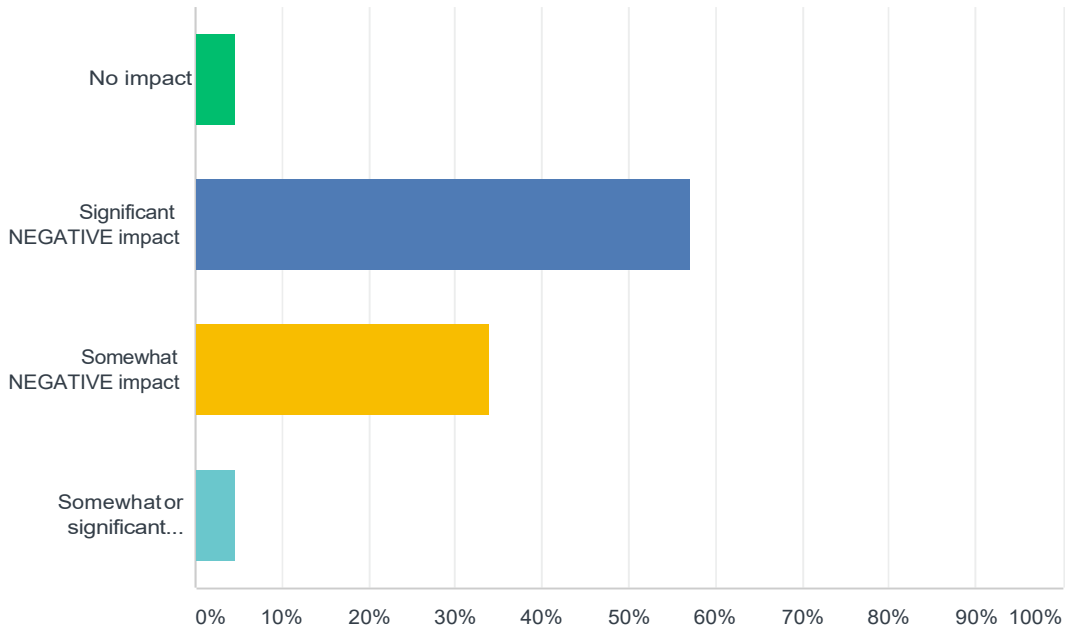


# Q1 What is your perception of the overall impact on patient clinical outcomes of PA practices?

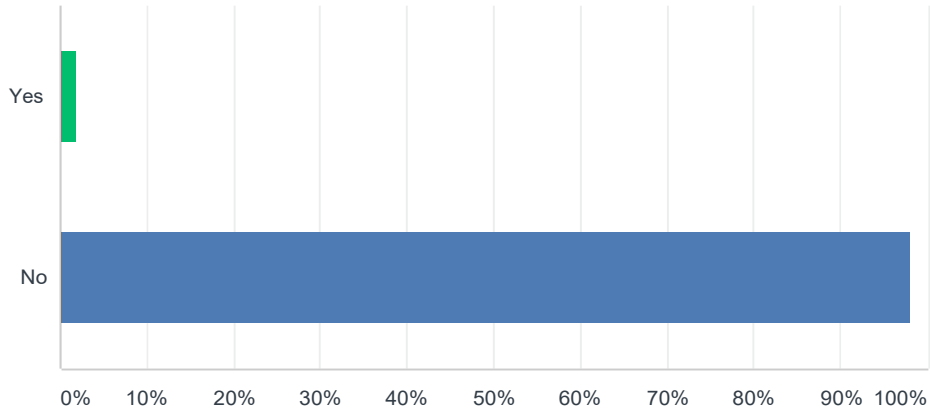
Answered: 219 Skipped: 0



ANSWER CHOICES	RESPONSES	
No impact	4.57%	10
Significant NEGATIVE impact	57.08%	125
Somewhat NEGATIVE impact	33.79%	74
Somewhat or significant POSITIVE impact	4.57%	10
<b>TOTAL</b>		<b>219</b>

### Q2 Do you think your patients who have been subject to PA practices have better clinical outcomes than those who have not, such as Medicare and Medicaid (which rarely require PAs)?

