Maine Medical Association

March 3, 2020

To: Senator Heather Sanborn, Representative Denise Tepler, Chairs
Joint Committee on Health Coverage, Insurance and Financial Services

From: Dan Morin, Director of Communications and Government Affairs

Re: **SUPPORT—LD 2106**, An Act Regarding Prior Authorizations for Prescription Drugs

Dear Chairs and members of the Joint Committee on Health Coverage, Insurance and Financial Services,

On behalf of the Maine Medical Association (MMA), representing over 4,300 Maine physicians, residents and medical students, we would like to take this opportunity to provide our support for LD 2106.

Imagine being diagnosed with a chronic health condition — one that interferes with your daily life and makes even the simplest tasks a challenge. Fortunately, your physician has prescribed a medication that's expected to make your condition much more manageable. But then you're shocked to learn that you have to wait days or even weeks. All the while, you're stuck in limbo. There's even a chance that, in the end, your insurer will decide not to cover the treatment, bringing you back to square one. Many patients are frustrated when they realize who is determining their health care needs. Is it their trusted physician or an insurance company?

It is important to note, this bill does not prevent prior authorizations from being utilized. Instead, it is meant to reform and streamline the use of prior authorization so the process does not create roadblocks for patients trying to access medications or restrict health care providers from being able to do their jobs effectively according to their extensive education, training and practice experience.

The prior authorization process diverts too time and too many valuable resources away from patient care. For patients, it delays care, it can lead them to abandon treatments that are recommended by their trusted physicians and it adds stress to those patients waiting for approval.

A nationwide survey of physicians by the American Medical Association found:

- 91 percent of members reported that prior authorization negatively impacts patients' clinical outcomes. Coincidentally, a recent MMA survey showed 91 percent of members believed that prior authorization has a significant or somewhat negative impact on patient clinical outcomes.
- 75 percent reported that prior authorization can lead patients to abandon treatment.
- Nearly 30 percent of physicians report that the prior-authorization process required by health insurers has led to serious or life-threatening events for patients.

The survey also found that more than a third of physicians/practices employ staff strictly to work on preauthorization tasks and every week a medical practice completes an average of 31 prior-authorization requirements per physician, which take the equivalent of nearly two business days (14.9 hours) of physician and staff time to complete.

LD 2106 gives Maine patients who are seeking relief from a diagnosis an opportunity to get the treatment that they've been prescribed in a timelier fashion, thereby improving outcomes for the patient.

Ultimately, LD 2106 will help reduce providers' mounting administrative tasks and 'paperwork', giving them

more time to do what matters most in their line of work: caring for patients. At the same time, patients will be able to more quickly access recommended treatments.

LD 2106 does the right thing. It puts patients first and brings much-needed improvements to a prior-authorization process that's outdated, inefficient, and can potentially harm patients. We urge the Committee to vote Ought to Pass. Thank you.

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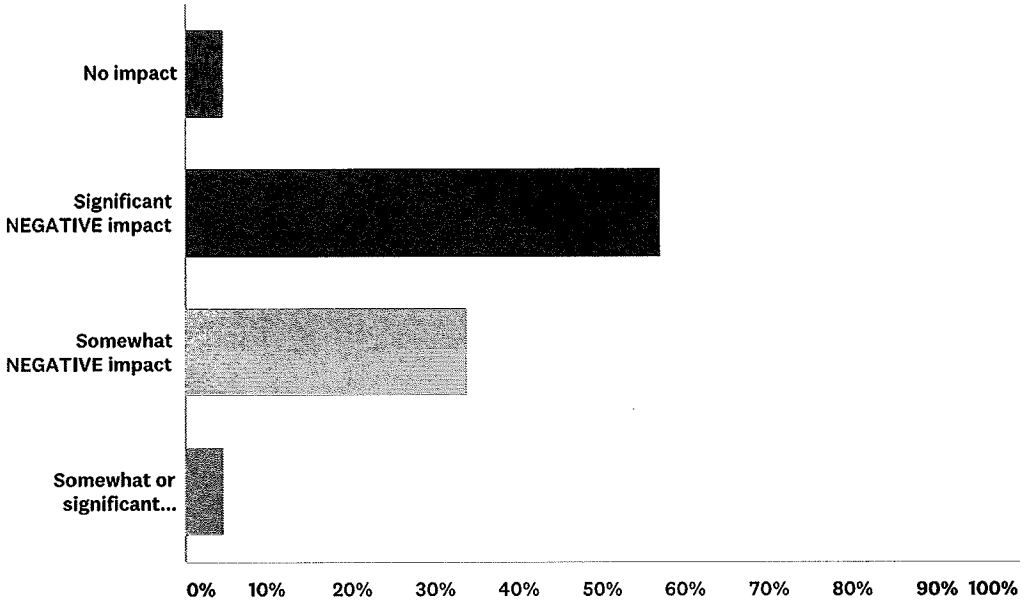
Q1 What is your perception of the overall impact on patient clinical outcomes of PA practices?

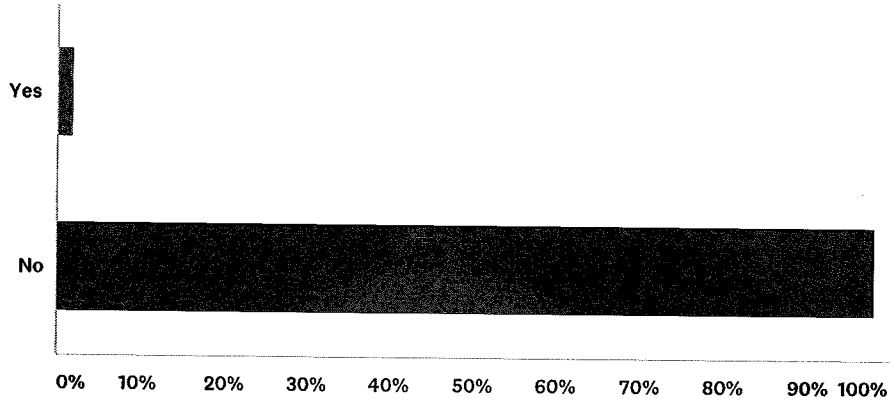
Answered: 219 Skipped: 0



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
TOTAL		219

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)?

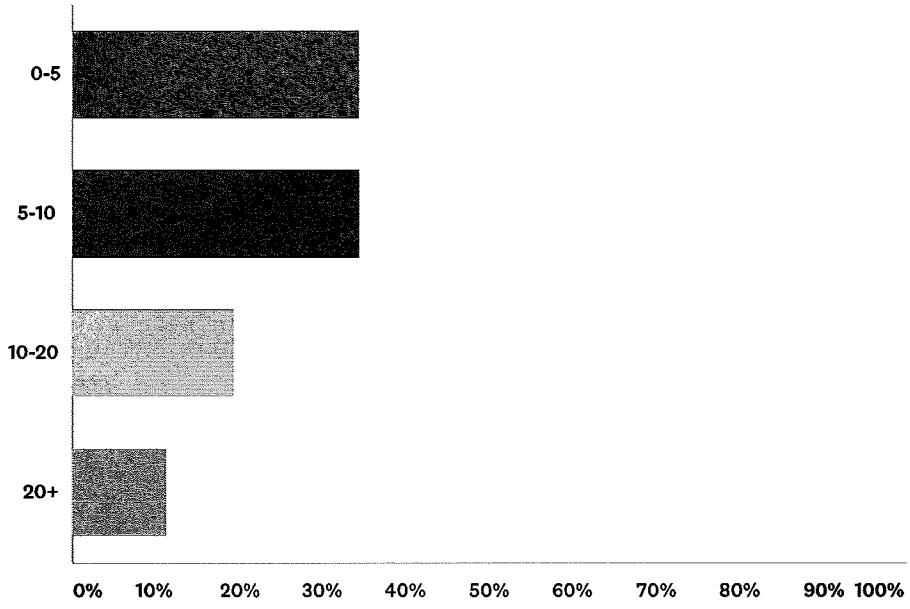
Answered: 218 Skipped: 1



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?

