



The Need for Prior Authorization Reform

Utilization management has been defined by the Institute of Medicine as “a set of techniques used by or on behalf of purchasers of healthcare benefits to manage healthcare costs by influencing patient care decision-making through case-by-case assessment of the appropriateness of care prior to its provision.”¹ Unfortunately, due to many different factors, a process that was intended to protect patients, has created an adversarial relationship between physicians and payers, and has grown indiscriminately, ultimately reducing time spent on patient care.

Delayed musculoskeletal care comes at a tremendous cost not only to the patient in terms of quality of life and productivity but to the overall health care system. According to the American Public Health Association, musculoskeletal conditions are a leading cause of disability in the U.S. accounting for more than 130 million patient visits to health care providers annually and the number one reason individuals to see their physician.²

As summarized by the American Academy of Orthopaedic Surgeons in a 2021 Orthopedic Advocacy Week letter to Centers for Medicare and Medicaid Services (CMS), “[the] push to expand prior authorization requirements is alarming because it illustrates a shifting focus from ensuring patient safety and well-being to cutting costs above all else... Such a significant outcome must call into question whether reduction in cost truly outweighs the benefits of accessible, necessary care to patients.”

Despite the relatively low peer-to-peer denial rates, insurer’s prior authorization and utilization reviews continue to focus on micromanagement aspects of care, typically driven by financial factors. These techniques are in direct conflict with the patients interests since the results pose unnecessary delays in routine musculoskeletal care and treatment.

It’s time we confront this growing problem.

¹ *Institute of Medicine (1989), Controlling Costs and Changing Patient Care?: The Role of Utilization Management*, Washington, DC, USA: National Academies Press, [doi:10.17226/1359](https://doi.org/10.17226/1359), [ISBN 978-0-309-04045-7](https://www.amazon.com/Controlling-Costs-Changing-Patient-Care/dp/0309040457), [PMID 25144100](https://pubmed.ncbi.nlm.nih.gov/25144100/).

² <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policydatabase/2014/07/08/14/21/musculoskeletal-disorders-as-a-public-health-concern>

NYS Society of Orthopaedic Surgeons, Inc.

150 State St. Fl. 4, Albany, NY 12207 | Web: www.nyssos.org | Phone: 518-439-0000

We Support

The NYS Society of Orthopaedic Surgeons supports policy changes that expedite necessary musculoskeletal care for patients in New York such as:

- Creating exemptions and expedited review processes for surgeons with an established "approval" track record.
- Peer reviewers should be in the specialty of care the ordering physician is in, have an active NYS medical license, and conduct reviews at mutually convenient times as to not disrupt patient care.
- Denials or delays should be processed well before the week of surgery.

S.8299 sponsored by Senator Neil Breslin / A.9908A sponsored by Assemblymember John T. McDonald, III, that would exempt health care professionals from preauthorization requirements in certain circumstances; and

S.6435 sponsored by Senator Neil Breslin / A.7129 sponsored by Assemblymember Richard Gottfried that would enact several reforms to address prior authorization barriers impacting patient care. These proposed changes would: limit the ability of a health insurer to require a physician and patient to repeat a previously obtained prior authorization, require that health insurer utilization review criteria be evidence-based and peer-reviewed; and reduce the time frames for an insurer to respond to a request for prior authorization.

By the Numbers

In April 2022, NYSSOS conducted a statewide survey of its membership concerning their experiences in complying with “prior authorization” requirements implemented by insurance companies.

The survey results (based on data from 76 members) were consistent, with nearly every respondent reporting that the requirements delayed needed care and often caused preventable harm, debilitation, and pain for patients.

Specifically, the survey found:

- **97%** of respondents reported that prior authorization **fails to achieve** its intended purpose of reducing healthcare costs by denying truly ineffective or unnecessary care.
- **88%** reported having **patients abandon care** due to delays associated with prior authorization.
- **94%** had patients **experience a deterioration of prognosis or quality of life** due to prior authorization delays.
- **96%** had patients **experience sustained or increased pain and/or symptoms** due to prior authorization delays.
- **89%** had patients experience a **delayed return to employment** due to prior authorization delays.
- **97%** say that **removing prior authorization would result in more expedient care** for their patients.
- **94%** say that **removing prior authorization would improve the quality of care** their patients receive.
- **94%** say the **administrative burden prior authorization places on their practice has gotten worse** in recent years.

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From the Orthopaedic Experience

“In addition to delaying or refusing care, denial of surgery is often one business day before the planned surgery. This disrupts the patient’s life, and the schedule of the operating room and me as the surgeon.”

~ Orthopaedist from Albany, NY

“The delay in care for weeks or months causes individuals to be out of work needlessly for months of time. They often lose their jobs because of this. Some cannot find other jobs. Some never return to work. Many develop depression and chronic pain because of the delays.”

~ Orthopaedist from Middletown, NY

“Generally, the delays in PA also stem from the fact that it seems someone with no medical knowledge is reviewing the case. If they don’t see a certain catchphrase, then it gets delayed.”

~ Orthopaedist from Buffalo, NY

“Insurance companies and their denials/prior authorization process are one of the leading drivers of physician burnout and staff burnout/stress. It has become increasingly more difficult to care for patients and it take a tremendous amount of advocacy and effort to provide the care we deem appropriate, medically necessary, and clinically indicated. More often than not, submissions are denied automatically or sent for peer to peer without review of the records provided. When I have the peer to peer it is as if the clinical documentation has never been reviewed and we are asked to regurgitate it to the reviewer to get their approval. The system is broken, and it is having a profound effect on physician well-being, clinical care, and patient health and wellbeing. We are in need of dire help addressing this and giving us a voice against the insurance companies.”

~ Orthopaedist from Bronx, NY

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