Importance of Authorization of Prescribed Treatment in U.S. Healthcare at DRG

By

Disha Didwani

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2017-2019

The IIHMR University, Jaipur

1, Prabhu Dayal Marg, Sanganer, Airport
Jaipur 302029, Rajasthan
Ph: 0141 3924700, Fax: 3924738
Website: **www.iihmr.edu.in**

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Website: **www.iihmr.edu.in**

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that **Disha Didwani**, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at **Decision Resource Group, Bengaluru** from **11th February 2019** to **10th May 2019.**

The Candidate has successfully carried out the study assigned to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

Col. (Dr.) Ashok Kaushik
Dean, Academics and Student Affairs
The IIHMR University, Jaipur

15 May 2019.

Piyusha 15/5/19

Dr. Piyusha Majumdar
Assistant Professor
The IIHMR University, Jaipur

DRG
DECISION RESOURCES GROUP

May 8, 2019

To Whom It May Concern

Disha Didwani
Emp Code - 102124

This is to certify that Disha Didwani has completed her dissertation project "Study the Importance of Authorization of Prescribed Treatment in US Healthcare" with DRG Analytics and Insights Private Limited from 11th February 2019 to 10th May, 2019.

We wish her all the best for her future endeavours.

Yours Sincerely,

Aswini Konda
Associate Manager – HR

Priyanka Srivastava
Senior Director - MedTech

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **A Study on the Importance of Authorization of Prescribed Treatment in U.S. Healthcare** and submitted by **Disha Didwani** Enrollment No. **IIHMR-U/01/2017-19/0561** under the supervision of **Dr. Piyusha Majumdar** for award of **MBA in Hospital and Health Management** carried out during the period from **11th February 2019** to **10th May 2019** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

Signature

ACKNOWLEDGEMENT

The journey to become a wise and responsible professional doesn't concise to classroom learnings. The experience that I gained while working with **Decision Resources Group** during dissertation period acquainted me with the practical aspect of the course & implementation of the theory in the real field. Any accomplishment requires the effort of many people & this work is no different. My sincere thanks to all for taking me ahead in this journey.

I would like to extend my sincere & heartfelt thanks to **Priyanka Srivastava**, **manager of provider team in India**, for providing me an opportunity to learn & develop professionally.

I extend my regards to **Jerica Hopkins**, **Research Director & Enrique Bakemeyer, ExecutiveDirector, Research**, for being constant support & guidance, & sharing their expertise & knowledge.

I also express my special thanks to **Dr. Piyusha Majumdar** for her guidance throughout the training period.

Last but not the least I thank my family for their constant support and for keeping me motivated throughout this journey.

ABSTRACT

The study is about to know the importance of Authorization of any prescribed treatment in U.S. Healthcare. Authorization is a process which requires physician to get approval prior to delivery of the prescribed treatment, authorization is a check run by some insurance companies or third-party payers before they will agree to cover certain prescribed medications or medical procedures. There are several reasons that insurance providers require prior authorization, including age, medical necessity, the availability of generic alternative, or checking for drug interactions. Authorization is the fourth step in revenue cycle process after scheduling, registration and benefits and eligibility verification. According to the AMA physicians in US receive 29 medical approvals per week, while 23 percent physicians report that they and their staff complete more than 40 PA request per week and 86% physicians report that PA burdens have increased over the past five years, while AMA projects to expect an increase of 20% per year in PA requirement. The objectives of the study is to know the importance of the authorization. to know the requirement for centralized authorization unit, to know how to avoid no authorization denials and to know the importance of dedicated Human Resource Staff in Authorization. The study is a descriptive observation design study and was conducted over a period of three months in a private company in bengaluru. The study instrument used for study to assess the importance of authorization were the case study and articles given by Healthcare Business Insights (HBI) which is a partner company of Decision Resource Group (DRG). The articles and case studies which were given by the HBI were studies thoroughly to assess the importance of authorization in U.S. Healthcare and all the collected data was systematically entered into Microsoft Excel and suitably formulated for statistical analysis using percentage and pie-charting and bar graph for data interpretation. The results of this study are that there are very few organizations who have staff dedicated for monitoring pre-authorization changes. Eligibility and benefits verification is the most common function performed by most of the organization's Pre-Authorization staff, 60% of the organizations have set pre-authorization performance benchmarks by service line or service setting. The conclusion of this study was that in order to improve the organizations have proper plans for denials, and make pre-authorization the part of the eligibility process to check

whether prior authorization is required for every visit, order, procedure and referral and for smooth pre-authorization process and to avoid denials the pre-authorization staff should double check the CPT codes, and the people working in that department should have open communication within the department and should have centralized authorization unit for efficient and effective working of the staff.

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ABOUT THE COMPANY

DRG is a global information and technology services company that provides proprietary data and solutions to the healthcare industry. We have brought together best-in-class companies to provide end-to-end solutions to complex challenges in healthcare. DRG reframes these challenges, enabling the customers to see the opportunities.

VISION:
The trusted partner for healthcare leaders, providing the industries best data, analytics and insights.

