For Immediate Release:
March 10, 2025 at 12:01 am PST

New Study Shows Prior Authorization Does Not Reduce Costs for Total Hip Arthroplasty, Delays Patient Care

SAN DIEGO (March 10, 2025)—Prior authorization is commonly used with commercial insurance companies as a cost-controlling policy. However, a study presented at the 2025 Annual Meeting of the American Academy of Orthopaedic Surgeons (AAOS) found that prior authorization was an ineffective cost-saving measure for patients undergoing primary total hip arthroplasty (THA). The study, "Prior Authorization Does Not Reduce Costs in Patients Undergoing Primary Total Hip Arthroplasty," also saw lower preoperative functional outcomes scores and significantly longer wait times before surgery when prior authorization was required. It is the first study to quantify the time and costs associated with obtaining prior authorization in patients undergoing THA.

"Prior authorization is employed more frequently for various orthopaedic procedures, and it is forcing an added administration burden on healthcare practices," said Elizabeth Abe, BS, MS4, lead author of the study. "This not only increases the time to get a patient approved for the procedure, but it ultimately leads to delays in patient care. If insurance denies a patient's surgery, sometimes the patient will give up and live in pain. Patients may try other nonoperative treatments that eventually fail them, and then the patient is spending more time and money to fail procedures that don't change the course of their treatment. Many times, they still need a total hip replacement."

Hip osteoarthritis (OA) is an age-related wear and tear type of arthritis that typically affects those 50 years of age and older and causes deterioration of the cartilage of the hip bone. This causes pain and stiffness and may eventually lead to end-stage OA, which is when the cartilage is almost gone and there is chronic inflammation.[i] Those with hip OA may eventually require THA. There are approximately 544,000 THAs performed each year in the United States and the procedure is growing as the population ages.[ii]

Oftentimes, insurance companies require patients to trial and fail a specified series of physician-documented, conservative therapies, including physical therapy (PT), muscle strengthening exercises, weight reduction, therapeutic injections, or anti-inflammatory medications, even if the surgeon believes these nonoperative treatments won't be beneficial to the patient.[iii] If the insurance company denies coverage, surgeons may be required to participate in a peer-to-peer (P2P) review with representatives from the insurance company. This can cause delays in patient care. In fact, in a 2023 survey by the American Medical Association, 93% of physicians surveyed said this prior authorization process had delayed their patients' treatments, 78% believed delays due to prior authorization led their patients to abandon necessary care, and 24% stated that delays from prior authorization led to avoidable, serious adverse events.[iv]

Prior authorization for THA shows no cost-saving benefits

The study included patients who underwent unilateral, primary THA for end-stage hip OA from January 2020 through December 2022 and were insured by a single, commercial payor. Patient-reported outcome measures (PROMs) that included the hip dysfunction and OA outcome score for joint replacement (HOOS-JR) and 12-item short form physical component score (SF-12 PCS) were recorded preoperatively and at 6-month postoperatively. Data recorded that was specific to the prior authorization process included approval or denial status, days to approval or denial, number of denials, number of P2P reviews or addenda required, and denial reasons.

The primary outcome of the study was the cost associated with obtaining prior authorization in patients that underwent primary THA. These costs consisted of:

- Conservative therapies, diagnostic imaging, and office visits required as part of the prior authorization process
- The costs incurred while patients waited to obtain authorization and approval from their initial surgery request to the date of surgery.

Secondary outcomes included time from surgery request date to the date of THA, preoperative PROMs, and postoperative PROMs.

A total of 3,922 commercially insured patients were included, including 2,840 (72.4%) patients whose insurance required prior authorization before THA and 1,082 (27.6%) patients whose insurance did not require prior authorization. Patients in the prior authorization cohort were more likely to be younger, male, identify as black, have an increased BMI and were more likely to undergo surgery as an inpatient. Patients requiring prior authorization also were more likely to have lower preoperative HOOS-JR scores (48.1 ± 15.5 versus 49.7 ± 14.7) when compared to patients not requiring prior authorization.