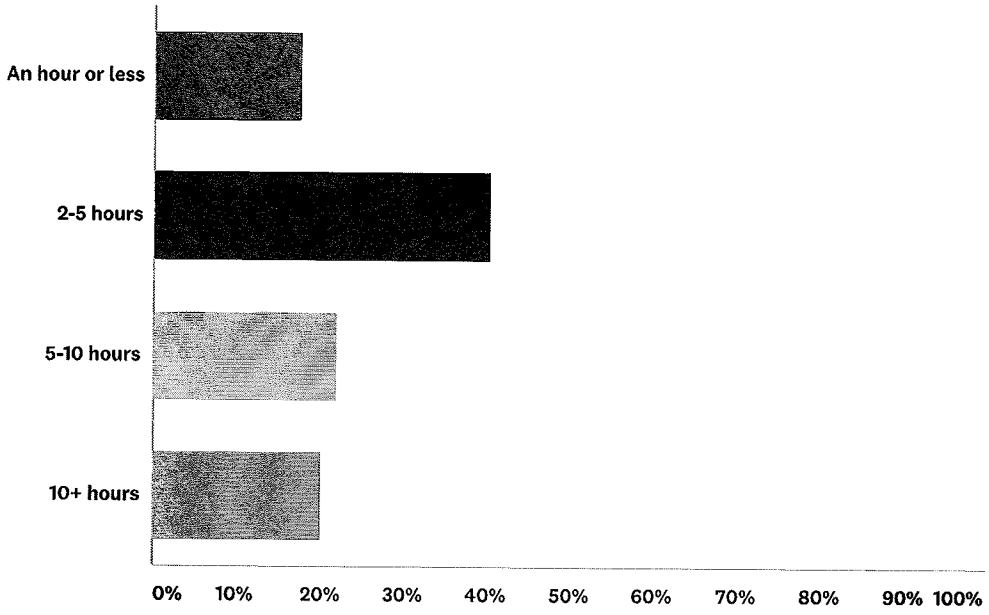
Answered: 211 Skipped: 8



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?

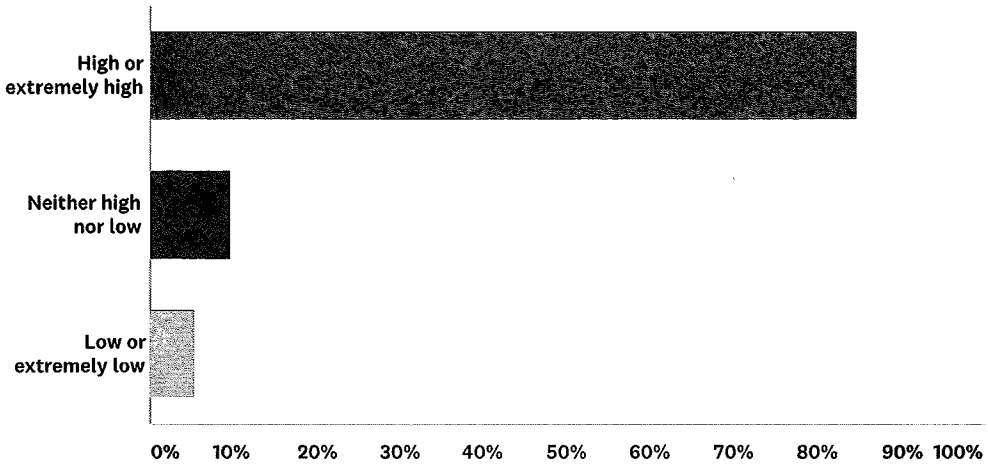
Answered: 210 Skipped: 9



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?

Answered: 155 Skipped: 64

#	RESPONSES	DATE
1	Epilepsy medications	11/26/2018 11:04 AM
2	Medical Imaging /testing ordered by specialist	11/26/2018 8:51 AM
3	PCP referrals, and all commonly used rx's for standard chronic diseases.	11/25/2018 8:20 PM
4	don't know	11/25/2018 6:28 PM
5	diagnostic studies	11/21/2018 2:45 PM
6	acute medications that the patient needs that day to treat an immediate condition	11/21/2018 12:37 PM
7	insulin, continuous glucose monitoring	11/21/2018 10:29 AM
8	All, unless the purported authorizing agencies take some responsibility for their decisions.	11/20/2018 7:51 PM
9	PA process just needs to be easier. duplicate faxes, wrong information when calling and then only being approved for 30 days is craziness.	11/20/2018 2:19 PM
10	Imaging studies Antihypertensives Antibiotics	11/20/2018 11:08 AM
11	All drugs other than experimental, and all medical services other than merely cosmetic.	11/19/2018 11:36 PM
12	Imaging; most medications except those most expensive chemotherapeutic and immunosuppressive agents.&	11/19/2018 11:30 PM
13	With reasonable medical documentation of necessity, neuro imaging and surgical procedures should be exempt	11/19/2018 7:26 PM
14	Very frustrating that easier for me to send patients to ED where can get urgent CT/US/MRI than order as oupt on urgent basis. Need better grandfathering- so if on med and doing well needs to stay on it. Shouldn't have to change brand of insulin every year or get PA for things.	11/19/2018 6:49 PM
15	Nothing should be subject to PA	11/18/2018 7:10 PM
16	All imaging COPD/asthma controller medications Novel anticoagulants Atypical antipsychotics Long-acting stimulants for ADHD management	11/18/2018 6:24 PM
17	All. This should be done through the "front end". First of all trust your clinician networks. Second share with them the clinical rules you expect to be followed. Thirdly if a clinician utilization performance metrics are excellent then cut them some slack. Fourth identify clinicians who don't follow the rules and focus on them. Fifth give utilization feedback to clinicians. Typically they love to know how they compare to their colleagues both locally and nationwide.	11/18/2018 6:19 PM
18	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; for example, deciding PPIs based on deals such as these are ridiculous. Very expensive meds , such as HEP C drugs, that truly should be managed by a specialist, can fall within the regime of a GI specialist. But most primary care docs treat diabetes, HTN, hyperlipidemia, etc In an ideal world, I should be able to order any study that I want at the time I want (for example, an MRI for a patient with an exam that in consistent with a herniated disc, even before the usually recommended waiting period) as long as I am not ordering tests such as these at a rate that is frequent (frequent can be defined by others). Allow me to have clinical judgement to make exceptions. If it is infrequent, allow me to order this in a timely manner without the gamesmanship of referring one to the ER where urgent tests are able to be done. It saves money if I can order these exceptions without my having to go through a PA approval. Let the burden fall to the insurance company to say, "hey, you're ordering this outlier too frequently. Let THEM have the burden of NOT prior approval.	11/18/2018 5:55 PM
19	Stress test, MRI, Ultrasounds, any generic medication	11/18/2018 3:39 PM