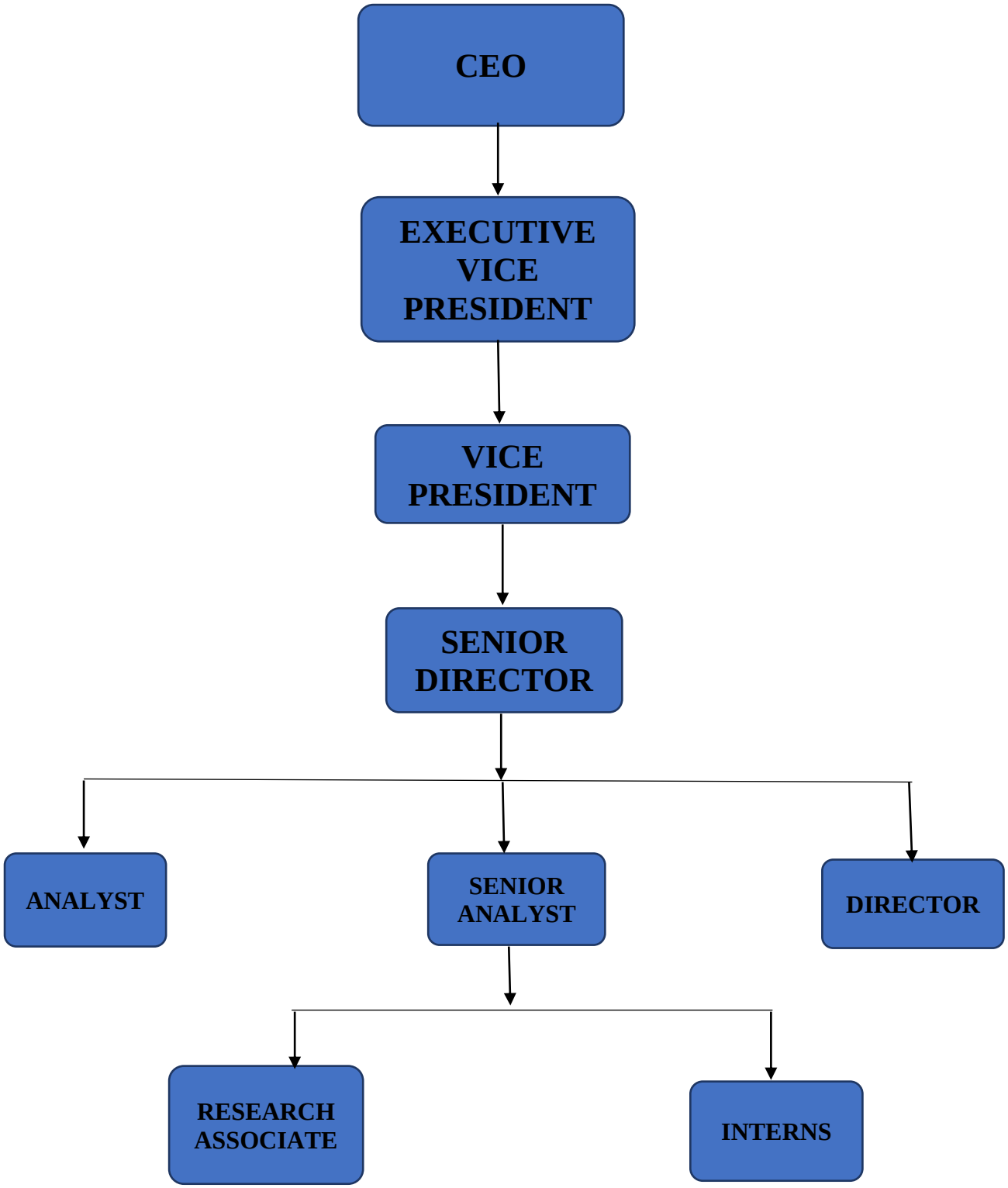
MISSION:
Reduce the burden of disease through insights.

VALUES:

- Knowledge
- Action
- Care

There are different teams within the organization which provide insights to the healthcare industry like MedTech, Market Access, Provider Team, Biopharma, Digital insights and more.

ORGANOGRAM OF THE COMPANY



INTRODUCTION

Pre-Authorization/ Authorization is a process which requires physician to get approval prior to delivery of the prescribed treatment. “Authorization is a check run by some insurance companies or third-party payers before they will agree to cover certain prescribed medications or medical procedures. There are several reasons that insurance providers require prior authorization, including age, medical necessity, the availability of a generic alternative, or checking for drug interactions. A failed authorization can result in a requested service being denied, or an insurance company requiring the patient to go through a separate process". Inefficient pre-authorization practices may result in denials and delays in patient care, and because of this, pre-authorization workflows may benefit from consistent monitoring. Authorization is the 4th step in the revenue cycle process after scheduling, registration and eligibility & benefit verification. For the authorization the demographic, clinical and financial information should be recorded correctly by both the parties i.e., healthcare organization and by the insurance company. If by any chance the mentioned information is not recorded correctly then there will be a situation of no-authorization which will result in denial of the claim. To avoid authorization denials healthcare providers and insurance companies need to work with each other and not against each other to improve and streamline the prior authorization process so that patients are ensured timely access to the evidence-based, quality healthcare they need.