In the prior authorization cohort compared to the non-prior authorization cohort, the findings included:

- Patients were more likely to experience denial on initial request for THA (1.5% versus 0.0%).
- Surgeons were more likely to be required to participate in a P2P review (0.6% versus 0.0%).
- An addendum was more likely to be submitted (9.4% versus 0.0%, *P*<0.001) as requested when additional documentation was necessary to determine prior authorization approval or denial.
- Patients more frequently experienced any form of denial (4.8% versus 3.0%).
- Patients experienced significantly longer wait times from initial surgery request date to the date of THA (40.4 ± 37.0 days versus 38.7 ± 36.0 days).
- In the year preceding THA, significantly less patients in the prior authorization cohort underwent x-ray imaging (63.8% versus 68.8%).

Obtaining prior authorization was found to increase time to surgery by 2.1 days. A higher preoperative SF-12 PCS score was found to decrease time to surgery by 0.3 days.

“The prior authorization process and the steps a patient has to go through do not help save costs in the year prior to surgery,” said Chad A. Krueger, MD, FAAOS, orthopaedic surgeon, Rothman Orthopaedics in Philadelphia. “Patients whose insurance required prior authorization were found to have significantly worse HOOS-JR scores, which is a measure of how badly their hip feels, so their hips felt worse before surgery, and they experienced longer delays in getting to surgery than patients whose insurance did not require prior authorization. We are delaying the inevitable and jumping through hoops to get to surgery. Orthopaedic surgeons and patients can use these findings as fuel to try to work with our Congressional members on both sides of the aisle to improve the prior authorization process.”

The study authors noted that when P2P reviews, addendums and changes in surgery designation from inpatient to outpatient were required, this may explain the time delay THA patients with prior authorization experienced and these additional steps may increase the administrative costs associated with maintaining a practice.

In a separate study by Sahni et al, each submission for prior authorization was estimated to cost between $40 to $50 for private payors and $20 to $30 for surgeons with each claim taking 4 to 6 weeks on average to process and pay.[v] That study also found that for private payors, more than 90% of prior authorization submissions were ultimately approved, further questioning the efficiency and cost-efficacy of the prior authorization process.

The researchers of the prior authorization study concluded that the current process actively increases the administrative burden of THA, contributing to delayed access to care with little consideration of evidence-based treatment and when various therapies would be most beneficial to patients.

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2025 AAOS Annual Meeting Disclosure Statement

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With more than 39,000 members, the American Academy of Orthopaedic Surgeons is the world’s largest medical association of musculoskeletal specialists. The AAOS is the trusted leader in advancing musculoskeletal health. It provides the highest quality, most comprehensive education to help orthopaedic surgeons and allied health professionals at every career level best treat patients daily. The AAOS is the source of information on bone and joint conditions, treatments, and related musculoskeletal healthcare issues; and it leads the healthcare discussion on advancing quality.

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[i] American Academy of Orthopaedic Surgeons. OrthoInfo. Osteoarthritis. Published April 2022. Accessed Jan. 30, 2025. https://orthoinfo.aaos.org/en/diseases--conditions/osteoarthritis/

[ii] American College of Rheumatology. Joint Replacement Surgery. Published February 2024. Accessed Jan. 30, 2025. https://rheumatology.org/patients/joint-replacement-surgery

[iii] Centers for Medicare & Medicaid Services. Loal Coverage Determination. Total Hip Arthroplasty (L34163) Accessed Feb. 6, 2025. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34163.

[iv] American Medical Association. 2023 AMA prior authorization physician survey. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

[v] Sahni NR, Gupta P, Peterson M, Cutler DM. Active steps to reduce administrative spending associated with financial transactions in US healthcare. Health Aff Sch 2023;1:qxad053.