20	PPIs, stimulants	11/18/2018 2:02 PM
21	not sure am emergency physician we do not do PA but run into difficulty completing work ups because of it or unable to get appropriate next step testing on an outpatient basis --feeling is all AP's are initially denied	11/18/2018 12:02 PM
22	Any medication that exists in generic form	11/18/2018 9:57 AM
23	Generic Drugs.	11/18/2018 9:08 AM
24	Lyrica, lidoderm patches	11/18/2018 7:12 AM
25	All except extremely high cost drugs and procedures	11/17/2018 2:22 PM
26	NSAIDs	11/17/2018 12:58 PM
27	I think I need to know the purpose of the PA process before I can answer this, and no one has explained this to me. Is it for the insurance companies to save money by not covering expensive medicines? Why don't they negotiate that with the drug companies then, or, better, with single payer, have the government negotiate? WHo is making profits here, and why?	11/17/2018 12:14 PM
28	Continuation of treatment	11/17/2018 9:11 AM
29	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. A major frustration that I have with getting prior authorization for imaging is that my staff will go through the process online and answer questions in the same way that I do but I still have to have a so called peer to peer conversation in which I share the same information and get approval. It is a major waste of my time. Another thing that has happened is that the authorization companies are now having us schedule appointments in order to do these calls. Sometimes I have to block off a patient seeing spot in order to be able to do the prior authorization. We are stretched thin as it is and have very few openings. This is an abuse of primary care.	11/17/2018 8:59 AM
30	All of them.	11/17/2018 7:49 AM
31	Buprenorphine+/- Naloxone, sleep aid, muscle relaxants, PPI, DM meds, all Hepatitis medications, Asprin, PA if patients get less than 90d supply of a med.	11/16/2018 10:13 PM
32	All surgeries and prescriptions. The decision for treatment should remain solely between physician and patient.	11/16/2018 5:52 PM
33	all. Patients can be told they have a higher co-pay for more expensive services or drugs but there should be no PA. Let the patient and doctor decide	11/16/2018 2:30 PM
34	Cancer care and associated practices	11/16/2018 2:25 PM
35	Lidocaine patches Insulin	11/16/2018 1:52 PM
36	Those medications prescribed by a board certified physician which fall within his or her area of expertise. e.g. Enbrel which prescribed by a rheumatologist for rheumatoid arthritis	11/16/2018 12:48 PM
37	diabetic meds, seizure meds	11/16/2018 12:32 PM
38	All medication should be approved to start and then a PA can be requested following an initial period of coverage. To often a patient goes without and the PA process fails and the patient is left in a gap.	11/16/2018 12:16 PM
39	All services and prescriptions with restrictions similar to medicare/mainecare	11/16/2018 12:10 PM
40	melatonin, stimulant medications	11/16/2018 12:03 PM
41	Ultrasounds, generic medications, insulin, respiratory inhalers, psychiatric medications, seizure medications	11/16/2018 12:01 PM
42	imaging studies for cancer patients; anti-nausea medications for cancer patients	11/16/2018 11:28 AM
43	If there is no other reasonable treatment, then PA is a waste of time	11/16/2018 11:11 AM
44	all	11/16/2018 10:53 AM
45	Anticonvulsant medications when prescribed an epilepsy fellowship trained specialist	11/16/2018 10:34 AM
46	They should make sense	11/16/2018 10:33 AM

47	epilepsy medications when prescribed by an epilepsy specialist, epilepsy monitoring unit admissions, MRI brain, PET scans when using standard accepted criteria (they are always approved); EEGs when ordered by neurologists	11/16/2018 10:29 AM
48	I would say basically everything. I don't feel that I order unnecessary testing or medications.	11/16/2018 10:18 AM
49	Phosphate binders are currently our number one issue in Nephrology	11/16/2018 10:14 AM
50	Rx and tests/procedures ordered by board certified specialists; any Rx or test costing less than $500 on a listed price before insurance;	11/16/2018 9:45 AM
51	All	11/16/2018 9:31 AM
52	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.	11/16/2018 9:27 AM
53	Asthma inhalers, CV meds, Diabetes meds, Dermatologic treatments,	11/16/2018 9:09 AM
54	antibiotics and pain meds post op	11/16/2018 9:00 AM
55	Insulin (long and short acting), inhalers (short acting and long acting), proton pump inhibitors.	11/16/2018 8:54 AM
56	all	11/16/2018 8:45 AM
57	echocardiography, stress echocardiography, cardiac PET, cardiac SPECT in an accredited laboratory	11/16/2018 8:26 AM
58	All medical services. Insurance company clerks with an English degree or business degree have NO medical knowledge and should not be telling doctors how to practice medicine.	11/16/2018 8:02 AM
59	Antibiotics, antihypertensives, chemotherapy	11/16/2018 7:39 AM
60	MRI and spine procedures, if the provider/practice has a proven track record of providing care per universal care guidelines.	11/16/2018 7:36 AM
61	Imaging, laboratory, surgery, consultations	11/16/2018 7:04 AM
62	Only PA practices that clearly are necessary should be there. PA's can be a learning practice not just a blunt brake. It's too difficult to find out really why something is not covered and what is needed to justify it.	11/16/2018 6:09 AM
63	All	11/16/2018 3:49 AM
64	Generics Suboxone	11/15/2018 11:54 PM
65	atypical neuroleptics	11/15/2018 11:53 PM
66	Standard imaging modalities, standard referrals	11/15/2018 11:21 PM
67	Obstetrical ultrasounds, postmenopausal gynecology medications, medically recommended first-line drugs for certain conditions	11/15/2018 10:53 PM
68	PPI	11/15/2018 10:31 PM
69	Most of them	11/15/2018 10:22 PM
70	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...	11/15/2018 10:06 PM
71	all	11/15/2018 9:48 PM
72	All	11/15/2018 9:46 PM
73	insulin, inhalers	11/15/2018 8:48 PM
74	Scheduling test and imaging can delay in diagnosis as well as treatment	11/15/2018 8:40 PM
75	antibiotics (PA causes delays in treatment that can result in death), nonnarcotic pain medications, including topical analgesics such as diclofenac, lidocaine.	11/15/2018 8:34 PM
76	specialist recommendations	11/15/2018 8:25 PM
77	The vast majority. Perhaps only very expensive brand only meds and unusual surgeries	11/15/2018 8:15 PM