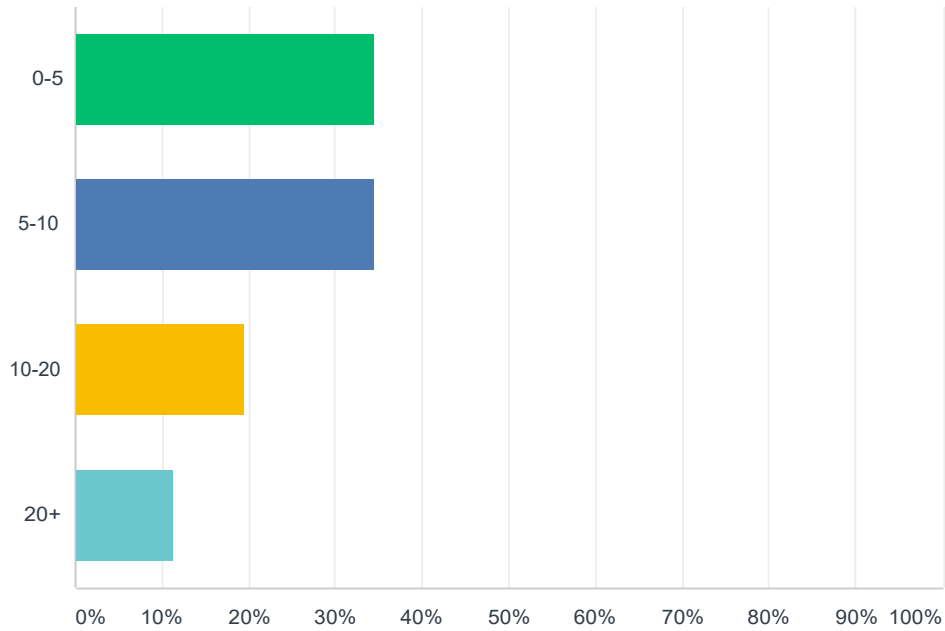
Answered: 218 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	1.83%	4
No	98.17%	214
TOTAL		218

