



MAG Prior Authorization Study

A Study of Prior Authorization/Precertification of Physician Services as Required by Georgia's Six Major Health Plans (Preferred Provider Organizations and Indemnity Plans) January 2009

Prior authorization, or precertification of medical services by health plans, continues to play an integral part of today's "managed health care" plan operations. The administrative time and expense that a physician spends on prior authorization requirements is considerable and begs the question on its continued value and effectiveness. Health plans have not provided a very clear picture on why prior authorization (PA) requirements remain in place. They have not revealed whether the process has been successful in determining if a service is indeed necessary and covered, or if the process is even cost-effective for its purpose. Physicians generally understand that the purpose of prior authorization is to save costs by preventing "so called" unnecessary care, and others, believe it is an unnecessary roadblock to care.

In fact, in speaking with a number of medical practices in the state, the Medical Association of Georgia has found that many physicians are simply unable to keep up with the widespread and frequently changing prior authorization requirements of the major health plans and with the varied requirements for each self-funded health plan. As a result, some physicians have resorted to asking for PAs every time they plan to provide a major procedure or service in order to avoid the risk of non-payment of that service.

Physician's assertions concerning the high administrative burden of prior authorization and its questionable value were strongly underscored as evidenced by the results of an email survey conducted of MAG members earlier this month. When questioned whether the physicians being surveyed thought prior authorization was a reasonable process in Georgia, an overwhelming 84% of the 79 respondents related that it was not. Some 84% of the surveyed physicians indicated that the insurer or payer did not provide a clear explanation when a request for PA was rejected and 81% agreed that it was not easy to determine which services or procedures even required prior authorization. In terms of administrative time spent with PA, almost half of the physicians indicated that they and their staff spent up to 20 hours a week on it, and 72% reported that, on average, it took several days to a week or more to obtain a prior authorization for a service or procedure. The survey also indicated that 54% of the time the person reviewing the request for prior authorization did not

even have a medical background, 27% didn't know their background and only 17% indicated that occasionally the reviewer appeared to have a medical background. Some 42% of the physicians surveyed indicated that their requests for prior authorization for services were approved on the first submission less than 80% of the time. Finally, it was significant to see that some 42% of physicians indicated that less than 5% of their requests for prior authorizations were ultimately rejected, and an additional 36%, for a combined total of 78%, indicated that only from 5 to 10% of their services were ultimately rejected. This is a sizeable percent of approvals for services being deemed in need of prior authorization because of possible mis-application of the service.

Overview of Study

In light of the often onerous prior authorization/precertification (PA) requirements imposed on physicians, MAG's Third Party Payer Committee decided, in November 2008, to pursue a study of the process in Georgia. The study was limited to the prior authorization of medical services, including medical equipment, imaging and injectable drugs, not prescription drugs. MAG obtained copies of the Prior Authorization/Precertification policies for Preferred Provider Organizations (PPO) and Indemnity plans of Aetna, Anthem Blue Cross, Cigna, Coventry, Humana and United health plans in order to assess and compare critical factors concerning the complexity, transparency, and service requirements of the prior authorization programs. The Committee also decided to poll MAG members about prior authorization and their views of the current process and how it affects them.

One of the principal purposes of the study was to determine just how significant prior authorization is in the every day practice of medicine. Moreover, MAG hopes the study can help answer whether prior authorization serves its purpose or compromises the medical care that physicians attempt to provide to their patients. How many services are required to have prior authorization? How difficult is the process? How consistent are the requirements among the various health plans? In addition, the Third Party Payer Committee hopes this study highlights the extent of administrative burden and interruption this process really represents to physicians and to the patients they serve. Finally, the Third Party Payer Committee hopes to identify ways in which the process can be more streamlined and useful for all parties.

In order to gather this information, MAG looked at the following for each plan:

1. Effective date for the list of services requiring prior authorization
2. General policy statement on prior authorization
3. Penalties for a physician's failure to obtain one
4. Unique aspects of its policy
5. Requirements for non-emergency, out of network referrals
6. Number of programs which require prior authorization
7. Modes of contact for obtaining a PA
8. Time period required for submission of the PA, if any
9. Response time back to the physician
10. Information required for a PA
11. Provision for an appeal
12. Number and kinds of services which require a prior authorization

Individual health plan prior authorization information is included on the attached table and is based on the latest data published on each health plan's Web site as of December 2008. An analysis and summary of this process is contained herein.