LITREATURE REVIEW

The American Medical Association defines pre-authorization/authorization as *"*any process by which physicians and other health care providers must qualify for payment coverage by obtaining advance approval from a health plan before a specific service is delivered to the patient". *"*Prior Approval is an aspect of utilization management, specifically prospective utilization review, where an insurance payer looks at a number of factors such as medical necessity, prior treatment, clinical indications, and total therapy cost to determine whether a cost-savings can occur". "PA is also commonly referred to as precertification, prior notification, prior approval, prospective review, prior review; and the colloquial pre-cert, pre-auth and prior-auth commonly used by specialist; as is the conversational shortened-form: "auth". On average physicians obtain 29 medical approvals per week, while 23 percent of physicians report they and their staff complete more than 40 PA requests per week. Eighty percent of physicians report they are either sometimes, often or always required to repeat PA requests for prescriptions when the patient has already been stabilized on a treatment. And 86% of physicians report PA burdens have increased over the past five years, while the AMA projects to expect an increase of 20% per year in PA requirement.

"Many insurers require patients to obtain referrals from a primary care physician before seeing a specialist." "Providers have different policies about what they do when a patient doesn't have a referral, preauthorization, or prenotification. Some providers postpone treatment until proper authorizations are obtained, while others may go ahead with a procedure and try to retroactively get authorization".

"It is expected that use of PA will grow in the foreseeable future, driven primarily by health plans' desire to control the high costs associated with new, innovative therapies. For example, there are new medications available to treat cancer, hepatitis C, rheumatoid arthritis, neurological disorders and other complex conditions, with additional novel therapies currently in development. These treatments offer significant improvements in patient

outcomes that were impossible even a few years ago. However, many of these therapies will come at a considerable expense, with single rounds of treatment costing tens of thousands of dollars. Due to the high costs associated with these advanced treatments, health plan utilization of PA is expected to grow in the coming years. Published estimates predict a 20 percent per year increase in the number of drug PAs.4 PA requirements are also expected to grow for medical services, particularly in the public sector. The Centers for Medicare & Medicaid Services (CMS) has implemented PA for a number of services, including a PA demonstration project for power mobility devices (PMD) that uses the Electronic Submission of Medical Documentation (esMD)

system. The PMD PA program has been expanded to additional states, and its timeline extended. CMS has indicated that PA requirements will likely be broadened and applied to other service types in the future. As health care payment transforms from the current fee-for-service system to a model based more on outcomes or value, PA usage may decline. However, this transition will take time, during which PA will continue to be a common resource utilization tool for health plans".

Author	Study Article	Result	References
Andrea DeStefano-Giraldo	Creating an effective Pre-Service workflow- A case study in forming a multinational team and Pre-Authorization tool	Memorial Health System's initial denials have decreased from an average of 17% to 2%	DeStefano-Giraldo, A. (2015). Creating an Effective Pre-Service Workflow . *Creating an Effective Pre-Service Workflow-A case study in Forming a Multifunctional Team and Pre-Authorization Tool* (p. 29). Milwaukee: Healthcare Business Insights.
Joseph Goedert	Prior authorization trends raise patient risks	65% patients on an average wait for at least 1 business day for a prior authorization to go through	Goedert, J. (2019). Prior Authorization trends raise patient risks . *AMA Survey finds Prior Authorization trends raise patient risks*, 2.

Charleeda Redman	Structuring a clinical denials department- A case study in absorbing appeals from physicians to increase efficiency	By segmenting the denial department based on areas of expertise, UPMC has been able to promote more positive account resolution	Craig, K. (2012). Strengthening Pre-Authorization Processes. *Strengthening Pre-Authorization Processes-A Case Study in Mitigating Imaging-Related Denials* (p. 31). Milwaukee: Healthcare Business Insights.
KarenCraig	Strengthening Pre-Authorization Processes- A case study in Mitigating Imaging Related Denials	ACH has greatly reduced its authorization-related denials in radiology	Craig, K. (2012). Strengthening Pre-Authorization Processes. *Strengthening Pre-Authorization Processes-A Case Study in Mitigating Imaging-Related Denials* (p. 31). Milwaukee: Healthcare Business Insights.
Kaitlyn Houseman	The Importance of Pre-Authorization	For smooth pre-authorization CPT codes should be correct	Houseman, K. (2015). The Importance of Preauthorization. *Group One Healthcare*.
Rhonda Johnson	Forming an Integrated Task Force to Prevent Denials – A Case Study in Detailed Data Reporting	Modified processes for updating authorizations, the revised oncology infusion workflow resulted in more than $5 million of reimbursement	Johnson, R. (2015). Forming an Integrated Task Force to Prevent Denials . *Forming an Integrated Task Force to Prevent Denials – A Case Study in Detailed Data Reporting* (p. 29). Milwaukee: Healthcare Business Insights.
Atlantic General Hospital	Minimizing Pre-Authorization Denials and Late Charges	By adding system alert when CPT codes are performed differed from those ordered and the rate of reduction decreased in Pre-authorization denials from 30% to 75%	Hospital, A. G. (2013). Minimizing Pre-Authorization Denials and Late Charges. *Minimizing Pre-Authorization Denials and Late Charges*, 2.
Oregon Facility	Promoting Financial Clearance and Authorization	77% of organizations ranking	Facility, O. (2016). Promoting Financial Clearance and Authorization Accuracy Through Efficient Workflows and

	Accuracy Through Efficient Workflows and Proactive Communication	Authorization issues as Top-Five Denial Root Cause	Proactive Communication. *Promoting Financial Clearance and Authorization Accuracy Through Efficient Workflows and Proactive Communication*, 2

3. RATIONALE:

To assess and study the importance of authorization of prescribed treatment in U.S. Healthcare and know the difference between the authorization in India and US healthcare and provide suggestions in the process of authorization by using various articles and case studies based on authorization.