### Q3 In a typical week, how many of your patient cases are the subject of PA practices?

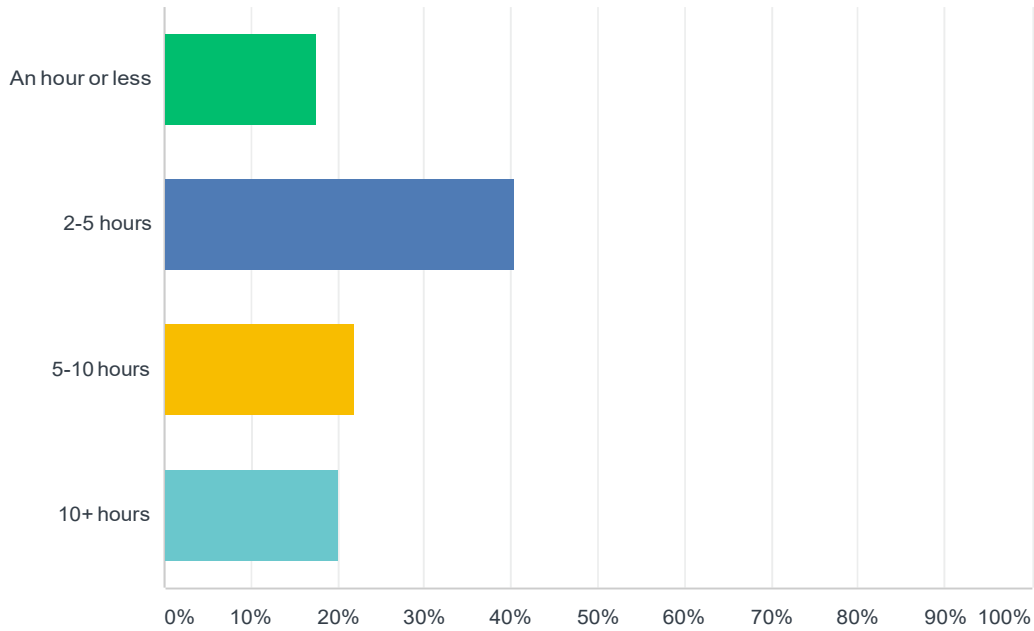
Answered: 211 Skipped: 8



ANSWER CHOICES	RESPONSES	
0-5	34.60%	73
5-10	34.60%	73
10-20	19.43%	41
20+	11.37%	24
TOTAL		211

### Q4 In a typical week, how much time do you or your staff spend pursuing PA requirements in your patients' cases?

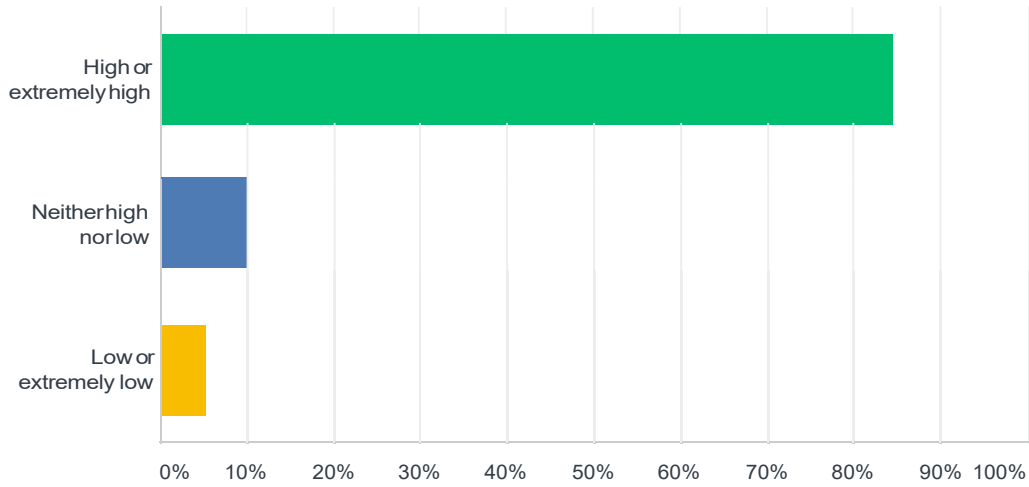
Answered: 210 Skipped: 9



ANSWER CHOICES	RESPONSES	
An hour or less	17.62%	37
2-5 hours	40.48%	85
5-10 hours	21.90%	46
10+ hours	20.00%	42
TOTAL		210

### Q5 How would you describe the burden associated with PA practices for the physicians and staff in your practice?

Answered: 217 Skipped: 2



ANSWER CHOICES	RESPONSES	
High or extremely high	84.79%	184
Neither high nor low	9.68%	21
Low or extremely low	5.53%	12
TOTAL		217