78	Virtually all except for the most expensive and least evidence based, especially new brand name drugs that are in the same class as inexpensive generics could require PA. However, insulins and inhaled medications should be exempt. I have had significant negative patient outcomes (including hospitalizations) occur due to PA practices in these categories.	11/15/2018 8:04 PM
79	I do not this all imaging should go to prior auth. Suboxone should not need prior auth PPIs are now over the counter - do away with prior auth For those meds that do need PA - a 30 days supply shoudl be given to the patient while a PA is pending as it can take days for the PA to be approved.	11/15/2018 8:02 PM
80	buprenorphine	11/15/2018 7:53 PM
81	Antibiotics, antidepressants	11/15/2018 7:50 PM
82	Antimicrobials, MAT	11/15/2018 7:28 PM
83	All	11/15/2018 7:23 PM
84	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. Getting the prior authorization the first time for the patient with multi-drug resistant virus, or patient who cannot tolerate alternatives should suffice and carry through from year to year, because it is not magically going to change.	11/15/2018 7:05 PM
85	For children: stimulants, SNRIs, SSRIs, bupropion, atomoxetine, mirtazepine, 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.	11/15/2018 7:00 PM
86	Viscosupplementation	11/15/2018 6:55 PM
87	All classes - We do not prescribe unless they assist in patient care	11/15/2018 6:47 PM
88	All	11/15/2018 6:44 PM
89	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 lenghty PA roicess.	11/15/2018 6:44 PM
90	any urgent meds-- antibiotics, inhalers, acute pain meds. I recommend a short supply be provided until there can be communication to the office what is preferred medication as a patient that received a PA will likely not get their medications for 24-72 hrs.	11/15/2018 6:36 PM
91	speciality practices ordering imaging in their field	11/15/2018 6:25 PM
92	MaineCare Over-the-counter items	11/15/2018 6:14 PM
93	Suboxone; at least make the process easier.	11/15/2018 6:13 PM
94	Generic medications.	11/15/2018 6:04 PM
95	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.	11/15/2018 5:44 PM
96	for Mainecare: PA for suboxone- purely political, not medical CT's, MRI's- I supposed these could be abused, but we order them responsibly, never get a denial after appeal, but it takes a lot of time.	11/15/2018 5:43 PM
97	Antidepressants, generic medications	11/15/2018 5:22 PM
98	ophthalmologic drugs (eye drops)	11/15/2018 5:21 PM
99	Imaging requests by specialists	11/15/2018 5:15 PM
100	Most	11/15/2018 5:09 PM
101	MRIs ordered by specialists (in our orthopaedic practice, we see a lot of wasted utilization of this by non-specialists, which has also been shown in the literature; then, when I try to get an actually clinically indicated, potential useful MRI for a patient with private insurance, we have to initiate preauth and sometimes are rejected). Viscosupplementation: although data is mixed, this treatment DOES help some patients and carries low risk if it doesn't work. The only possibility as to why this requires preauth is so that insurance companies can reject the request, thereby denying the patients in whom this might be a helpful treatment of pain relief.	11/15/2018 4:58 PM

102	all of it.	11/15/2018 4:56 PM
103	N/A retired	11/15/2018 4:47 PM
104	birth control, mirena IUD for menorrhagia	11/15/2018 4:39 PM
105	buprenorphine and naloxone - it's an opioid epidemic. MaineCare is as bad on the buprenorphine as anyone else.	11/15/2018 4:33 PM
106	Anti hyperglycemics and equipment for diabetics	11/15/2018 4:29 PM
107	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.	11/15/2018 4:23 PM
108	Antibiotics, opiates, MRI, CT, stress tests, cardiac echo, ultrasound	11/15/2018 4:18 PM
109	I think we should have "good prescriber" thresholds for prescribing and ordering practices that is not drug specific, but generalized. Once you are with 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. There is no drug or service that should be exempt as PA practices came about because of documented irregular/poor prescribing and ordering practices	11/15/2018 4:14 PM
110	ALL have PAs ever been shown to improve outcomes or save money ever? What is the point of these? they drive physicians out of medicine, what is the cost of that?	11/15/2018 4:14 PM
111	all	11/15/2018 4:14 PM
112	hypertensives, insulins, inhalers, oral blood thinners..	11/15/2018 4:06 PM
113	Generic drugs, drugs that are stable maintenance medications should not need a PA every 6-12 months,	11/15/2018 4:03 PM
114	1.routine xrays or/or screening ct scans to diagnose presumed active or chronic disease 2. basic surgeries to stop recurrent disease and improve QOL.	11/15/2018 4:01 PM
115	buprenorphine Mainecare PA currently required to prescribe under a 90 day supply of psychotropics	11/15/2018 3:59 PM
116	Antidepressants, antihypertensives	11/15/2018 3:46 PM
117	advanced imaging ordered by specialist	11/15/2018 3:45 PM
118	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.	11/15/2018 3:36 PM
119	office based procedures.	11/15/2018 3:35 PM
120	Most. Anything that is not clinically approved for an indication, including antibiotics for chronic Lyme and the new meds for muscular dystrophy need PAs.	11/15/2018 3:34 PM
121	chronic anti-VEGF treatment in ophthalmology after the patient has passed the initial PA	11/15/2018 3:30 PM
122	Diabetes medications	11/15/2018 3:30 PM
123	CT scans many medications (i.e. biologics) sleep studies	11/15/2018 3:26 PM
124	oral steroids, topical pain relievers (i.e. Lidoderm patch).	11/15/2018 3:25 PM
125	All	11/15/2018 3:16 PM
126	long acting depot antipsychotic medications generic psychotropic medications	11/15/2018 3:06 PM
127	We should not have to pile authorize a CAT scan for suspected appendicitis because if we do we send him to the ER and if it's negative and they go home that your cost is high we should not his primary care doctors have to do referrals which is different but I bring it up we should not have to do referrals to ophthalmology if optometry says they need to go nor should we do referrals to orthopedic surgeons if there is a fracture because we don't do that care and it's not gatekeeping Also I don't think we should have to prior authorize cardiac rehab when someone has just had a heart attack that's ridiculous these few things would help us a lot	11/15/2018 2:59 PM
128	Interventional Pain Management	11/15/2018 2:57 PM