4. RESEARCH QUESTION:

What are the best practices that can be implemented to avoid no-authorization or authorization denials?

5. OBJECTIVES:

- To know the importance of authorization
- To know the requirement for centralized authorization unit
- To know how to avoid authorization denials
- To know the importance of dedicated Human Resource staff in authorization.

6. METHODOLOGY:

Study Design: Descriptive Observation study design

Setting: The research work was conducted at DRG (Decision Resource Group).DRG is a global information and technology services company that provides proprietary data and solutions to the healthcare industry.

Study Tools: Healthcare Business Insights (HBI) articles and case studies

Inclusion Criteria: Only those organizations who are members at HBI
Exclusion Criteria: Those organizations who are not members at HBI

Duration Of The Study: 3 months (February-April)

Sample Size: Articles (10) and Case studies (10)

Data Analysis Plan: A thorough review and conclusion will be done on the basis of articles and case studies of HBI

METHODOLOGY

- The study had andescriptive observation design and was conducted over a period of three months in a private company in Bengaluru
- The study Instrument used for study to assess the importance of authorization were the case studies and articles given by Healthcare business insights (HBI)
- The articles and case studies were studies thoroughly to assess the importance of authorization in US healthcare and know the difference between the authorization in US and Indian Healthcare system
- All the collected data was systematically entered into Microsoft Excel and suitably formulated for statistical analysis using percentage and pie-charting for data interpretation.

STATISTICAL ANALYSIS

FINDINGS:

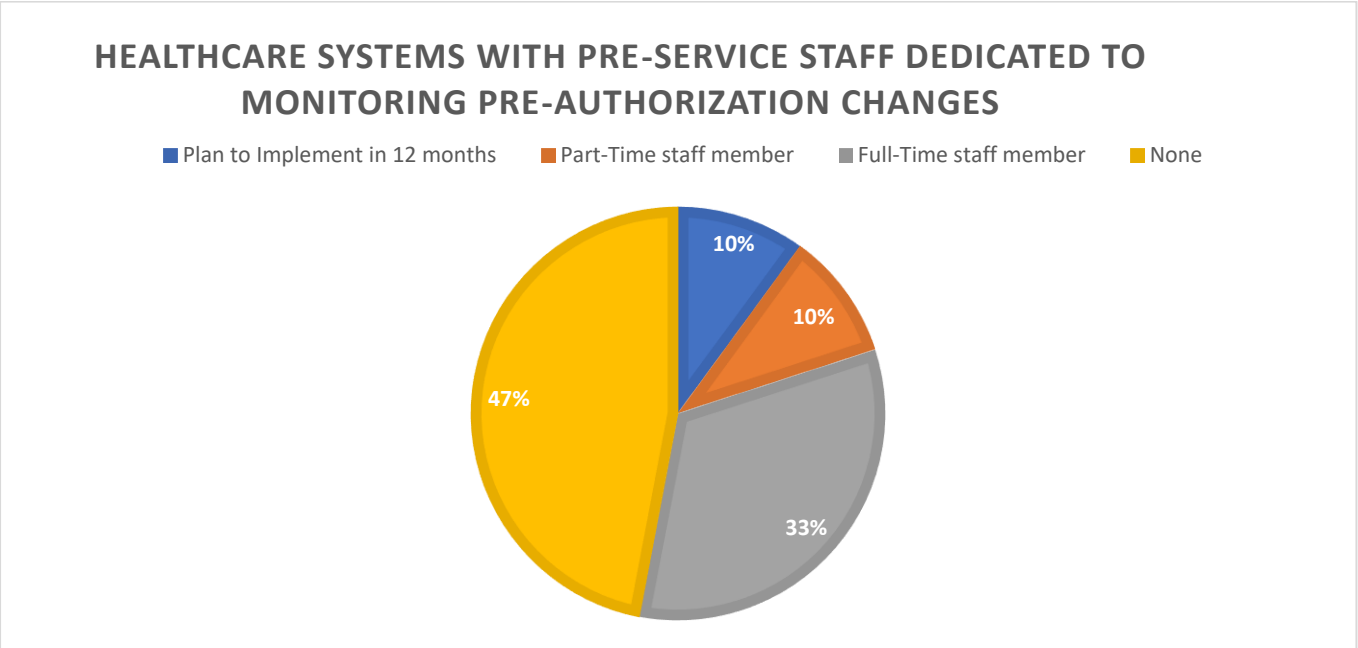
Salient Findings are summarized below in relevant tables and graphs:

Availability of Human Resource for monitoring of Pre-authorization Process

To have a separate dedicated staff for pre-authorization is very important because it will reduce the waiting time of the patients, it will increase the efficiency of the organization and the staff will be specialized in handling Pre-Authorization process which will ultimately result in reduction of the authorization-related denials.