MAG's Georgia Health Plan Prior Authorization Study Results:

Effective Dates for Prior Authorization Requirements

Health plans generally include a chapter in their annual provider manuals and/or accompanying materials of their prior authorization lists of services and its effective date or method for submitting the name of a medical services and/or AMA CPT code to the plan for determination of whether it is required. All of the health plans stated that their PA list was effective for 2008, except for United Health Care, where the date was December 2007. Importantly, however, many of the plans also explain that the lists of services are subject to change and may, in fact, be reduced or expanded, particularly for self-funded groups. Since the list of services for prior authorization are subject to change, it suggests that a physician must check prior authorization requirements multiple times during the year or each time a service is submitted for prior authorization. A prior authorization list, therefore, is constantly in flux and must be re-verified each time a new request is made, an ongoing and repetitive task for the medical practice.

Prior Authorization Policy Statements

Georgia's health plans use a variety of terms for prior authorization in their policy statements about PA, sometimes calling the program precertification, preadmission, preauthorization or notification. The plans were fairly consistent in stating that prior authorization is a utilization review process which determines whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage and medical necessity.

Some plans differ in what degree of information is requested in the PA process. For example, Aetna's policy calls its process pre-certification and makes a distinction between a notification and a coverage determination, either of which may be required. It states that notification is simply a process of recording a coverage request and that it is only a data-entry process, which does not require a lot of additional clinical data for a judgment or interpretation for benefits coverage. On the other hand, Aetna states that a coverage determination requires the review of plan documents and clinical information regarding the service or supply to determine whether clinical guidelines/criteria for coverage are met. Similar to Aetna, United Health Care identifies its entire process as Advance Notification, which it requires for certain planned services contained on its Advance Notification List, which may or may not require additional clinical information.

All health plans but one make the physician responsible for prior authorizations. United departs from other plans by making facilities, rather than physicians, responsible for Admission Notification to inpatient facilities, a move usually favorable to physicians. Patients are generally only required to obtain a prior authorization when the physician or facility is outside of the patient's plan network. United is also the only health plan that has allowed physicians who have been given a Premium Designation Status to be exempt from some notifications.

At least two plans include a requirement for eligibility determination and coverage as a part of the prior authorization process. Other plans merely suggest that the provider should verify both before making the prior authorization request. It's clear that a physician is risking whether he will receive

full payment for the service, unless he has verified the patient’s status in all three areas —patient eligibility, patient plan coverage, and prior authorization of the service.

Even after a physician carries out their due diligence in obtaining the eligibility, the plan coverage and the prior authorization, the physician is still not assured of receiving payment for the service. Most of the prior authorization policies contain statements to the effect, “that the PA does not signify coverage for benefits. For example, if a company fails to report to the health insurance company right away that the employee has left their job, changed their coverage, etc., it is often the physician who becomes liable for the loss of payment for the service. A physician may not find out until months later, after the service was provided, that the patient didn’t have coverage at the time. Often, it is too late to bill for the service and/or locate the patient for billing.

Blue Cross Blue Shield of Georgia and Coventry Health Care are the only two health plans that spell out what clinical criteria they use in their PA reviews, referencing the Milliman Care Guidelines for utilization review, with additional support by the medical director and peer advisers. Coventry also references criteria from the Institute for Health Care Quality.

Physician Penalties for Not Obtaining a Prior Authorization

Five of the six major health plans studied clearly indicate that a physician is penalized, if he/she failed to obtain a prior authorization for a designated service. Cigna does not indicate any penalty, although that may not be the case. Blue Cross and Coventry stated that such failure could result in a full denial of payment for the service. Humana and United stated that it could result in a 50 percent reduction of payment, and Aetna stated only that it may result in reduced benefits. Health plan information does not indicate how many services have failed to receive PAs, when required, or the plan’s income for the application of a physician penalty.

Unique Features of the Prior Authorization Process

Cigna appears to offer the most transparent and efficient method for determining what precise services must be preauthorized. It publishes a 28-page list of PA requirements for 883 services, by description and CPT code. It also provides a quick Web-based method for prior authorization which allows a service to be approved immediately or pended for review. It also allows for a physician to obtain an update on the status of the request.