129	hydrocortisone, especially suppositories	11/15/2018 2:57 PM
130	everything	11/15/2018 2:57 PM
131	All	11/15/2018 2:49 PM
132	asthma drug,synagis,steroids,acne,birth control meds,psych-all meds	11/15/2018 2:46 PM
133	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.	11/15/2018 2:39 PM
134	Out patient surgeries MRI from sub specialists	11/15/2018 2:32 PM
135	specialty testing ordered by Boarded specialist	11/15/2018 2:32 PM
136	US, CTs	11/15/2018 2:30 PM
137	stress testing and lipid lab testing	11/15/2018 2:28 PM
138	any short term meds, like acute pain meds most imaging studies ordered by a specialist	11/15/2018 2:27 PM
139	generic anything	11/15/2018 2:26 PM
140	Asthma inhalers	11/15/2018 2:26 PM
141	for oncology, any care falling within the NCCN guidelines	11/15/2018 2:25 PM
142	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).	11/15/2018 2:23 PM
143	All prescribing of Suboxone or Subutex. Antipsychotic and antidepressant prescribing.	11/15/2018 2:20 PM
144	lowering doses of narcotics, ordering generic meds	11/15/2018 2:20 PM
145	While I understand the need for PAs, there should be some sort of process by which specific types of clinicians can DO THEIR JOB and recommend specific tests or specific medications based on their specialty. For example, most genetic testing SHOULD NOT be ordered by people not trained to interpret them. If a Board Certified geneticist orders a test, it seems likely that they have more training and evidence for the test's appropriateness than anyone who wrote the PA manual. Having to discuss PA denials with "peers" who do not even understand what is being ordered is IDIOTIC. It seems that restricting ordering or prescribing access to different types of clinicians for different specialties would be an easy "first pass' authorization process. Most of the errors in test or medication ordering that I see are requested by people who should never have been requesting them in the first place.	11/15/2018 2:18 PM
146	radiology routine surgical procedures	11/15/2018 2:18 PM
147	Neurologic tests- MRI/EEG/EMG and medications being ordered by a board certified neurologist for a neurologic condition.	11/15/2018 2:13 PM
148	Referrals for consultations All vaccinations	11/15/2018 2:12 PM
149	All	11/15/2018 2:11 PM
150	-If a patient is admitted to an inpatient entity then there should be no extra requirement for prior authorization. -Maine VA prior authorization for patients own primary visits in nursing home setting should be eliminated. -Eliminate class exemptions: ie certain drugs are only authorized if patients have a certain daiagnosis or benefit. i.e atropine drugs are only approved for hospice patients, but they are clinically used for non hospice Parkinson's patients with excessive drooling. This type of PA is actually not even a PA since there will never be an authorization outside the parameters set by payer source. -Eliminating PA on services and drugs that have zero denials. This type of PAs are design to ration by inconvenience.	11/15/2018 2:09 PM
151	stimulants for ADHD; acne medications	11/15/2018 2:05 PM
152	all	11/15/2018 2:03 PM
153	Emergency	11/15/2018 2:02 PM
154	Prior authorization for imaging is time consuming and rarely helpful.	11/15/2018 2:02 PM
155	For procedures follow Medicare guidelines. Insurance companies are putting up time consuming barriers to care Soley for profit.	11/15/2018 1:58 PM

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).

Answered: 128 Skipped: 91

#	RESPONSES	DATE
1	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, the patients and insurers would both benefit.	11/26/2018 8:51 AM
2	This amount of time on these PA's take valuable time away from pt care in an already time compressed model.	11/25/2018 8:20 PM
3	little impact in my pediatric primary care practice	11/25/2018 6:28 PM
4	PAs add to my cynicism about my job which contributes to burnout.	11/21/2018 12:37 PM
5	The majority of my patients use insulin. The basal insulins in particular are not interchangeable. Kinetics and pharmacodynamics are distinct. 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. Many PA's are denied, so the patient uses an insulin that causes them significant disturbances of glucose control. This takes many hours of multiple professional staff to treat. Those who don't call us or whose glucose control deteriorates too rapidly for us to help end up in the emergency department. We spend hundreds of hours of staff time each year addressing this issue.	11/21/2018 10:29 AM
6	Those most affected are PCPs. I would weight that group as having suffered most.	11/20/2018 7:51 PM
7	Medication formulary changes are also a major challenge (insulin, BP meds, cholesterol medications, etc). I wonder the impact of missed medications with formulary change issues + time it takes to get it corrected.	11/20/2018 2:19 PM
8	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.	11/19/2018 11:36 PM
9	Denial of approval of an abdominal/pelvic CT for a young woman with ovarian cancer leading to a delay in diagnosis.	11/19/2018 11:30 PM
10	They're all onerous	11/19/2018 7:26 PM
11	I feel like providers who are prudent in ordering/prescribing practices should not need to do PA. Some of rules are just absurd- need 2 separate inhalers with meds A and B instead of trelegy which is 1 inhaler with both A and B in it. At some point whoever making decisions about what needs PA needs to be more logical. My notes should be enough to explain why I want test- to have to get on phone as provider and read my note bit by bit until approved by provider rep is waste of everyone's time. Clear reason for denial- IE we want f/u visit documenting pain worse- can be easily communicated with staff. Sounds need provider to provider conversation. If pt calls and says feeling worse on phone seems like more affordable to skip visit and go to the test planned at initial visit. IF neurology has consulted on case and wants MRI before they see patient, shouldn't take 10 min of my day to justify to insurance rep.	11/19/2018 6:49 PM
12	Delaying diagnosis of cancer	11/18/2018 7:10 PM
13	It's pretty obvious CHO is trying to solve their financial woes/mismanagement by restricting care through PAs - shame on them and the state's rose-colored attitude toward the CHO product. It was/is a pipe dream.	11/18/2018 6:24 PM
14	its annoying and demeaning.	11/18/2018 6:19 PM
15	Decisions are often made by people with limited medical knowledge.	11/18/2018 4:59 PM

16	It is currently out of control. It is slowing patient care and absorbing staff time preventing them from caring for patients.	11/18/2018 3:39 PM
17	as above, it was mentioned that insurance companies may delay to following year to shift costs to patient whom may have met co-pay for year already	11/18/2018 12:02 PM
18	I am now retired. I found PAs on meds to be the most upsetting. For some years I worked 2 days/week along with another MD who 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 choice of preferred drugs were not even in the same drug class; crazy! When I was in med school I was taught to select drugs and stay with them so that you were totally familiar with them. PAs for meds forced me to Rx meds I didn't normally use; increasing the time it took me to Rx and increasing my likelihood of error. A negative for patient safety. 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.	11/18/2018 9:08 AM
19	Having to answer questions that are not relevant to my request, because the person has a check list	11/18/2018 1:33 AM
20	Getting PT, imaging is absolutely onerous	11/17/2018 12:58 PM
21	The hassle is that each does it 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.	11/17/2018 12:14 PM
22	See above.	11/17/2018 8:59 AM
23	So far, Anthem is probably the easiest to deal with, but PA still requires some work and time out of my day that I don't have.	11/17/2018 7:49 AM
24	I think there just has to be enhanced more thoughtful communication . I think sometimes the insurance company has a good thought - and I think sometimes I would be happy to try something else based on their recs- but there are also many times where I have thought through things and I do need a test or medicine - and for me to then get that pushed through often is a 20-30 minute phone call - which I think 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 softwares that other companies use where rather than being on hold we could quickly converse and talk clinically about the case to a provider.	11/16/2018 11:21 PM
25	Time waisted which could be spent on patient care. Patients/family angry, risk for conditions to deteriorate waiting for their medications.	11/16/2018 10:13 PM
26	The Medicare part d commercial/managed plans are the worst. Utterly inflexible and frequently quite irrational, even for generics such as olanzapine or guanfacine. Please send another survey about Mainecare!	11/16/2018 8:29 PM
27	Just as bad and intrusive.	11/16/2018 5:52 PM
28	Staff complain bitterly that they cannot execute a doctors 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. PA's are a big thorn in the side of MDs and a contributor to physician burnout and frustration	11/16/2018 2:30 PM
29	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	11/16/2018 2:25 PM
30	There are a variety of different processes with each insurance and that can make it difficult for staff to consistently support patients.	11/16/2018 12:16 PM