## Q6 What medical services or prescription drug classes do you think should be exempt from PA practices?

### RESPONSE

- Epilepsy medications
- Medical Imaging/Testing ordered by a specialist **(Multiple Responses)**
- PCP referrals, and all commonly used Rx's for standard chronic diseases.
- Diagnostic studies
- Acute medications that the patient needs that day to treat an immediate condition **(Multiple Responses)**
- All, unless the purported authorizing agencies take some responsibility for their decisions
- PA process just needs to be easier. Duplicate faxes, wrong information when calling and then only being approved for 30 days is craziness.
- Imaging studies, Antihypertensives, Antibiotics
- All drugs other than experimental, and all medical services other than merely cosmetic.
- Imaging; most medications except those most expensive chemotherapeutic and immunosuppressive agents.
- With reasonable medical documentation of necessity, neuro imaging and surgical procedures should be exempt
- Very frustrating that it's easier for me to send patients to ED where can get urgent CT/US/MRI scans than to order them on an urgent basis. Also need better grandfathering- if on med and doing well, need to stay on it.
- All imaging COPD/asthma controller medications. Novel anticoagulants Atypical antipsychotics Long-acting stimulants for ADHD management
- Any medication that falls within acceptable guidelines, such as SGLT2 for diabetes should be acceptable. It should not be dependent on financial deals made between insurance companies and pharmaceutical companies. In an ideal world, I should be able to order any study that I want at the time I want, as long as I am not ordering tests at a rate that is frequent. Let the burden fall to the insurance company to say, "hey, you're ordering this outlier too frequently. Let THEM have the burden.
- Stress test, MRI, Ultrasounds, any generic medication
- PPIs, stimulants
- Generic Drugs. **(Multiple Responses)**
- Lyrica, Lidoderm patches
- All except extremely high cost drugs and procedures **(Multiple Responses)**
- NSAIDs
- Continuation of treatment
- Sometimes a medication is being used outside of FDA approval but within clinical guidelines. A medication being used within standard clinical guidelines should be approved without having to go through the PA process.
- All of them. **(Multiple Responses)**
- Buprenorphine+/- Naloxone, sleep aid, muscle relaxants, PPI, DM meds, all Hepatitis medications, Aspirin, PA if patients get less than 90d supply of a med.
- Cancer care and associated practices
- Lidocaine patches, Insulin
- Diabetic meds, seizure meds
- All services and prescriptions with restrictions similar to Medicare/MaineCare
- Melatonin, stimulant medications
- Ultrasounds, generic medications, insulin, respiratory inhalers, psychiatric medications, seizure medications
- Imaging studies for cancer patients; anti-nausea medications for cancer patients
- Phosphate binders are currently our number one issue in Nephrology
- Suboxone is already highly regulated, and the PA process may be life threatening to patients in treatment. PPI medications- this is just a way for insurance companies to fight with drug companies and we get caught in crossfire.

- Asthma inhalers, CV meds, Diabetes meds, Dermatologic treatments
- Antibiotics and pain meds post op
- Insulin (long and short acting), inhalers (short acting and long acting), proton pump inhibitors. **(Multiple Responses)**
- echocardiography, stress echocardiography, cardiac PET, cardiac SPECT in an accredited laboratory
- Antibiotics, antihypertensives, chemotherapy
- MRI and spine procedures, if the provider/practice has a proven track record of providing care per universal care guidelines.
- Imaging, laboratory, surgery, consultations
- Only PA practices that clearly are necessary should be there.
- Generics, Suboxone
- Atypical neuroleptics
- Standard imaging modalities, standard referrals
- Obstetrical ultrasounds, postmenopausal gynecology medications, medically recommended first- line drugs for certain conditions
- Ultrasounds, home sleep studies, PPIs, thyroid hormones, Lyrica, insulins, ACEI and ARBs that are now mostly generic anyway, to name the top ones that come to mind...
- Antibiotics (PA causes delays in treatment that can result in death), nonnarcotic pain medications, including topical analgesics such as diclofenac, lidocaine.
- Buprenorphine
- Antibiotics, antidepressants
- Antimicrobials, MAT
- Should not have to get prior authorization every year on my patients on antiretrovirals. I am clearly not going to stop their treatment, and not going to change medications on a yearly basis because an insurance company changes their formulary or purchasing agreement.
- For children: stimulants, SNRIs, SSRIs, bupropion, atomoxetine, mirtazapine, melatonin. The lockout from metabolic monitoring for atypical antipsychotics needs to stop. This practice leads to children being discharged from hospitals and unable to continue the medication that has stabilized them.
- Viscosupplementation
- Any med or service that might commonly be ordered from an ER., whether or not it is ordered from the ER. An urgently needed CT scan or MRI for example should not require a patient go to the ER in order to avoid a lengthy PA process.
- MaineCare, Over-the-counter items
- Suboxone; at least make the process easier.
- None. We see large variability in physician practice patterns that can be costly and unsafe for patients and families. Volume driven approaches that support over-testing and direct to patient marketing of newer more expensive and unproven drugs are causing inordinate expenses for the healthcare system that are unsustainable for federal and state governments.
- MaineCare: PA for suboxone- purely political, not medical CT's, MRI's
- Antidepressants, generic medications
- Ophthalmologic drugs (eye drops)
- Birth control, Mirena IUD for menorrhagia
- Buprenorphine and naloxone - it's an opioid epidemic.
- Fracture reductions and fixation, Debridements, Nerve compression surgeries (carpal and cubital tunnel syndromes), laceration and open injury repairs, hematoma evacuation and repair, tendon ruptures (Quadriceps, achilles, biceps, triceps, hand tendons, etc.), nerve lacerations, open hand injuries.
- Antibiotics, opiates, MRI, CT, stress tests, cardiac echo, ultrasound

