Prior authorization and its impact on access to obstetric ultrasound

Vanita D. Jain, MD; Fadi A. Bsat, MD; Michael S. Ruma, MD, MPH; Anthony C. Sciscione, DO; Brian K. Iriye, MD

The Problem

Prior authorization is approval from an insurer that is required before a patient receives a procedure to be covered by that payer. Payers have traditionally sought oversight of imaging practices because of a history of overuse when a physician has an ownership interest.

The persistent failure to responsibly manage conflicts of interest by some physicians led to suspicion if not distrust by payers. Payers attempted to solve this issue with the creation of prior authorization. However, what started as monitoring for very specific procedures has now expanded to industry-wide efforts by payers to reduce their immediate costs and decrease utilization within all aspects of patient care.[1]

The problem now involves numerous insurance companies across the country, leading to increased administrative burden to practices and a potential barrier to care for patients. According to a 2017 survey by the American Medical Association, 92% of physicians reported preauthorization sometimes, often, or always delays access to care. In the same survey, 64% reported waiting an average of at least 1 business day for insurers to provide preapproval for a test, procedure, or drug; 30% reported waiting at least 3 business days.[2] Of concern, 92% of physicians reported preauthorization had a negative impact on clinical outcomes. Comparing these results with 2016, the negative impact on patient care is worsening.[3]

Some payers utilize an intermediary, such as a radiology benefits management company, to act on their behalf to review provider requests to perform imaging. This adds an additional waiting period for a verdict, potentially creating hazardous delays for pregnant patients. Our patients have immediate medical needs, complicated obstetric histories, or a travel of significant distances for care (39% of reproductive-aged women live in counties without maternal-fetal medicine [MFM] providers).[4]

There is also concern for conflict of interest. If the intermediary saves payers money by limiting the approval of ultrasound services, they implicitly increase their likelihood of rehire by insurers because they have directly improved payer profitability while simultaneously decreasing access. The process lends itself to direct/indirect financial incentive.

Intermediaries may also choose who they want to hire to adjudicate their claims. It is not surprising then that they prefer nonsubspeciality clinicians (registered nurses or physicians in non-obstetric fields) for these positions for cost savings purposes. These gatekeepers may not have clinical experience with specific pregnancy imaging services or the same knowledge bank as the board-certified subspecialty physician requesting the procedure. These providers deny claims for imaging based on unknown authorization guidelines.

Guidelines are not always vetted by subspecialty providers and are not necessarily published or readily available to the physician. This represents an unregulated ability to control care in association with increased payer profitability.

Altering the medical approach to pregnancy care to comply with burdensome requirements created by health plans place patients at risk for adverse perinatal outcome. For example, requiring prior authorization for screening cervical length in patients with a prior history of preterm birth,[5,6] or growth ultrasound for women at risk for fetal growth restriction, only delays care and could have an impact on outcomes.

Requiring preauthorization prior to imaging fetal anatomy (a standard of care in pregnancy) delays care and could have an impact on the gestational age at which the patient undergoes that ultrasound. Timely evaluation of fetal anatomy to identify a congenital birth defect is crucial to allow a woman to consider all her reproductive choices. A pregnant woman may be required to return for care only after approval is granted pushing that gestational age window for when imaging is performed.

As of Sept. 1, according to the Guttmacher Institute, 17 states ban abortion at 22 weeks from the last menstrual period (20 weeks after fertilization in state law).[7] Days matter for women seeking reproductive choice. Prior authorization is an obvious impediment. Because of an approval for imaging procedures, patients may face additional costs for transportation, child care, and lost wages. In our current health care state with increasing gaps in care because of lack of resources, prior authorization exacerbates the health inequities faced by pregnant women attempting to access medical care.