31	very challenging and time consuming as each insusror has their own formulary and formularies can vary within and insurance company depending on level of benefits. Patients are unaware of this process often 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- Patients are after all paying the premiums!! There also should be some education for the insurance companies andrequirement to take responsibility for their formiulary decisions. As an Athem 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. Not helpful.	11/16/2018 12:10 PM
32	Its a form of white collar crime disguised as a quality issue	11/16/2018 12:10 PM
33	minimal experience	11/16/2018 12:03 PM
34	The burden of PA's 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.	11/16/2018 12:01 PM
35	If anything, they are worse than the government	11/16/2018 11:11 AM
36	this is obviously a ploy to deny services to patient and for insurances to rake in higher profits	11/16/2018 10:53 AM
37	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 unecessary; so I find the prior authorization process with regard to diagnostic tests particularly onerous. A good example would be a patient with an acute severe disk herniation and sciatica with a progressive neurologic deficit. I do not need an insurance company to tell me that I need to have an MRI scan without 6 weeks of physical therapy or conservative treatment. But it will require me a 45 minute process to do a peer-to-peer review in order to get what I want. It makes me wonder why I went to the trouble of being trained as a specialist, when I have to answer to a high school graduate reading from a manual, or a retired physician who know less about what I am doing than me.	11/16/2018 10:35 AM
38	Although I only infrequently care for pts with autoimmune neurologic illness, the inability to obtain medications for this (such as IVIG, Remicaid, 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.	11/16/2018 10:34 AM
39	They function as an obstruction when they should be an enhancement to care.	11/16/2018 10:33 AM
40	cover my meds web portal has been very helpful, has reduced time by 50%. Imaging and testing is more time consuming	11/16/2018 10:29 AM
41	Imaging prior PAs that are originally denied are then approved when peer to peer done relating the exact same information that was provided in the original order. Also, having to "schedule" time for a peer to peer review is difficult with busy practice schedule.	11/16/2018 10:18 AM
42	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?	11/16/2018 9:45 AM
43	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. In my office THEY WILL NOT WIN. The patients will win but at great expense to us.	11/16/2018 9:31 AM
44	Cover My Meds website helps with most of these- but often where there is a rejection it takes another hour to figure out what is actually ON formulary. Our software is not yet good enough to run interference on this- if the insurance carriers want to push us into lower cost utilization, they should step up and help the EMR software companies do this better, rather than torturing us	11/16/2018 9:27 AM
45	AEtna, Cigna and CHO have very low reimbursement rates to physicians and require more effort to provide care to patients due to referral and prior auths. Staff spends more time on these and increased cost to primary providers. Pts do not get treated as effectively or quickly.	11/16/2018 9:09 AM
46	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.	11/16/2018 8:54 AM

47	Prolonged time on hold waiting to even speak to insurance representatives drives up health care cost	11/16/2018 8:46 AM
48	very frustrating and often antagonistic opinions not in line with patient's presentation	11/16/2018 8:45 AM
49	Question 3 above doesn't adequately capture what you intend -- the number is lower than what it would be because knowledge that I have to wrangle with PA affects what a I order for certain patients. For cardiac PET in Medicare patients, as Medi HMO requires PA and straight Medicare does not, this means there's a double standard present for optimal testing. PET is superior to SPECT.	11/16/2018 8:26 AM
50	I've wasted 30 min to get PA for melixicam, a $$ medication. That $4 medication costs me $100+ in lost provider time. Insurance company clerks with their business degree have NO medical knowledge and should not be telling doctors how to practice medicine.	11/16/2018 8:02 AM
51	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, but frequently the information is actually in the notes provided. It seems that many requests are just denied to add another administrative barrier to payment of services. this office provides epidural steroid injection treatment for acute disc herniation, and many times there is availability to provide the treatment to the patient on the same day of consultation, but we cannot do so as the procedure needs prior authorization. This can delay treatment for a painful condition, and require a return to the office for a second visit to get the injection. this results in additional time out of work for the patient and/or family members assisting in patient care. 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.	11/16/2018 7:36 AM
52	Much time is spent with the preauthorization process but because appropriate tests are being ordered, they are almost always authorized. 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.	11/16/2018 7:04 AM
53	My above numbers are low because I only work 1-2 days a week. Staff have to be trained, Doing PA's instead of other work to benefit patients. Patients have delays.	11/16/2018 6:09 AM
54	I have had great difficulty with multiple insurance carriers, but Cigna is particularly problematic. They have declined necessary care which has put patients at risk. Moreover, Cigna suggested that I order testing that was medically unnecessary at cost to the patient. (46 year old with LLQ pain and tenderness and fever x months. CT scan abd/pelvis was denied. Cigna suggested that an ultrasound of the abdomen had to be ordered first.) 38 year old healthy woman with stroke symptoms with a physical exam suggestive of stroke. An MRI of the brain was denied.) I feel our institution should not accept Cigna insurance because of this. The PA process is burdensome, delays care, and increases ER visits (can't get PA, refer to ER). 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. Kirsten Staples, MD	11/16/2018 5:44 AM
55	Am now retired, but clearly recall the inordinate amount of time and effort spent by staff to address PA practices with no apperent benefit to patient care.	11/16/2018 1:31 AM
56	Long times on hold taking away from patient care.	11/16/2018 12:47 AM
57	Medicare C plans are the worst	11/15/2018 11:54 PM
58	Mainecare requires some meds to be brand name over generic. This should be an automatic substitution state wide not requiring doc or office involvement.	11/15/2018 11:53 PM
59	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 and hour of work to get through, and these are mostly clinically noncontroversial situations (ie neck MRI for new onset arm weakness). 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.	11/15/2018 11:21 PM
60	Delays or denials of payment for obstetrical dating ultrasounds. Multiple submissions of different prescriptions in attempts to find what is covered by the patient's insurance. Denials of coverage for drug of choice treatment, for example, clobetazole for lichen sclerosis.	11/15/2018 10:53 PM