TABLE 1: HEALTHCARE SYSTEMS WITH PRE-SERVICE STAFF DEDICATED TO MONITORING PRE-AUTHORIZATION CHANGES

ACTIVITY/OBSERVATION	TOTAL (%)
Plan to hire the staff in 12 months	10
Part-time staff member	10
Full-time staff member	33
None	47
TOTAL	**100**



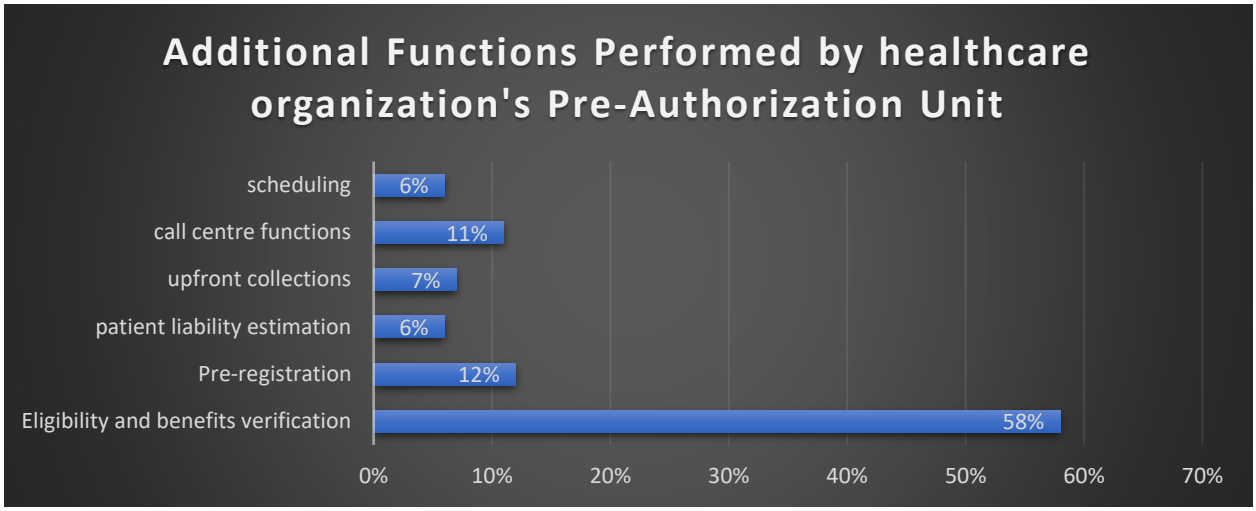
Pre-Authorization Process performed by staff

The Pre-Authorization process which is performed by the staff is as follows:

- Verify eligibility and benefits to determine if a pre-authorization is needed
- Prepare documentation for request
- Contact the physician or patient for additional information, if needed
- Submit pre-authorization request
- Retrieve and send additional clinical information to the payer, if needed
- Document the payer's decision
- Inform referring physician of payer decision
- Appeal payer refusal/submit request if necessary

TABLE 2: ADDITIONAL FUNCTIONS PERFORMED BY HEALTHCARE ORGANIZATIONS PRE-AUTHORIZATION STAFF

ADDITIONAL FUNCTIONS	TOTAL (%)
Eligibility and benefits verification	58
Pre-registration	12
Patient Liability Estimation	6
Upfront Collections	7
Call Centre Functions	11
Scheduling	4
TOTAL	**100**



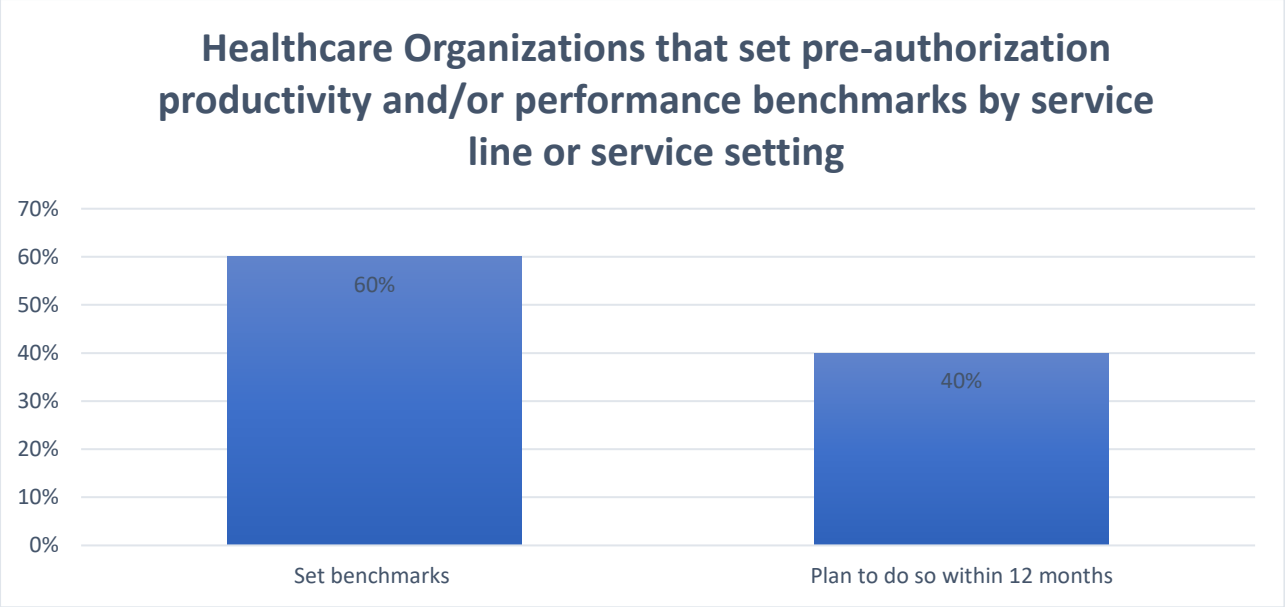
Setting of Performance Benchmark Prior to authorization