A PubMed search using the key words prior authorization, obstetric, pregnancy, and ultrasound yielded no results. This illustrates a lack of current evidence to support prior authorization as beneficial to patients or to improved health

From the Delaware Center for Maternal-Fetal Medicine of Christiana Care, Inc, Newark, DE (Drs Jain and Sciscione); the Department of Obstetrics and Gynecology, University of Massachusetts Medical School–Baystate, Springfield, MA (Dr Bsat); Perinatal Associates of New Mexico, Albuquerque, NM (Dr Ruma); and the High Risk Pregnancy Center, Las Vegas, NV (Dr Iriye).

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Corresponding author: Vanita D. Jain, MD.
vjain@dcmfm.com

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outcomes, specifically related to obstetric imaging.[8]

Within our field in general, prior authorization has had an impactd on patient access. Limited studies are published; however, one example is a 2018 study, identifying the administrative burden of preauthorization as a key barrier to 17 alpha-hydroxyprogesterone caproate injections in a Medicaid population, emphasizing the impact on impoverished pregnant women.[9] Our concern remains that while preauthorization may be financially advantageous for the health plan in the short term, its use may cause harm and increase the cost of care for pregnancy.

Prior authorization for the provision of routine and medically indicated obstetric ultrasound, being performed by providers following the standard of care, evidence-based guidelines as well as national guidelines impedes the timely provision of care, creates uncompensated work for providers, escalates administrative overhead within their offices, and contributes to physician burnout.

In other procedure-based subspecialties in which high-risk patients may require imaging procedures at the time of the first visit, a similar plight is noted. In 2017, the American College of Cardiology stated that patient care and safety are at risk secondary to the use of prior authorization, with 77% of cardiologists noting less time was spent on patient care than on the time required for medical documentation necessary for the preauthorization process.[10]

Payers have a right to be concerned for unnecessary utilization of obstetrical imaging and overuse by certain providers. However, data from radiology suggest that a no-denial policy, that is, eliminating denial provisions for advanced diagnostic imaging, in fact did not increase utilization.[11] There are other strategies that could be employed rather than the use of preauthorization.

The Solution

First and foremost, we advocate that payers should eliminate the requirement entirely for obstetric imaging. If payers continue with preauthorization, we recommend the following comprehensive strategies.

1. Overuse of diagnostic imaging must be curtailed. In 2013, Drs O'Keefe and Abuhamad[12] published data on obstetric ultrasound utilization in the United States using insurer data in the management of high-risk pregnancies. The study noted an increase in imaging of low-risk pregnancies and a higher-than-expected utilization of the targeted fetal anatomy survey (Current Procedural Terminology [CPT] 76811). The question was posed then was this due to appropriate or inappropriate use of the detailed/targeted fetal anatomy survey (CPT 76811)? How could we determine value, quality, and competency for obstetric imaging?

Recognizing this, the Society for Maternal-Fetal Medicine (SMFM), the American College of Obstetricians and Gynecologists (ACOG), the American Institute of Ultrasound Medicine (AIUM), and the American College of Radiology have worked tirelessly to provide up-to-date guidelines on indications to perform imaging in pregnancy.[13,14] These practice parameters detail appropriate use criteria for obstetrical ultrasound defining when to do and how often to do procedures in the context of scientific evidence and expert consensus. These criteria are rigorously reviewed, edited, and debated to help physicians, policymakers, payers, and medical societies ensure patients receive appropriate care during pregnancy.

There is still more work to be done in this arena. Development of guidelines for all antenatal testing and imaging studies by speciality societies should be created so that individual variation in practice can be decreased. The overuse of obstetric imaging must be managed. Imaging studies that are inappropriate, unnecessary, wasteful, or redundant must be eliminated.[15]

Obstetric imaging that follows published evidence-based guidelines should not be subject to prior authorization requirements because this is clearly of low value and unnecessary. Fear of malpractice may have an impact on the use of obstetric imaging.[15]

Meaningful tort reform is needed, but publication of clinical guidelines may help in the interim. MFM physicians should be proactive by educating their referring providers about available evidence-based indications for performance of certain studies. Lastly, MFM physicians must also acknowledge their own potential conflicts of interest. Additional ultrasound imaging/testing under the recommendation of the MFM should be considered carefully and only if indicated as per published guidelines.