- I think we should have "good prescriber" thresholds for prescribing and ordering practices that is not drug specific but generalized. Once you are within 2 standard deviations of your peer group, you have no PA requirements. Outliers are subject to PA, which may be relieved if practice is determined to have some unique features.
- Hypertensives, insulins, inhalers, oral blood thinners.
- Generic drugs, drugs that are stable maintenance medications should not need a PA every 6-12 months
- Routine x-rays or/or screening CT scans to diagnose presumed active or chronic disease. Basic surgeries to stop recurrent disease and improve QOL.
- Buprenorphine, MaineCare - PA currently required to prescribe under a 90-day supply of psychotropics
- Antidepressants, antihypertensives
- I would personally like to see PROVIDERS that meet certain benchmarks (such as generic prescribing practices) be exempt from needing PAs. Also, patients that receive prior authorization for a maintenance medication should be PERMANENTLY authorized to receive that medicine for life.
- Office based procedures.
- Anything that is not clinically approved for an indication, including antibiotics for chronic Lyme and the new meds for muscular dystrophy need PAs.
- Chronic anti-VEGF treatment in ophthalmology after the patient has passed the initial PA
- CT scans, many medications (i.e. biologics), sleep studies
- Oral steroids, topical pain relievers (i.e. Lidoderm patch).
- Long acting antipsychotic medications, generic psychotropic medications
- Interventional Pain Management
- Hydrocortisone, especially suppositories
- I work in oncology where national guidelines are available. When treatment (medications/radiology) meets a standard national guideline, it should be exempt from PA practices.
- Outpatient surgeries MRI from sub specialists
- US, CTs
- Stress testing and lipid lab testing
- Any short-term meds, like acute pain meds most imaging studies ordered by a specialist
- For oncology, any care falling within the NCCN guidelines
- Imaging (especially when requested by specialist), surgery (when insurers say they have "up to 21 days" to review, the patient suffers; significant health and economic consequences for the patient).
- All prescribing of Suboxone or Subutex. Antipsychotic and antidepressant prescribing.
- Lowering doses of narcotics, ordering generic meds
- Radiology, routine surgical procedures
- Referrals for consultations. All vaccinations
- If a patient is admitted to an inpatient entity, then there should be no extra requirement for prior authorization. Eliminate class exemptions: i.e. certain drugs are only authorized if patients have a certain diagnosis or benefit. Eliminating PA on services and drugs that have zero denials. These types of PAs are designed to ration by inconvenience.
- Stimulants for ADHD; acne medications
- Prior authorization for imaging is time consuming and rarely helpful.
- For procedures follow Medicare guidelines. Insurance companies are putting up time consuming barriers.



**Q7** Please share any comments about your experience with PA practices of the primary non-governmental health insurance carriers doing business in Maine (Anthem Blue Cross Blue Shield, CIGNA, Aetna, Harvard Pilgrim, and Community Health Options).