Few of the benchmarks which are usually set for the pre-authorizations staff are as follows:

- Specializing Staff by service lines
- Orienting staff performance by time
- Monitoring Account Touches

TABLE 3:HEALTHCARE ORGANIZATIONS THAT SET PRE-AUTHORIZATION PRODUCTIVITY AND/OR PERFORMANCE BENCHMARKS BY SERVICE LINE OR SERVICE SETTING

ACTIVITY/OBSERVATION	TOTAL (%)
Set benchmarks	60
Plan to do so within 12 months	40
TOTAL	**100**



Strategy to handle Clinical Denial

Centralized Denial Management Team is team which consists of 5-6 members to handle denials related to authorization in a healthcare organization and this team is located centrally in the healthcare organization for the effective and efficient working. The denial management team handles denial by collecting the correct information by physicians and patients and then communicating it to the insurance companies at the right time.

TABLE 4: HEALTHCARE ORGANIZATIONS WITH A CENTRALIZED DENIAL MANAGEMENT TEAM

ACTIVITY/ OBSERVATION	TOTAL (%)
Have a centralized team	56
Do not have a centralized team	27
Planning to in next 12 months	17
TOTAL	**100**

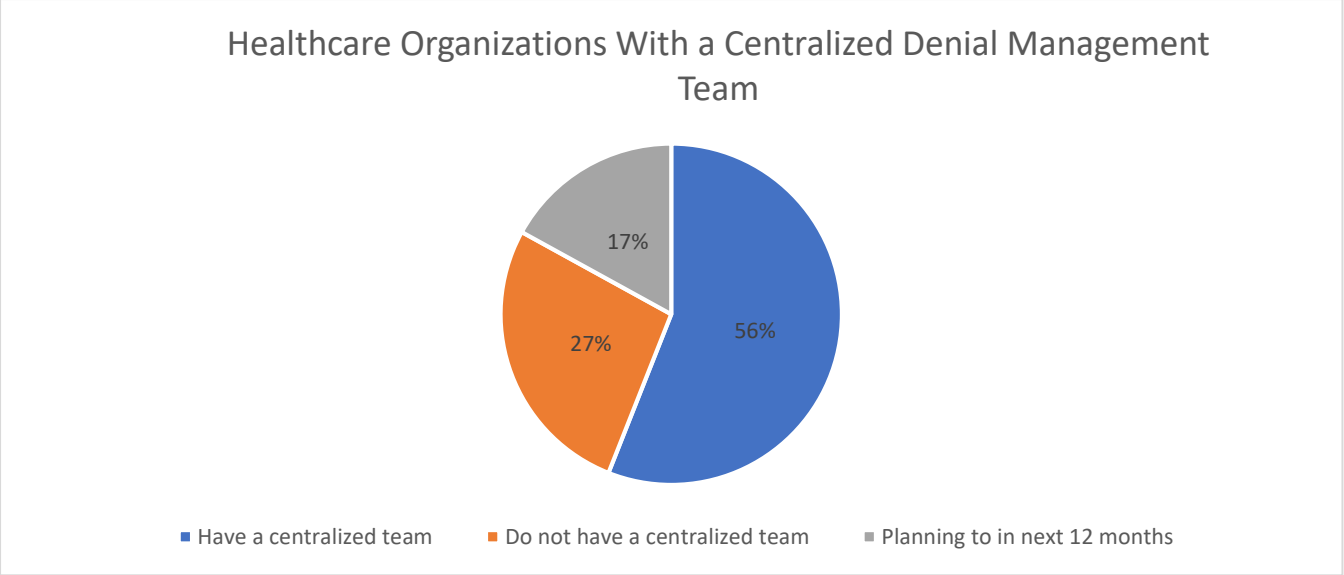


TABLE 5: STAFF RESPONISBLE FOR APPEALING CLINICAL DENIALS AT HEALTHCARE ORGANIZATIONS

STAFF RESPONSIBLE	TOTAL (%)
Other	24
Revenue Cycle Management	24
Dedicated Clinical Denials Team	18
Case Management	13
Billers	13
Nurse auditors	8
TOTAL	**100**

