Editorial

Human Currency, Part II: Defining the Problem

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Prior authorization, also known to me as "prior aggravation," is my new second career. Increasingly, as managed care plans try to limit spending and mandate therapies, I find myself on the phone attempting to obtain prior authorization for a myriad of prescriptions. Transferred from person to person on the phone, and filling out piles of forms, I still get rejected in a few cases for some reason or another. Recently, I was asked for the first time to provide a clinical photograph to justify the use of isotretinoin. I could probably spend my whole day doing this, and so could my staff.

My experience with one recent patient was representative of the problem. The patient had a diffuse dermatophyte infection, involving the face, buttocks, groin, and nails. When I prescribed 2 weeks of a systemic antifungal for the cutaneous part of the infection, the prescription was rejected. I spoke to a service representative on the phone, to whom I explained that a topical would not suffice in this case; a systemic medication was medically necessary. I then received a fax, with a further rejection, stating that I had to try and fail a formulary medication first.

At least we are not alone. A neurologist recently recounted a case of a patient who was having a cerebrovascular accident in his office, when the doctor phoned the patient's plan to request authorization to perform an imaging study. The person on the phone said that the patient had to return to his primary physician first to obtain this authorization, even though he was in the neurologist's office with partial loss of vision in both eyes.

I have now come to understand the root of our misunderstanding with managed care. We do not correctly understand the definitions of managed care terminology. My best guess is that my dictionary never arrived with my enrollment packages. Without this dictionary in hand, I have assembled a list of some of the most popular vocabulary and the meanings I have been able to piece together empirically. As you can see, some of the terms have multiple usages.

Approval: You can prescribe the drug *for now*.
Rejection: You cannot prescribe the drug *ever*.
Prior authorization: (1) A convoluted mechanism to dissuade physicians from using expensive medications. (2) A process involving *at least* 3 phone calls, conversations with 6 different people, and 2 faxes. (3) It will take you so long to obtain this medication that you will wish you never tried.
Third-tier co-payment: (1) A mechanism to dissuade patients from using expensive medications. (2) We are not paying for these—the patient must pay for them.
Formulary drug: A cheap drug.
Nonformulary drug: An expensive drug.
Requirement for prior therapies: Drugs that are either so ineffective or dangerous that physicians do not want to use them.
Off-label indication: (1) There is no way that we are paying for this. (2) See rejection.
On-label indication: You may get to use this, but we won't make it easy.
Medically necessary: Needed only in the case of major organ failure or impending death.
Appeal: See rejection.
Dispense as written: Too expensive.
Cost-effective: Profitable for managed care.
Inappropriate use: Use of high volume of expensive medication, even if medically warranted.
Covered service: (1) This is approved philosophically, but we will not necessarily pay for it. (2) If we do pay, it will be a small fraction of what is reasonable.

As with any new language, it takes time to become fluent. If you take the time to learn this language, however, everything becomes a lot clearer.