuals served don't fit within current guideline categories
  - Expectation for progress being made is not reasonable
  - Denials if not enough progress is being made
- Childserve – PT/OT/ST were not required prior to 2016 but now are even though almost 100% approved
  - Criteria is often adult criteria when approval is for a child
- Reasoning for decisions often do not match what was requested for authorization
- Requests for peer-to-peer are very time consuming – would have to do multiple peer-to peer every other week for each auth
- Request physician do peer-to-peer rather than treating therapist – causes delays and sometimes not able to connect with physician within required 48 hours

Are there services where PA requirement does not feel aligned with intent of service

- Cannot request another request within 90 days (or other time period) if all authorized visits are used
- Center rehabilitation – frustration with pediatric authorizations with ITC and peer-to-peer review requests
- Covered services for first 5 visits but then claims are denied even though guidance is included in provider manuals
- Every Step – Title V – both MCOs do not currently follow the same guidelines for home visits (AGP requires with 100% approval but ITC does not)
  - Other issues with prenatal and post-partum education visits
- ABCM – have tried to get clarity on skilled admissions under Medicaid
  - Following Medicare criteria or other?
  - Not clear why this is necessary when they get paid the same
  - Pressure to get individuals discharged from hospitals
- Why do PWC batteries require authorization?
- Mobility device repair authorizations – members need these functional immediately
- Conflicting information on OB deliveries – call center says no auth needed but then claim denied – need clarity

- Waterloo CMHC – community supports/outreach
  - ITC does not require PA
  - AGP does
  - Creates challenges in getting services to individuals
  - 7 days follow ups and mobile counseling require PA – these are urgent to keep individuals out of ER and hospital admission
- Iowa Specialty Hospital – bariatric unit
  - Need greater transparency on when 43775 (E66.01) needs auth
  - Gastric sleeve surgery – challenges with eligibility between IHWP traditional and medically exempt
- MTM Specialist
  - Would be good to look at continuous glucose monitoring requirements
  - Current criteria used to be relevant when tech first came out – it feels outdated now compared to commercial insurance (requirement to submit blood sugar logs)
  - There are differences in how MCOs apply PA criteria for medications – will ask questions not even listed or denied for questions not asked in the first place
    - True for psychological testing as well – asks what measures a clinician will be using even though nothing on form to indicate the type of test
  - Challenges with getting asked unnecessary and repetitive questions (example: will you supply the directions for use)
  - Trulicity – ITC requires PA by strength while AGP has blanket PA allowing for titration
  - Same is true to ADHD titrations

Are there areas where PA process/timeline unreasonably delays care

- Auths are taking 14 days so by the time approved have to go through PA again
- Appeal timelines and turnaround delay care (taking whole 30 days)
- Providing care before get the response because often approved but if they waited for PA it would delay
- With OWL – opposite practice, waiting for PA before providing service because of shortened visits and denials
  - In one circumstance, not receiving needed care resulted in poor outcome
  - Having to follow up multiple times on PA
- Clark and Associates – start PA but have to provide service even without approval because emergent (trauma services)
  - Doesn't appear that putting urgent on the form makes a big difference
  - Had one service provided that was denied and had to absorb cost of service
- Delays when fax lines are down
- Bilateral authorization denied for duplicate (retina clinic)
- Need clarity on psych testing
- Imaging vendor system goes down which creates delays in auths
- Pas for rehab for newly replaced joint take too long – 14 days

Are rationales for decisions clear enough for follow up/action

- OWL – had submitted a request for speech equipment and received denial saying that speech therapy was not needed
- Childserve – often feels like didn't review any of the documentation already submitted
- UnityPoint – also feels like documentation provided is not reviewed (happened twice last week)
- IHCA – volume of required documents is big but come back requesting information within those documents
- Timeline to respond with more information or arrange a peer-to-peer is short – have 2 weeks to review request but provider turnaround is very fast
- UIHC psych – don't get back denials in time to submit peer-to-peer request
- Suggestion to move from 2 day turnaround to 5 day turnaround and/or leverage the specialist rather than requiring a physician for peer-to-peer
- Clark and Associates – also have gotten denials late
- Should not have to submit an appeal when information was already submitted
- Denials and appeals delay care – anything that can be done to avoid both will help members

Recommendations for process improvement

- MercyOne NE
  - Used to be able to submit Pas online but now have to submit to separate websites for MCOs or paper forms for FFS – creates bigger delays
- Collaborate on set of rules for rare diseases and niche practices – use the same references for medically necessary
- Similar guidelines for FFS/MCOs would be really helpful
- Submitting one PA for PT/OT/ST would be helpful rather than submitting 3 separate
- Having an Iowa Medicaid staff person available to staff (Medicaid call centers direct to MCOs) to help with issues as they crop off
- Hard to track on differences between all of the Medicaid payers
- Claims denials saying that they are over the limits even when they have an authorization
- Unclear what max units are and how they apply by service
  - IHWP has limit of 60 units/year no matter what facility but MCOs don't track and then deny because other facilities had used – had to figure out on own
- Uncertainty around when Pas are required when there is TPL – sometimes denied sometimes not
- Claim denials for no PA when PA was received – mostly home health rather than facilities (IHCA)
  - Have to follow up and prove that auth was received – takes a lot of work when did the right thing on the front end

- It doesn't make sense to wait for auth before service is provided – for other payers, providers can call and get approved on the phone immediately
- Suggestion that EDISS allowed multiple checks at one time – get conflicting answers related to batch eligibility checks
  - AGP does have a portal where you can get everything all at once
- Consistent and uniform published medical necessity criteria
- Should not need a PA when the MCO refers a member for services
- Look at process from start to finish on how Pas are in system, claims are reconsidered, etc.
- Reference numbers should match up with authorization numbers after approval
- Tech advances – seems like fax machines are not checked regularly