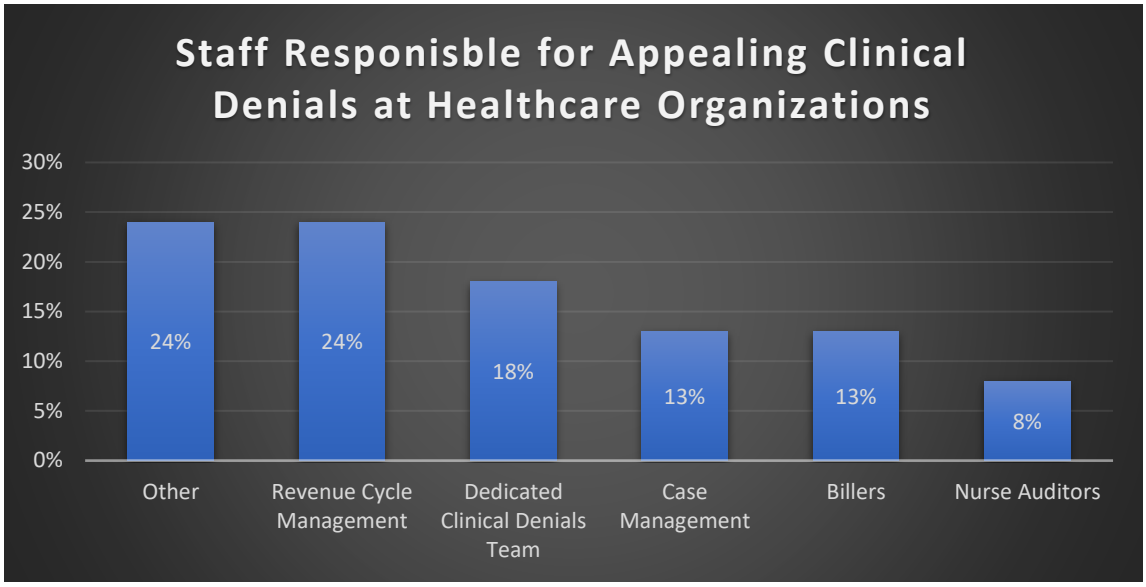
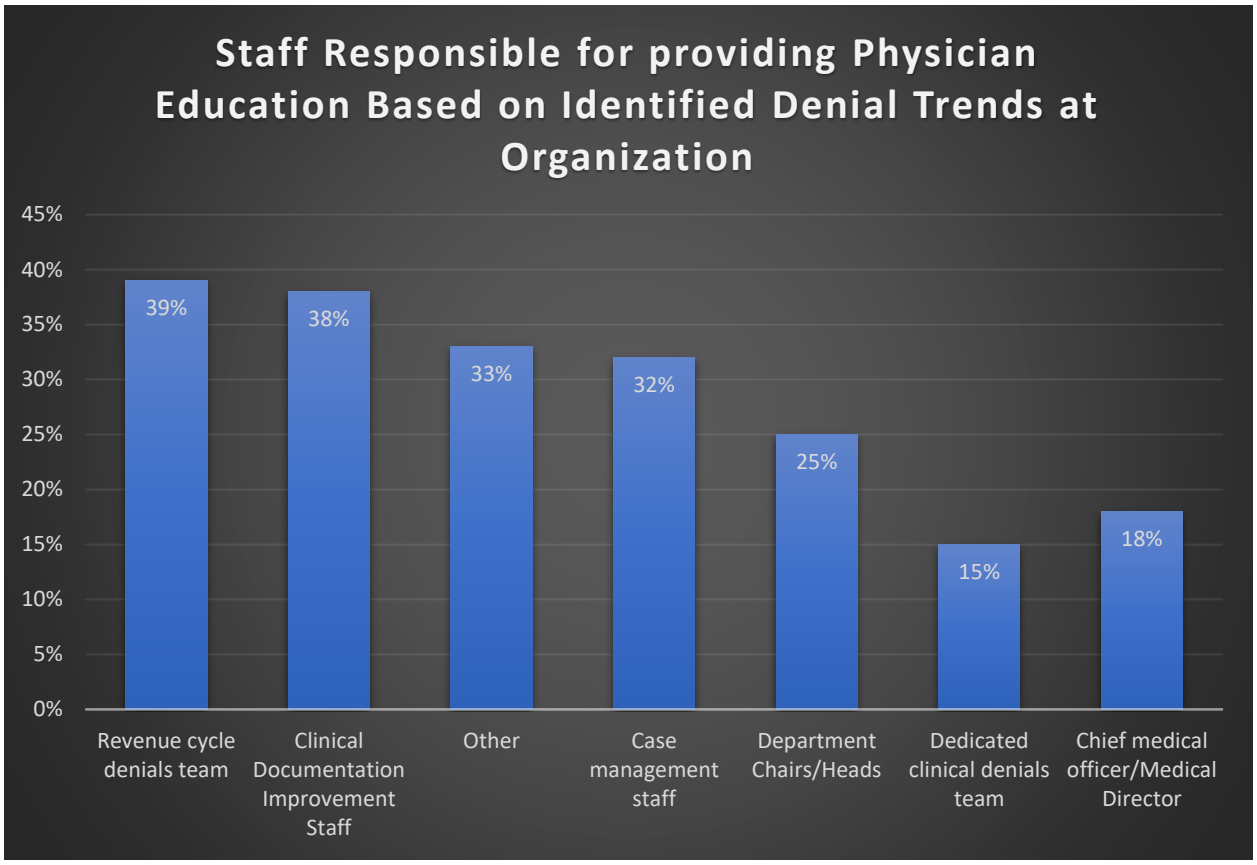