#### RESPONSES

- Most PA policies are designed primarily to save money for the insurer. They are not evidence-based medical care. If PA policies were based on guiding patients toward better care, both the patients and insurers would benefit.
- The amount of time spent on these PAs take valuable time away from patient care in an already time compressed model. **(Multiple Responses)**
- PAs add to my cynicism about my job which contributes to burnout.
- Most of my patients require insulin. About twice per year, hundreds to thousands of our patients are asked to switch insulin type or petition with a PA. This requires, in my estimation, about one quarter of our staff to spend their time on changing prescriptions or completing PA's. We spend hundreds of hours of staff time each year addressing this issue.
- Medication formulary changes are also a major challenge.
- Preauthorization requirements for drugs, imaging and specialists means many hospitalized critically ill people do NOT get the medical care necessary for prevention of rapid readmissions with recurrence of the same critical illness.
- Denial of approval of an abdominal/pelvic CT for a young woman with ovarian cancer leading to a delay in diagnosis.
- I feel like providers who are prudent in ordering/prescribing practices should not need to do PAs. Some of rules are just absurd (ex. Patients need separate inhalers with meds A and B instead of one inhaler with both A and B in it). My notes should be enough to explain why I want a particular test. Having to get on the phone until my orders are approved by provider rep is waste of everyone's time. **(Multiple Responses)**
- Delaying diagnosis of cancer
- It's pretty obvious [REDACTED] is trying to solve their financial woes/mismanagement by restricting care through PAs.
- Decisions are often made by people with limited medical knowledge.
- It is currently out of control. It is slowing patient care and absorbing staff time preventing them from caring for patients.
- Insurance companies can delay to the following year to shift costs to patient (who may have met co-pay for year already).
- I am now retired. I found PAs on meds to be the most upsetting. For some years I worked 2 days/week. To come to the office on Thursday and deal with a prior auth from the previous Friday was absolutely infuriating ... to put 6 days between action and result is obnoxious. I filled in PAs for old generic drugs like betamethasone cream...absurd! Sometimes the preferred drugs were not even in the same drug class; crazy! I agree that overuse of expensive drugs is common among physicians. But PAs that delay care, slow offices and worsen care to save a few cents are unacceptable and represent the triumph of corporate values over medical needs.
- Getting PT or imaging is absolutely onerous.
- The hassle is that each company does PAs differently. Many have no idea what they are doing, or why. Nor do I. The system from my (admittedly blind) vantage point seems yet another example in the health care system of an utter waste of time and money and resources.
- I think there has to be enhanced communication. Sometimes the insurance company has a good thought, but there are also times where I have made a decision - and for me to then get pushed through a 20-30-minute phone call is ridiculous and often hurts the patient given it can take a while to set up. I would love if the insurance companies had something like those "real time chat" online software that other companies use where, rather than being on hold, we could quickly converse and talk clinically about the case to a provider.
- Time wasted which could be spent on patient care. Patients/family angry, risk for conditions to deteriorate waiting for their medications.

- Staff complain bitterly that they cannot execute a doctor's wishes without a big-time burden and somewhat hassled experience. Doctors are aware of the expense associated with certain tests and drugs, they also are aware of the expense of delaying appropriate treatment. PAs are a big thorn in the side of MDs and a contributor to physician burnout and frustration
- Terrible. It seems that everything needs PA and, in general, is denied. Huge burden on practice staff and physicians. They ignore standard of care and quote guidelines which are their own internal guidelines not even based on national guidelines
- There are a variety of different processes with each insurance and that can make it difficult for staff to consistently support patients.
- Very challenging and time consuming. Each insurer has their own formulary, and formularies can vary within an insurance company depending on level of benefits. Patients are unaware of this process and get frustrated by the delay. All formulary and procedure limitations should be accessible to patients, in patient-friendly language at the beginning of each policy year and kept updated. There also should be a requirement to take responsibility for their formulary decisions. As an [REDACTED] patient as well as provider I have been appalled at how little information the customer service reps have about medications. I have had a customer service rep try to convince me that an over the counter medication works as well as a prescription one- in a situation where that was false. Customer service reps also tend to blame the doc for choosing something not covered.
- It's a form of white-collar crime disguised as a quality issue
- The burden of PAs is one of the reasons I am looking to leave the profession of general internal medicine (primary care). I have been in practice for 17 yrs.
- If anything, they are worse than the government
- This is obviously a ploy to deny services to patients and for insurances to rake in higher profits.
- I am biased because I am a specialist. However, by the time I either order a specialized test or prescribe a specific prescription drug, I have already considered all the alternatives and options. I do not order tests that are unnecessary. I find the prior authorization process with regard to diagnostic tests particularly onerous.
- Although I only infrequently care for pts with autoimmune neurologic illness, the inability to obtain medications for this (such as IVIG, Remicade, pheresis), despite consensus statements and literature suggesting benefit is a detriment to pts and often requires inpatient admission for clearly outpatient infusions, thereby causing increased unnecessary cost for system.
- They function as an obstruction when they should be an enhancement to care.
- Cover my meds web portal has been very helpful, has reduced time by 50%. Imaging and testing are more time consuming
- We need data to see whether PAs are worthwhile - what is their purpose, are they saving money, are they promoting better patient outcomes, are they based on well-designed algorithms or are they just arbitrary?
- This is designed to save them money by blocking more expensive but medically necessary procedures and treatments. They do so by trying to wear down physicians and staff.
- Cover My Meds website helps with most of these.
- Push-back on imaging studies requires a physician to physician consultation by phone which is a waste of time and rarely denied after calling. Switching meds within classes also annoying such as inhalers, proton pump inhibitors and insulins - insurance companies change their formularies year to year based on cost.
- Very frustrating and often antagonistic opinions not in line with patient's presentation
- I've wasted 30 min to get PA for meloxicam. That \$4 medication costs me \$100+ in lost provider time. Insurance company clerks with their business degrees have NO medical knowledge and should not be telling doctors how to practice medicine.
- Frequently MRI studies or interventional spine procedures are denied due to reported lack of documentation of 6 weeks of conservative care in the provided documentation. Frequently the required information is in the notes provided. It seems that many requests are denied in order to add another administrative barrier to payment of