61	Limited.	11/15/2018 10:31 PM
62	WAY too much time taken up with WAY too many on-line steps, that then fail and lead to talking to WAY too many people who have different takes on what is covered and isn't or just don't know, leading to WAY too many instances where the doctor has to SCHEDULE to get on the phone with a "peer" who usually fights you to get anything approved and then often eventually gives a confirmation number after you get fed up and complain about this insane process.	11/15/2018 10:06 PM
63	At best, they slow down the provision of care. At worst, they increase suffering.	11/15/2018 9:46 PM
64	It usually does not say in the denial letter, what other alternative medications are covered by their insurance. It is a process to try to look online to find what is covered or call the number that this listed. This process is EXTREMELY time-consuming. I would rather not spend ANY time on going through PA processes for drugs like insulin and inhalers. If it is for rare types of medications, this may be more warranted.	11/15/2018 8:48 PM
65	Sometimes the physician has to order studies or has the patient go through less effective treatment before the insurer will Pre authorize the most effective treatment plan.	11/15/2018 8:40 PM
66	Our practice of 5 providers has a full time employee managing prescription prior authorizations. We have an entire department for referrals.	11/15/2018 8:34 PM
67	They unduly burden physicians and their practices and they have made me think twice about caring for the patients on some of these plans. It's truly ridiculous. I have personally had to spend over an hour making calls on behalf of a patient with Community Health Options. The study was absolutely indicated and ultimately approved, but it required my personal attention during a busy day of patients. It was absolutely maddening and I believe they are being obstreperous just to save money and deny care.	11/15/2018 8:15 PM
68	I disagree that mainecare and medicare do not require PA especially for medications, they are just as frequent. They change formulary on many meds annually or even more often. They force changes in medication that are harmful to patients or leave them without medications. They waste an inordinate amount of time on the part of physicians, medical staff, pharmacists and patients. It cannot possibly be worth it and should be heavily lobbied against. I am happy to receive notifications that I could save my patient (or even the insurance company!) money, and how much, by changing medications at my discretion. That would be a better system.	11/15/2018 8:04 PM
69	I was just told today that an imaging test was denied because it had the wrong CPT code, despite the fact that the order had the correct CPT code. I was then told that I needed to restart the enture process over again. My practice has also been told by Aetna and Anthem that we are not in the preferred provider list so we are not allowed to get the PA for imaging. We are still trying to figure this out as we are listed as the patient's PCP and take their insurance?	11/15/2018 8:02 PM
70	need to do away with this prior auths entirely! What also bugs me is when they decline to cover a med they usually don't say on the same paper what alternative similar med they might cover without a prior auth. Almost always the prior auths 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"	11/15/2018 7:23 PM
71	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; they should offer alternatives to the medication or list formulary items that they prefer.	11/15/2018 7:13 PM
72	If we try to get approval for a hepatitis C drug (for example) and the company denies since it is not on their formulary, it would be nice if they could let us know what IS on their formulary, rather than making us redo all the paperwork again and again (in patients who we actually have choices of agents) until we hit upon the right drug.	11/15/2018 7:05 PM
73	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.	11/15/2018 7:00 PM
74	Recently I have had to do PAs for EGDs which I have never had to do.	11/15/2018 6:59 PM
75	Peer to peers take a significant amount of physician time	11/15/2018 6:55 PM
76	PA process accomplish very little in providing quality care	11/15/2018 6:47 PM
77	The purpose of PA is to deny appropriate and needed health care in order to save money for the insurer and increase profits.	11/15/2018 6:44 PM

78	The frequent office PA's is a HUGE burden on providers and office staff and it is not uncommon to have staff members spend 1 hr on phone to assist a patient through the PA process on a needed medication. there need to be several urgent changes to 1. help providers know up front what meds are covered and what meds require pa's to reduce this PA process. 2. I become most infuriated with insurance companies when I get a notification from an insurance carrier that a pt "needs a PA" without any other information. With that notice of needing a PA, I absolutely need to know what medication should have been tried or that is" in plan" to be tried that does not require a PA. this will then save my staff hours of time a week 3. 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.	11/15/2018 6:36 PM
79	review is by non-qualified individuals, whether physicians or nurses.	11/15/2018 6:25 PM
80	The commercial plans are terrible! Express Scripts and CVS Caremark just make life for my patients miserable and prevent patients from getting the meds they need. MaineCare P.A.s are a breeze and the staff is terrific at helping my patients and me in accessing the medications they need. Why Express Scripts and CVS Caremark cannot provide such excellent service as MaineCare is tragic and has hurt my patients. It's ironic Maine medicaid patients have better coverage than us doctors and only wish the folks that run PAs for MaineCare managed our own benefits.	11/15/2018 6:22 PM
81	I have very few CHO patients and NO OTHER private insurance patients due in part to the onerous tasks of PA's. Same for Medicare. I find the Medicaid/MaineCare system fairly easy and fair EXCEPT it is very difficult to get some patients to list me as PCP. They DO require PA for specialist to see my patients and for many medications.	11/15/2018 6:14 PM
82	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.	11/15/2018 6:13 PM
83	Community Health Options has been particularly problematic. Every test seems to be questioned. I understand the reason for questioning some tests, but there are times when tests may be necessary despite what the algorithm shows(i.e. LBP with sciatica without weakness not responding to steroids and present for 8-10 weeks-while not likely a surgically responsive case, identifying anatomy to explore epidural steroid injection, synovial cyst aspiration(had 2 with prompt symptom relief) or pursuing non back cause of symptoms(diabetic amyotrophy in 2 cases) are benefitted by having the MRI. Cost to patient of unresolved pain is likely greater the cost savings for insurance company denying the test)	11/15/2018 5:57 PM
84	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.	11/15/2018 5:44 PM
85	I can't differentiate between the different insurance companies, would have to check. Basically, my impression is that the insurance companies throw up barriers, in hopes that the bother of challenging will make it go away; one challenged with their "expert review", they back down. All of this adds hours of phone exchanges, paperwork, useless energy.	11/15/2018 5:43 PM
86	Optum and Aetna are by far the most painful to deal with. Their formulary is capricious and stepped care algorithms aren't consistent with expert consensus guidelines.	11/15/2018 5:22 PM
87	-	11/15/2018 5:21 PM
88	Consistently a waste of my time - many times am asked to do a "peer-to-peer" session on phone, only to find that my "peer" at the reviewing company has ZERO experience in anything even close to my specialty	11/15/2018 5:15 PM
89	Anthem Blue Cross Blue Shield is far and away the worse of the lot. 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.	11/15/2018 4:58 PM
90	Just did an MRI Pa from BCBS. it was irritating but reasonably efficient.	11/15/2018 4:56 PM

91	after nearly losing my patience with a "peer to peer" discussion I learned a great deal as to where some of the issues with PA are and what might be done to help the situation. I had to do a peer to peer discussion for a AAA screening. Epic picks these folks out for us and reminds us that they are 1) male 2) 65-75 years old and 3) smoked cigarettes. what I did not put in my note was that the patient smoked more than 100 cigarettes in their lifetime. When I finally was able to talk with the department lead, I learned that they deal with practices where physicians are ordering 2+ ultrasound tests per patient per year. (they own the ultrasound machines). This is a part of why the PA process exists. So, we need to somehow police ourselves better. Secondly, 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.	11/15/2018 4:53 PM
92	N/A retired	11/15/2018 4:47 PM
93	I spent 2 hours, then my nurse spent another hour, trying to get a $10 antibiotic covered for a patient with cellulitis from Workman's Comp.	11/15/2018 4:33 PM
94	Stressful for physicians, staff and patients.	11/15/2018 4:29 PM
95	They all suck.	11/15/2018 4:23 PM
96	Patients are not getting stress tests within the recommended time frame from chest pain presentation due to PA	11/15/2018 4:18 PM
97	The process(not the people) for all of the organizations(some worse than others) is harassment except Maine Care which is the best of the lot for reliability and predictability making it only annoying. 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. We work in a HPSA and this decreases our capacity to see more patients.	11/15/2018 4:14 PM
98	Waste of time resources energy, frustrating for staff and patients. They are rude on the phone to staff. My staff has been insulted because they are not physicians. "We only will speak with the physician" particularly around PAs for imaging, yet in the State of Maine there are not enough physicians to do the work so patient care is managed by FNPs or PAs who order these tests and know the pts best. The work is time consuming and disruptive. It is a huge dissatisfier for health care providers.	11/15/2018 4:14 PM
99	PA's are just another barrier to make it more difficult to do our jobs. "If we throw up enough blocks, maybe the patient will just pay for it themselves....."	11/15/2018 4:07 PM
100	The amount of time is extremely variable. One PA can take 15 minutes or can take a dozen or many more hours within 2-3 weeks. There can be none in a week or 4. Four time consuming PAs can grind my practice to a halt and put all my other patient care behind. There is no "typical week". Medicare patients are also subject to PAs and they can be very challenging as well. The PAs are often not based on clinical criteria. Spending significant time to get a PA for a sleep medication when the only clinical question "Does the patient have difficulty sleeping?" is a waste of time. The process itself is full of obstacles and rarely, other than if a drug is expensive and has no generic, is there any discernible clinical basis for requiring a PA for a drug.	11/15/2018 4:03 PM
101	Harvard Pilgrim and CHO seem to be the worse when it comes to PA.	11/15/2018 4:01 PM
102	Medicare part D plans are typically most cumbersome Often PA info required has nothing to do with clinical care and feels entirely perfunctory and only serves as a delay to patient accessing needed medication	11/15/2018 3:59 PM
103	Martin's Point is horrible when it comes to authorizing US, CT, or MRI. These tests are routinely denied without any feedback to the provider as to why. After this first denial, the insurance company will not accept any additional documentation to support the order or to reverse the ruling. It is then sent for a peer-to-peer discussion which places a significant burden on the ordering provider. When the provider calls the medical reviewer, the reviewer expects the provider to plead their case, while they themselves have not even reviewed any of the documentation.	11/15/2018 3:36 PM
104	Very difficult to access carrier. Long wait times holding on phone. Impediments to reaching a live individual	11/15/2018 3:35 PM
105	I am a pediatric Hospitalist, so this impacts me very little	11/15/2018 3:34 PM
106	Similar across the board	11/15/2018 3:30 PM