Aetna and Cigna offer a Web search mechanism that allows physicians to enter a CPT code to find out if a service requires prior authorization, although Cigna also provides a complete service listing of all CPT codes as well, making the full list more transparent to physicians.

United has provided some flexibility to physicians by allowing a hospital/facility to seek the inpatient PAs and they have also allowed some “designated physicians” to be exempt from the process.

Health Plan Programs Which Require an Additional and Separate Contact Number

Five of the six health plans indicated that separate numbers had to be called for certain prior authorizations.

Cigna appeared to be the only plan in which a single telephone number is listed for all prior authorizations.

Blue Cross appears to have the most additional, separate contacts for prior authorization, at six. They require physicians or their offices to call separate numbers for Congenital Heart Disease, Diagnostic Imaging, Initiation of Cancer Treatment other than Surgery, Mental Health, Outpatient Radiology, Pharmacy and Transplant Evaluations.

United had a total of three additional numbers included for Optum Health, Cancer, and Mental Health. Humana also had three additional numbers required for services included under Cancer, Mental Health and Outpatient Radiology.

Aetna and Coventry both had two separate, additional telephone numbers to be contacted for Pharmacy and Transplants and Imaging and Mental Health, respectively.

Modes of Prior Authorization Submission

All health plans allow telephone contact for request of a prior authorization. All health plans except Coventry allowed for PA requests through the health plan's Web site. Five of the six plans allowed for PA submission by fax, except for Humana. At least two plans, Aetna and Cigna, identified EDI as an efficient way to make multiple prior authorization requests at the same time.

Time Period Requirements for Prior Authorization Submission

Four of the six health plans set required time periods for submission of a PA request. Aetna and Humana provided some flexibility for physicians by not having set time periods, simply stating that the PA request had to be made prior to the service being rendered.

At least three health plans --Blue Cross, Cigna, and United Health Care-- stated that all prior admissions to hospital/inpatient facilities must be made within a set time frame, 24 hours or the next business day for Blue Cross, 48 hours for Coventry, and 24 hours for United Health Care.

Other health plan preauthorizations were set at "72 hours before a scheduled service" for Cigna, three days for Coventry, five days for United, and 15 to 30 days for Blue Cross. Obviously, there is considerable variation among the time requirements for submission of the prior authorization which makes the process increasingly confusing for the physician and their office staff when they contend with multiple health plans.

The Health Plan's Response Time

The Health Plan's response time to a physician request for prior authorization of a service varies, with some times based on the urgency of the request and others based on a fixed time period.

Aetna and Coventry, said the response time is based on whether the request was urgent or not. Aetna stated that urgent PA requests would be responded to within 72 hours and non-urgent requests up to 15 days. Coventry also stated that a response could be made within 24 to 72 hours for urgent procedures or upon receipt of all clinical information.

Blue Cross provided the longest response time, stating that its response could be made within three to 15 days. Cigna indicated that if the PA was obtained on its Web site, that some responses might be made immediately and others could take from 24 to 48 hours. United also stated that, on average, it would respond within two business days from the initial date of the request and that a written response would be sent on the third business day.

Information Required for the Prior Authorization

The information that is required for a prior authorization was fairly consistent among the health plans. All health plans required at least 15 elements of information, including the subscriber and patient name, ID, and date of birth as well as the ordering physician name, phone number, fax and contact person. All health plans required that the diagnosis and CPT code and the date of the procedure be included, as well as the facility name and ID. Several health plans also asked for the type of plan (e.g., HMO, PPO, etc) and the name of the rendering physician and their NPI. Three of the health plans asked for copies of the clinical exam, diagnostic tests, lab findings, and use of prior conservative treatment and the patient's response to that treatment as a part of the initial PA request. At least three plans asked for verification of the patient's benefits on the PA form.

Prior Authorization Appeals

At least four of the six health plans clearly stated that the physician could appeal an adverse prior authorization denial—Aetna, Blue Cross, Cigna and Coventry. Humana and United Health Care might allow for appeals, but it was not spelled out in their prior authorization information.

Health Plan Services Which Require Prior Authorization

All health plans provide a "List" of what services, procedures and/or devices are required for prior authorization. All health plans were consistent in stating that prior authorizations must be obtained for all emergency and acute inpatient admissions and skilled nursing home admissions. Prior authorizations/notifications for hospital admissions following emergency room visits were usually allowed up to 24 hours for the notification after the admission or the next business day. At least five plans indicated that PA was also required for inpatient rehabilitation, except for United Health Care.