services. The other problem is that not all insurance providers utilize the same criteria so, frequently, there is a guessing game as to what needs to be done to get approval for a study or procedure.

- The whole process bogs down the system and is costly to our office and the insurer for employee time spent. The patient must wait unnecessarily for this process, and ultimately pays a higher price because of the cost involved in the process.
- The PA process is burdensome, delays care, and increases ER visits. Moreover, when calling the insurance companies, I often am unable to speak with a nurse, physician or pharmacist and am left trying to explain clinical medicine to a non-medical insurance representative who is blindly following a coverage algorithm which sometimes makes no clinical sense. I am leaving primary care for hospital medicine in March 2019 and prior authorizations are part of the reason for the change.
- The nature of my practice is that I do not require much outside referral or imaging input but, when I do, the burden is extreme. It is rare that a PA requires less than an hour of work to get through, and these are mostly clinically noncontroversial situations. It is not clear to me that these provide real cost savings, rather than just transferring cost to the PCP. I would support requiring insurance carriers to pay for time spent on PAs, so they would have an incentive to perform a real cost/benefit analysis.
- At best, they slow down the provision of care. At worst, they increase suffering.
- Sometimes the physician has to order studies or go through less effective treatment before the insurer will pre-authorize the most effective treatment plan.
- Our practice of 5 providers has a full-time employee managing prescription prior authorizations. We have an entire department for referrals.
- They unduly burden physicians and their practices, and they have made me think twice about caring for the patients on some of these plans. I have personally had to spend over an hour making calls on behalf of a patient. I believe they are being obstreperous just to save money and deny care.
- I was just told today that an imaging test was denied because it had the wrong CPT code, even though the order had the correct CPT code. I was then told that I needed to start the entire process over again!
- We need to do away with prior authorizations entirely! Almost always the prior authorizations are approved, but they can delay treatment and they take up much too much time for me and my staff--even with tools like "cover my meds"
- It is not only medications, but also PAs for X-rays and other tests. Part of the problem is that you don't know what rules they are following.
- I can almost always make a simple phone call throughout the business day (even after 2pm) to get an approval with private insurers. There are far fewer PAs needed for private insurers.
- The PA process accomplishes very little in providing quality care
- The purpose of PAs is to deny appropriate and needed health care in order to save money for the insurer and increase profits.
- PA are a HUGE burden on providers and office staff. It is not uncommon to have staff members spend 1 hour on the phone to assist a patient through the PA process on a needed medication. Insurers need to help providers know up front what meds are covered and what meds require PAs to reduce this PA process. In an urgent situation a patient should never be denied an initial script until the PA process can be sorted out as this may impact patient care.
- Review is by non-qualified individuals, whether physicians or nurses.
- Private carriers are trying to make it "easier" with an online program, but it doesn't have much flexibility and often results in duplicating efforts by phone.
- There is a learning curve with disparate processes, but the oversight is necessary to support reliable evidence-based practices that counterbalance a volume and intervention driven fee-for-service market place.
- My impression is that the insurance companies throw up barriers, in hopes that the bother of challenging will make it go away; once challenged, they back down. All of this adds hours of phone exchanges, paperwork, and useless energy.
- I'm VERY strict with my indications for surgery (and in general) and have had significant issues with classic PA stories such as telephone calls denying PAs for clearly indicated total joint surgeries.