107	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.	11/15/2018 3:26 PM
108	Obviously the program is meant to discourage practitioners from prescribing "high cost" meds, but sometimes "low cost" meds are included as well.	11/15/2018 3:25 PM
109	Burdensome and unnecessary.	11/15/2018 3:16 PM
110	The majority of the time authorization was granted but the process sucked up a great deal of staff time	11/15/2018 3:07 PM
111	In the last year, 3 of my clients have had costly hospitalizations due to disruption of access to long acting antipsychotic medications-- so penny wise and pound foolish, as well as the distress and destabilization of a human being; 2 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 in progress notes, phone calls etc that seem primarily focused on derailing the PA process by making it too costly and cumbersome (as time is not reimbursable) to pursue rather than on patient safety or fiscal prudence. For example, generic guanfacine for hyperactivity or PTSD should be a very cheap medication but there is lots of paperwork now to continue rx's even for clients for whom longterm benefit is well established, Drug pricing remains in general very confusing. Pharmacies and insurance companies should be collaborating to inform clients when a cheap generic would be less costly to buy out of pocket rather than going through a lengthy PA process that results in a higher copay for the client.	11/15/2018 3:06 PM
112	My main experiences with anthem they have Alm services You can go online where it's a little better than on the phone but if you called him on the phone you must punch in your NPI and member ID and then they proceed to ask you the NPI in the member ID this sends doctors through the roof I am respectful of the privacy laws and that there needs to be some verification but I also note that when I called dominoes they know where I live and when I called budget rent a car they know what car I rented two years ago so why can't these people know my NPI that's not a big secret I have to type that in all the time on the main care forms growl	11/15/2018 2:59 PM
113	PA is designed to SLOW care to save money for the carrier. They try to force doc to commit to a specific location or technique for fluoro guided injection. Patient presentation on procedure day or first fluoro image sometimes forces a change in plan. PA interferes with that! Does not matter if PA is non-government or government. Also, peer to peer "appeal" is BS! The insurance company doc reads from a textbook. It is a waste of time.	11/15/2018 2:57 PM
114	they don't help	11/15/2018 2:57 PM
115	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.	11/15/2018 2:49 PM
116	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. In one case, a patient was repeatedly denied the first line standard treatment for metastatic breast cancer because some pharmacist didn't understand the guideline he was reading and had no direct experience with breast cancer. It was weeks of extra waiting for the patient and many hours of time spent by people in our office	11/15/2018 2:39 PM
117	Nonconsistant policies from each insurance carrier	11/15/2018 2:32 PM
118	Overall they consume time and resources of our office staff without perceived benefit except for the pockets of insurance companies. No improvement in outcome.	11/15/2018 2:27 PM
119	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. Should not happen.	11/15/2018 2:26 PM
120	way too many prior auths and disruption from Cigna, Aetna, and martins point generations advantage	11/15/2018 2:25 PM

121	It is a big, big problem. Please feel free to call our office (Maine Spine Surgery 553-6054) to hear all about just how crazy this is getting. Patients are suffering while insurers sit on their hands. It is unconscionable.	11/15/2018 2:23 PM
122	At least 50% of my MA's time in the office is spent pursuing prior authorizations by commercial payors. She is on hold on the phone 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. OF COURSE prescribing antipsychotics to the demented elderly is dicey. OF COURSE prescribing two antipsychotics at once is seldom advisable. OF COURSE atypical antipsychotics can cause metabolic derangement and appropriate labs should be drawn. Just REMIND us of these things if you must, even to the point of using he words "potential source of liability". Just don't treat us like errant kids or people who cheated their way through school.	11/15/2018 2:20 PM
123	mainecare pa approval is simpler than many private insurance companies. It is possible to quickly get to someone who can tell you what the rules are, this is not true with private insurance.	11/15/2018 2:20 PM
124	Anthem is a nightmare, their on-line system frequently does not work and often does not provide the needed information. We actually ahd a QI project last year on their portal and found that we were spending upwards of 20-40 minutes dealing with them. After which they don't approve things anyway. Aetna's PA process for pricy medications is so onerous that they likely expect to save money through attrition alone (PAs are good for 2 months....for a chronic medication, and then we get to do the paperwork all over again). CIGNA has a specific form for Genetic testing that requires a signature by a D Geneticist or a genetic counselor and that speaks to the issue I brought up in question 6.	11/15/2018 2:18 PM
125	Requirements delay or prevent being able to provide appropriate diagnostic testing and treatment.	11/15/2018 2:13 PM
126	PA for physician visits for Humana and subsidiaries and community health services are required before inpatient visits. Something physicians are often unable to do or unaware of, leading to unnecessary denials of clinically necessary visits. This type of PA and denial is designed to abuse the logistical barriers to obtaining PAs when it comes to physician visits in inpatient settings. PA of ambulance transfers for patients in winter time is a concern for Mainers who are using assistive devices and being discharge home with a nonambulance service instead.	11/15/2018 2:09 PM
127	My practice is limited to EM where I use limited and mostly generic meds	11/15/2018 2:06 PM
128	As above. We are interventional pain medicine practice. PA practices, frequent changes in requirements, forms to fill out, then denials, then appeals, patients waiting for care frustrated patients. Multiple staff hours. The worst is having to get a prior authorization by phone call. On hold, waiting to get through, dropped calls. No incentive for insurance company to make it user friendly. The opposite. The more procedures they turned down. The more money they make.	11/15/2018 1:58 PM