It must also be stated that some denials are reasonable. Clinical situations in which limited data or contradictory data are present may lead to a denial to perform imaging. Using fetal growth restriction as an example, there are limited data on the use of Dopplers outside the umbilical artery Doppler. A denial for additional Doppler studies (examplea; ductus venosus dopplers) may be appropriate in this clinial scenario. The overarching goal is to limit or prevent denials for reasonable clinical scenarios, for example, the use of umbilical artery Doppler only with fetal growth restriction.

2. Consider quality measures. National organizations such as the SMFM, ACOG, and AIUM emphasize that a part of their mission is to support the clinical practice of obstetrics by providing education to optimize the health of pregnant women. These efforts reduce unnecessary health care costs and limit variations in care delivery by improving patient safety and outcomes.

The AIUM and SMFM have worked together to encourage patients have imaging performed at accredited practices and for insurers to reduce or eliminate reimbursement to nonaccredited ultrasound units if accredited options exist.[16–18] The 2017 Quality Measures in High-Risk Pregnancies workshop (SMFM, ACOG, *Eunice Kennedy Shriver* National Institute of Child Health and Human Development) underscored that practices who undergo ultrasound accreditation have improved compliance with published standards and guidelines for the

performance of obstetrical ultrasound examinations and recommended accreditation as a quality measure.[19,20]

The SMFM has created educational courses surrounding coding and billing compliance to educate its membership on appropriate indications for obstetrical ultrasound. As noted in the previous text, however, if more clinical guidelines were available, payers could then limit prior authorization or claim review to those studies performed and not conforming with the nationally agreed-upon guidelines.

Payers should consider sending representation to these courses to improve transparency and increase their understanding of the science behind such guidelines. It must be emphasized that MFM physicians should take the lead in creating quality measures. The 2017 workship aforementioned was led by an MFM physician (senior author B.I.). Physicians can use the 2017 publication to review their own internal practices. This information should be presented to their payers as evidence of adherence to published guidelines, which should in turn lead to a decrease in prospective approval.

In 2018, the Beyond Ultrasound First Forum also addressed the issue of quality in ultrasound. One of their key findings was that quality can be improved with examination standardization, compliance with published guidelines, and the implementation of ongoing oversight and quality review among individuals performing or interpreting the imaging.[20]

3. Link databases to identify outliers. Payers could share data on practice patterns and overutilization with providers. Physicians could partner with payers to identify outliers that may be disproportionately using imaging services. The SMFM has previously presented data on ultrasound utilization.[21] Providers with higher utilization could then be alerted and subsequently assisted through education and on-site visits. The practice management division of the SMFM is currently assisting practices across the country by improving their coding and billing processes through this method.

Payers should examine and improve their databases to link CPT codes for ultrasound with up-to-date *International Classification of Diseases*, 10th revision, indications. This information could be used to create data for risk-adjusted utilization. A collaboration between the SMFM/ACOG/AIUM and insurers would have a positive impact on health plans through decreased utilization by focusing on practices with the highest percentiles of use. This would diminish unnecessary hardship for the majority of providers following guidelines and performing obstetrical ultrasound for appropriate medical indications.

These shared data could provide the basis for comparative cohort studies on the utilization of obstetrical ultrasound to improve evidence-based care for a variety of diagnoses. Once outliers are identified, health plans could create gold card or exception programs for the majority of practices with appropriate utilization and exclude them from preauthorization requirements.[1]

Practices following national guidelines and not inappropriately utilizing obstetric ultrasound could negotiate their contract to avoid prior authorization. Concerns exist about this option because noncompliance may be random among practices, and even the most compliant medical practice may inadvertently have errors.[22] Identifying outliers is not advocated as the primary solution but perhaps an intermediate step to the eventual elimination of the process.