- I would advocate that the prior auth system needs to have an individual rating system so folks who are doing it right can easily order their testing, and those who are taking advantage of the system, or following bad protocols will need to justify their ordering. I think this would go a long way to helping, but I am not sure how to get it done.
- I spent 2 hours, then my nurse spent another hour on the phone with [REDACTED], trying to get a \$10 antibiotic covered for a patient with cellulitis.
- Stressful for physicians, staff and patients.
- The process (not the people) for all of the organizations is harassment. There are some instances wherein substantial individual harm has occurred as a consequence of delays, but the most significant impact is the distraction from caring for patients.
- Waste of time, resources, energy. Frustrating for staff and patients. They are rude on the phone to staff.
- PA's are just another barrier to doing our jobs, "If we throw up enough blocks, maybe the patient will just pay for it themselves."
- One PA can take 15 minutes or a dozen hours. There can be multiple a day, or none in a week. PAs grind my practice to a halt and put all my other patient care behind. PAs are often not based on clinical criteria. The process itself is full of obstacles and rarely is there any discernible clinical basis for requiring a PA for a drug.
- Often PA info required has nothing to do with clinical care and only serves as a delay to patient care
- Many insurers have labor-intensive PA submission processes. Some are online, whereas others require paper submissions. PAs cause delays in diagnosis and treatment and substantially higher costs for practices (we need to employ staff just to handle PA requests for tests and medications). The insurers then limit the times a peer review can be conducted and cause physicians and APPs to spend valuable time on the phone on hold waiting to discuss a case. This situation is out of hand.
- The program is meant to discourage practitioners from prescribing "high cost" meds, but sometimes "low cost" meds are included as well.
- In the last year, 3 of my clients have had costly hospitalizations due to disruption of access to long acting antipsychotic medications. Two of these individuals has not regained their former baseline. Non- governmental insurers require layers of repetitive paperwork, including filling out forms with info that is already available, and phone calls that seem primarily focused on derailing the PA process by making it too costly and cumbersome.
- PA is designed to SLOW care to save money for the carrier.
- The biggest problem is reviewers who have no understanding of what the specialist does, then requiring "peer to peer" review with another person who doesn't understand the issues. On top of this, they make the process of obtaining a "peer to peer" overwhelmingly cumbersome. It is a thinly veiled effort to get us to give up and cancel the test or procedure simply to save them money. It is a despicable practice.
- Our practice of three doctors has two full time employees working on drug authorizations plus 4 front office staff working on radiology/procedure authorizations. Often doctor to doctor calls are inconvenient, time consuming, and involve answering questions clearly evident in the clinical information submitted at the time of order.
- Inconsistent policies from each insurance carrier
- They consume the time and resources of our office staff without perceived benefit (except for the pockets of insurance companies). There is no improvement in outcome.
- My main complaint is insurances that deny certain meds but do not list which meds are covered. It is incredibly onerous to have to go into individual formularies searching.
- It is a big, big problem. Patients are suffering while insurers sit on their hands. It is unconscionable.
- At least 50% of my MA's time in the office is spent pursuing prior authorizations by commercial payors. She is on hold for 30 minutes at a time, sometimes multiple times daily. We appeal every denial every time and our appeals are almost all eventually granted. The payor gains nothing and we lose plenty. We need to replace prior authorization with information about proper pharmacology.
- Requirements delay or prevent being able to provide appropriate diagnostic testing and treatment.
- No incentive for insurance company to make it user friendly. The opposite. The more procedures they turned down. The more money they make.

