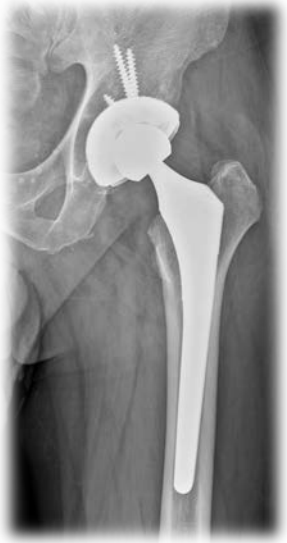
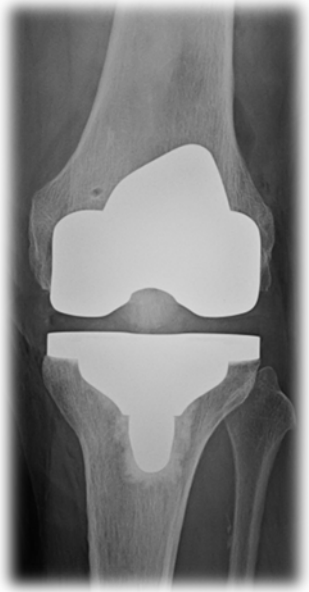
Prior Authorization in Total Joint Arthroplasty: Burdensome and not Evidence-Based



AAHKS 2022 Health Policy Fellow Report



Charles P. Hannon, M.D., M.B.A.
Assistant Professor
Department of Orthopedic Surgery

Disclosures

- **Individual Product Development Agreement**
  - **Orchard Medical**

- **Research Support**
  - **Stryker Corporation**

- **Board or Committee Member**
  - **AAOS Evidence Based Quality and Value Committee**
  - **AAHKS Evidence Based Medicine Committee**

Introduction

- Prior authorization is a payer cost-control process that requires providers to obtain approval before performing a service

- In 2018, Medicare alone denied 1.5 million prior authorization requests

- 20% of these were denied despite meeting Medicare coverage rules
  - Commonly affected orthopedic surgeons

- 2022 Improving Seniors' Timely Access to Care Act

Purpose

1. What is the impact of prior authorization on total joint arthroplasty surgeons and their practices?

2. What are the most common reasons for prior authorization denial?

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24 question survey to AAHKS members

March 2022 – 3 Reminders

353/2802 respondents (13%)

Demographics

- **Mean years in practice: 17 (range, 1 – 42)**
- **53% operate in an ambulatory surgery center**

Type of practice (%, n)	
Private Practice	60% (211)
Hospital Employee	17% (59)
Academics	18% (64)
Solo private practice	5% (19)

Case volume in 2021 (%, n)	
<100	5% (16)
100-199	14% (49)
200-299	19% (68)
300-399	23% (82)
400-499	14% (49)
>500	25% (87)

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95% Surgeon respondents indicated that prior authorization denials had increased in the past five years

71% Surgeon practices employ at least one staff member to focus exclusively on prior authorization

15 Hours / week
(Range 1-125)

18 Denials / week
(Range 1-250)

Top Reasons for Prior Authorization Denial

1. A specific nonoperative treatment had not been tried

2. Nonoperative treatment was not attempted for a long enough duration of time

3. Concerns regarding imaging

Impact on Patient Care

87%

Most surgeons indicated prior authorization leads to negative clinical outcomes

96%

Almost all surgeons indicated prior authorization leads to delays in patient care

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2022 Clinical Practice Guideline for the Optimal Timing of Elective Hip or Knee Arthroplasty: Can a Delay in Surgery Improve Outcomes?

AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

Purpose

1. What does the evidence say regarding the effectiveness of nonoperative treatments in patients indicated for TKA or THA?

2. What is the impact of delaying surgery for nicotine cessation, improved glycemic control, and weight loss on postoperative outcomes?

Nonoperative Treatments

- **In patients indicated for TKA or THA do not delay surgery to pursue additional nonoperative treatment including:**
  - **Physical therapy**
  - **NSAIDs**
  - **Ambulatory Aids**
  - **Injections**

- **Conditional recommendations**

- **Low and very low quality of evidence**

Risk Factors

- **Obesity** alone is not a reason to delay surgery, but weight loss should be strongly encouraged
- Delay of surgery is recommended for **nicotine cessation/reduction** and **improved glycemic control**
- Strict cutoffs should not be utilized including BMI, HbA1c, etc.
- Conditional recommendations
- Low and very low quality of evidence

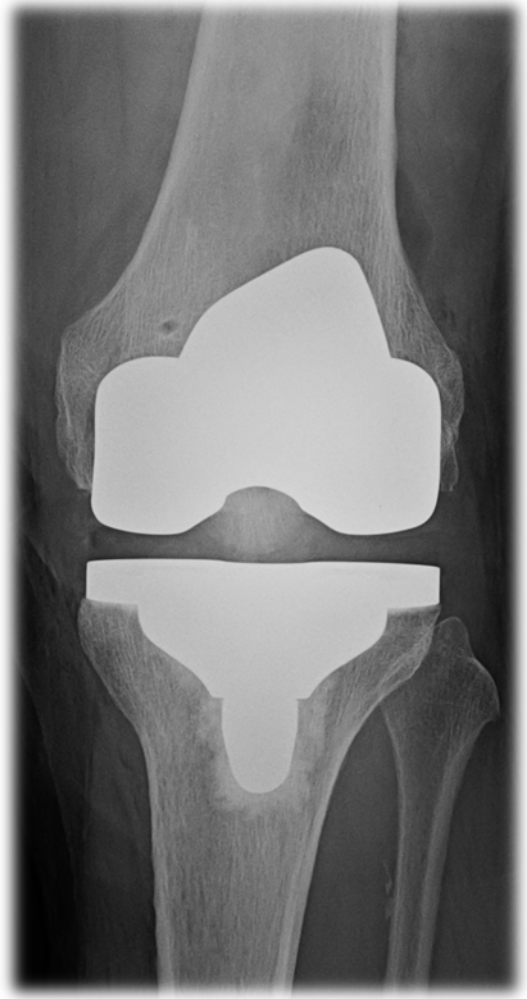
Summary

- **Prior authorization is burdensome leading to delays in patient care and in some cases jeopardizing patient outcomes**

- **Denials for continued nonoperative treatment are not evidence based and lead to unnecessary delays in surgery**

- **Delaying surgery to achieve specific targets such as BMI or HbA1c are not evidence based, but nicotine cessation/reduction and improved glycemic control are recommended**

- **Advocacy is important for this legislative priority!**



Thank You