Aetna, Cigna, Coventry and United identify to some degree both the medical service and the specific AMA CPT code for their list of outpatient services requiring prior authorization, allowing more precision in the identification of the service. As mentioned earlier, Cigna is the only plan that offers a complete list of all services and CPT codes which require prior authorization. Aetna and Cigna make code search mechanisms available on their Web sites which allow physicians to find out if a specific code requires a precertification.

Three plans also required prior authorization for inpatient hospice services and for observations stays over 23 hours.

The service "List" for outpatient services was less consistent. A total of some 1,096 outpatient services were listed by the six major health plans as requiring prior authorization. It was difficult to make completely accurate comparisons between the six health plans' outpatient service requirements because of the different methods that are used by each plan for identifying services. Cigna clearly identified 883 specific services by CPT code which required prior authorization; there were only 103 separate services listed among all the other health plans combined.

The five health plans each listed somewhere between 43 and 55 total services that required prior authorization, except for Blue Cross--which listed just 22. The wide differences in total services listed between Cigna and the other health plans can be contributed to the number of subcategories that Cigna listed within each major service/CPT code group. If the other plans included comparable subcategories, their numbers would be more comparable to Cigna's, at 883, or even more.

The health plans generally categorized services into the following six major groups: 1) Outpatient services (16 services) 2) Diagnostic Imaging Procedures (12 major services) 3) Other Services (35 services) 4) Plastic Surgery/Reconstruction (14 services) 5) Outpatient Therapy (4 services) and finally 6) Medical Injectables (10 services).

Due to the sheer magnitude of services covered, we did not identify and apply Cigna's services to each of the main categories. For example, five of the plans listed the CT service only once, whereas Cigna had 21 defined variations or areas of the body specified. For CTAs and MRAs, the other five plans listed the service only once, while Cigna identified some 20 CPT subcategories; for MRIs, one versus 53 defined variations or areas of the body; for PET scans, SPECT scans, pathology and labs, one versus 16 separate CPT codes, one versus 26 defined areas for radiation therapy. Finally, Cigna listed some 129 Department of Medicine CPT codes versus the much smaller listings by the other health plans.

If each health plan identified all the subcategories or CPT codes within the broader service categories, the average count of prior authorizations required per plan clearly would have been closer to the 883 mark or higher, rather than the 22 to 55 services listed by five of the six plans.

Excluding Cigna, only three of the 103 outpatient services were similarly listed by all six major health plans, including: 1) Imaging services of CTAs and MRAs 2) MRIs and 3) PET Scans.

Five of the six health plans listed four of the same services: 1) Home Health 2) CT scans 3) Mental Health and 4) Transplant services. Four of the health plans listed: 1) Hospice 2) Stress tests 3) Blepharoplasty and 4) Breast Reconstruction. A total of three health plans listed at least seven of the same services: 1) orthognathic/TMJ 2) Genetic Testing 3) Hyperbaric Therapy 4) Back Surgery 5) Oral TMJ 6) Plastic Surgery-Vein Stripping and 7) Bariatric Surgery.

Once Cigna is removed from the mix, there are some 60 comparable outpatient services that require prior authorization among the other five major health plans in Georgia, when considering services listed by at least three or more health plans—keeping in mind that there are 1,036 Cigna services subparts which are not detailed in the listings.

Summary and Conclusions

In general, our study shows that the prior authorization process is not simple. It has many steps and intersecting points; it is constantly changing, and its purpose and effectiveness are not totally clear to its physician participants and their patients. Importantly, there is not a lot of continuity among Georgia's major health plans in how they apply the prior authorization process with physicians.

Health plans certainly have improved the process over time, but it remains flawed in serious and significant ways. The total number of services requiring prior authorizations remains high, the required clinical information lengthy, and the penalties unfair. There are significant differences among health plans in the services that require prior authorization, in the processes used to obtain prior authorization, in the time periods required for submission and response, and in the number of telephone calls which must be made.