Working with payers involves contracting. The idea of gold carding may lead to a discussion of pay-for-performance models of contracting. This may in turn provide the basis for even newer models of payment such as episodes of care. These contracting models might unburden physicians and patients from prior authorization. Overutilization would then be at the expense of the provider. These at-risk contracts could be retrospectively evaluated for overutilization, which would have an impact on future contracting.

4. Physician-led legislative advocacy. Health care providers should advocate for change. In 2016, Delaware, with advocacy efforts of physicians, passed House Bill 381 recommending increased transparency with prior authorization policies.[23] In April 2019 because of the efforts of local physicians, the New Mexico Medical Society, ACOG, SMFM, and the American Medical Association, the state of New Mexico passed Senate Bill 309, which prohibits the use of prior authorization for gynecological and obstetrical ultrasounds.[24] It is the first bill to preemptively prohibit preauthorization use and protect the rights of women to medically necessary ultrasound.

The bill received unanimous support in 3 hearings, the House, and the Senate, leading to signature by the governor. The bill incorporated an emergency clause stating, "It is necessary for the public peace, health, and safety that this act take effect immediately." Physicians in these states advocated directly to protect patients from medical harm and reduce undue administrative tasks.

We call to action all health care providers performing obstetrical ultrasound to consider the efforts in Delaware and New Mexico as a blueprint for their states seeking to prohibit the use of preauthorization when medical care is deemed appropriate by board-certified specialists and subspecialists.

5. Advocacy through national societies. The SMFM is currently seeking input on conflicts related to preauthorization requests via their Coding Committee website. The SMFM hopes to develop an enhanced understanding of the problem, time burden to medical practices, and member experience with peer-to-peer reviews. This information can be utilized to address conflicts with health insurers and medical benefit companies as well as state insurance officials and legislators.

In August 2019, ACOG composed a list of recommendations to the Center for Medicare and Medicaid Services in a letter entitled Patients over Paperwork. One of the key issues addressed was preauthorization. ACOG called for Center for Medicare and Medicaid Services to develop a strategy to reduce the

volume of prior authorization requirements, eliminate low-value prior authorization, consider automation, and lastly improve transparency and accountability for its use.[25]

Summary. Health plans should reconsider and possibly eliminate prior authorization for obstetric imaging. In the interim the process must be made more transparent, conflict of interests must be resolved, administrative burden to the patient's medical team must be reduced, and focus must be returned to timely patient-centered care. Data regarding demonstrated benefit or lack of harm to medical outcomes for patients caught in the middle of this process should be demanded from payers. Reform of prior authorization is necessary to return the focus to provision of appropriate, high-quality medical care during pregnancy without limits or delays that could result in adverse perinatal outcomes. ■

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ABSTRACT

Prior authorization and its impact on access to obstetric ultrasound

Prior authorization is a process requiring health care providers to obtain advance approval from a payer before a patient undergoes a procedure for the study to be covered. Prior authorization was introduced to decrease overutilization of ultrasound procedures. However, it has led to unanticipated consequences such as impeding access to obstetric imaging, increased administrative overhead without reimbursement, and contribution to physician frustration and burnout. Payers often use intermediary radiology benefit management companies without providing specialty-specific review in a timely manner as is requisite when practicing high-risk obstetrics. This article proposes a number of potential solutions to this problem: (1) consider alternative means to monitor overutilization; (2) create and evaluate data regarding providers in the highest utilization; (3) continue to support and grow the educational efforts of speciality societies to publish clinical guidelines; and (4) emphasize the importance of practicing evidence-based medicine. Understanding that not all health plans may be willing or able to collaborate with health care providers, we encourage physicians to advocate for policies and legislation to limit the implementation of prior authorization within their own states.

Key words: diagnostic imaging, obstetric imaging, overutilization, prior authorization