Prior Authorization is not Just Obtaining an Approval for a Service. Prior authorization is more complex than getting services approved for a patient; it also involves identifying the eligibility and

coverage of each patient and gathering significant information. Prior authorizations require substantial information about the patient, the physician, the planned facility, the service, and the clinical process--all which must be gathered from the clinical record and applied to a prior authorization request form or process. Some services require a simple notice, while others ask for more substantial clinical information. The physician is principally responsible for carrying out the PA request and is severely penalized by the health plan if they do not. The process could be simplified and improved if the health plan was responsible for checking its own data base of information for eligibility and coverage. The PA information is probably reasonable for its purpose, if it were limited to a fewer number of services.

Prior Authorization: A Black Box or Transparent. Prior authorization is something of a black box. The physician is generally not provided with the specific clinical criteria (not guidelines or policies) that are used to decide if the service is clinically necessary or precisely covered under the health plan. Just two of the major health plans even reference the source of their clinical criteria and only one state that it provides a reason for why the service was rejected.

Transparency is lacking throughout prior authorization. It is not present in the health plans' prior authorizations lists of services indicated, in its selection of services, in the criteria used or in its cost and service efficiency. Cigna, for example, is the only health plan that clearly published the precise list of medical services, definitions and CPT codes which were required for prior authorization. The health plans do not discuss the criteria for why a service is on the PA list, they do not provide the clinical criteria used for PA decision-making, and most importantly; they do not report on how the process has improved the medical care system. Health plans should be more forthright with physicians about the full list of services which require prior authorization and about other aspects of the process which demonstrates its effectiveness: the clinical criteria, the reason for disapproval of a service, the percent of services approved, why services are added or dropped, etc.

Penalties. Not surprisingly, the penalties for a physician's failure to obtain a prior authorization were fairly standard among the health plans. Physicians would not be paid for their services which were not prior authorized at amounts of 50 percent of the total approved amount, at 100 percent of the total, or at an undisclosed amount. A more equitable solution is needed when a physician fails to obtain prior authorization. The process has too many variables and the penalty for physicians who fail to comply isn't reasonable. In essence, a penalty is being applied in an arbitrary way as the health plan weighs its criteria over the clinical judgment of the attending physician as they attempt to provide the treatment and patient care. A penalty should only be applied when there is a repeated pattern of failure by a physician to obtain a prior authorization.

Unique Features Which Can be Built Upon. At least three health plans offered unique features of their prior authorization process that could improve the efficiency of the process for physicians. Cigna's complete and transparent list of required services for PA--with both a description and a CPT code--should be standard among all health plans. The immediate Web-based approval method that allows updates are minimum features which should be available through all health plans. Aetna and Cigna's EDI process for submission is more in line with today's electronic environment and should be standard among all plans.

A Single Entry Point. Only one health plan identified a central telephone number to submit all prior authorizations. The other plans had multiple numbers for their various programs. Blue Cross listed as

many as six different offices that had to be contacted for prior authorization requests. Health prior authorization processes should have single entry points for all services.

Submission and Response Time Periods. The time periods required for submission and response of the prior authorizations were inconsistent. Only two plans, Aetna and Humana, did not specify timeframes for submission of the PA which for physicians and their staff appeared to be the most reasonable approach. Other than inpatient hospitalizations, the time periods ranged broadly from 72 hours, to as long as 30 days. Aetna and Coventry assured physicians that they offered a quick response for urgent PA. Other plans varied in their response time--from 24 hours to 15 days--another aspect of the PA process that could be standardized among the health plans.

The Information Required for Prior Authorization. Although there was considerable consistency in the information required for a prior authorization, the high numbers of services requiring a PA makes it a very time consuming and unwieldy process for many practices. Only one or two plans requested several additional data items that might not need to be included in a standard format.

The Prior Authorization Service List. As noted earlier, the prior authorization lists simply contain too many services. The health plans appear to require over 800 separate services for prior authorization. The services constantly change during a plan year, causing the rules of the game to fluctuate for the physician players. The pure number of services, their constant changes, and the physicians' responsibilities for knowing them are only compounded by the number of health plans with which the physician must deal with and by the variations of service listings among the plans. Health plans must streamline their list of services and provide some uniformity between plans. Health plans could simplify the process immediately, for example, by instituting annual service requirement updates.

Unfortunately, the health plans all fail to address why a particular service is targeted for medical review or why it might be dropped or added to the review list. Certainly, the question of why there is such a large volume of services required for prior authorizations remains unanswered. These questions need to be answered so that physicians, patients and health plans can understand and support the process that's being imposed.

The Lack of Evaluative Data. A general assumption concerning the purpose for prior authorization of a service is that it is reviewed because of its high complexity and appropriateness for care and/or cost. However, many physicians and others are not convinced that prior authorizations actually achieve this goal. Unfortunately, health plans generally do not provide any evaluative information about their prior authorizations, i.e., whether it is really necessary to determine if every service meets the clinical criteria for a patient; whether the process has been effective; whether physician judgment has been appropriate in meeting clinical standards; and whether most prior authorizations are generally approved or not.

Likewise, health plans do not explain the cost effectiveness of the prior authorization for a particular service, i.e., the added cost and value of the service versus a more modest approach. They do not let the physician know, for example, how many times a procedure or service is given initial approval or approval after an appeal; how much savings is achieved from denials; or whether some services are simply not approved because of the innate barrier of the prior authorization and appeal process. Plans certainly need to make sure that unnecessary or uncovered services are not being given, but the

checks and balances need to be reasonable and worth the effort and expense made by the health plan and the physicians. Health plans need to provide information to justify the process.

Finally, this study has allowed us to more carefully study the prior authorization process and its pluses and minuses. It has allowed us to pinpoint the inconsistencies and difficulties in its method. It has also allowed us to identify a number of unanswered questions concerning its usefulness and effectiveness. MAG believes that this is a good first step in better understanding the process, and MAG looks forward to working with Georgia's health plans to address these questions and to streamline the process of prior authorization so that it more fairly balances its cost and effectiveness between health plans and physicians and their patients.

RECOMMENDATIONS TO THE MAG BOARD OF DIRECTORS

1. MAG recommends that as a part of any prior authorization program, the health insurance plans rather than the physician should append the patient's eligibility and coverage information to the request for prior authorization file, as well as any special requirements concerning site of service.
2. MAG recommends that patient and plan information that's obtained by a physician from the health insurance plan's Web site in conjunction with a request for prior authorization should be considered forever valid by the health plan for claim's payment and any other audit process.
3. MAG recommends that health insurance plans should only allow physicians who perform the medical service or procedure to submit the request for prior authorization.
4. MAG recommends that once a prior authorization request for a service or procedure is approved by the health insurance plan--and the health plan validates the patient's eligibility and coverage--the health plan is obligated to pay for the service that's billed by the physician.
5. MAG recommends that all managed care contracts include the provisions that are highlighted in these recommendations.
6. MAG recommends that all health insurance plan requests for patient clinical information made in conjunction with a physician's request for prior authorization be commensurate with the procedure or service that's requested.
7. MAG recommends that a health insurance plan should provide a specific reason when it denies a medical service or procedure in response to a physician's prior authorization request.
8. MAG recommends that a health insurance plan shall not deny a prior authorization request for a medical service or procedure for a minor or immaterial mistake on the request form, i.e., change of date for the service.
9. MAG recommends that if a medical service or procedure is urgent, a health plan shall not deny payment of that service for failure of a physician to obtain a prior authorization.

10. MAG recommends that all health insurance plans clearly display a complete list--by name, description and CPT code of services or procedures which require prior authorization—that's easily obtainable by the attending physicians on its Web site and/or other normal methods of communication.
11. MAG recommends that all health insurance plans provide a standard of acceptable prior authorization communication including contact by telephone, fax, and Web site.
12. MAG recommends that all health insurance plans are transparent in their communication with physicians about the basis for their prior authorization program, including: a) the specific criteria used for determining the medical necessity of the service and the accompanying administrative structure who oversees the process, i.e., national advisory boards, etc., b) the basis for placing a service/procedure on the prior authorization list; c) the cost-effectiveness of the process, and d) the profits gained through denial of a PA service or procedure.
13. MAG recommends that health insurance plans eliminate the financial penalties that are levied against physicians for failing to obtain a prior authorization.
14. MAG recommends that all health insurance plans have a central point for submission for all prior authorization requests, with additional options available as needed.
15. MAG recommends that all health insurance plans standardize their response times to prior authorization requests to between 24 to 48 hours.
16. MAG recommends that all health insurance plans allow submissions of prior authorization requests without deadlines, other than that it occur before the service or procedure.
17. MAG recommends that the list of services required for prior authorization by health plans should be reasonable, consistent among plans, and based on scientific literature which substantiates a reasonable need for the service to be questioned; it should not be solely based on the cost of the service.