TABLE 6: STAFF RESPONISBLE FOR PROVIDING PHYSICIAN EDUCATION BASED ON IDENTIFIED DENAIL TRENDS AT ORGANIZATION

STAFF RESPONSIBLE	TOTAL (%)
Revenue Cycle Denials Team	39
Clinical Documentation Improvement staff	38
Other	33
Case Management Staff	32
Department Chairs/Heads	25
Dedicated Clinical Denials Team	15
Chief Medical Officer/ Medical Director	18

TOTAL	200



Turnaround time for Pre-authorization Responses

The standard time approval of pre-authorization process is 1-2 business days and it can get delayed because of the following reasons:

- Incorrect demographic information
- Incorrect insurance information
- Miscommunication between the insurance company and the healthcare organizations
- Delay in getting the information from the patient or physician
- If the procedure has been changed

TABLE 7:AVERGAE WAITING TIME FOR PRE-AUTHORIZATION RESPONSES

WAITING TIME	TOTAL (%)
Under 1 hour	5
A few hours	12
More than a few hours but less than 1 business day	11
1 business day	20
2 business days	19
3-5 business days	19
More than 5 business days	7
Don't know	7
TOTAL	**100**

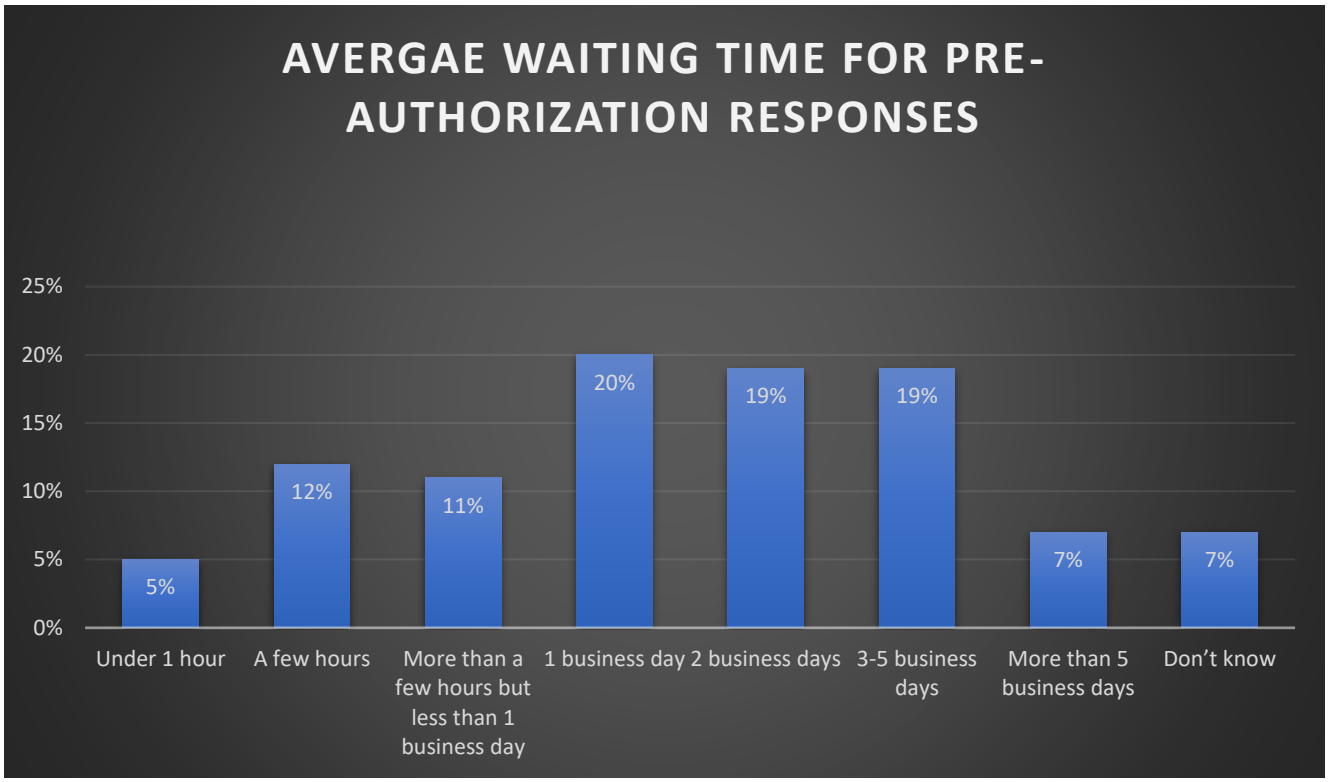
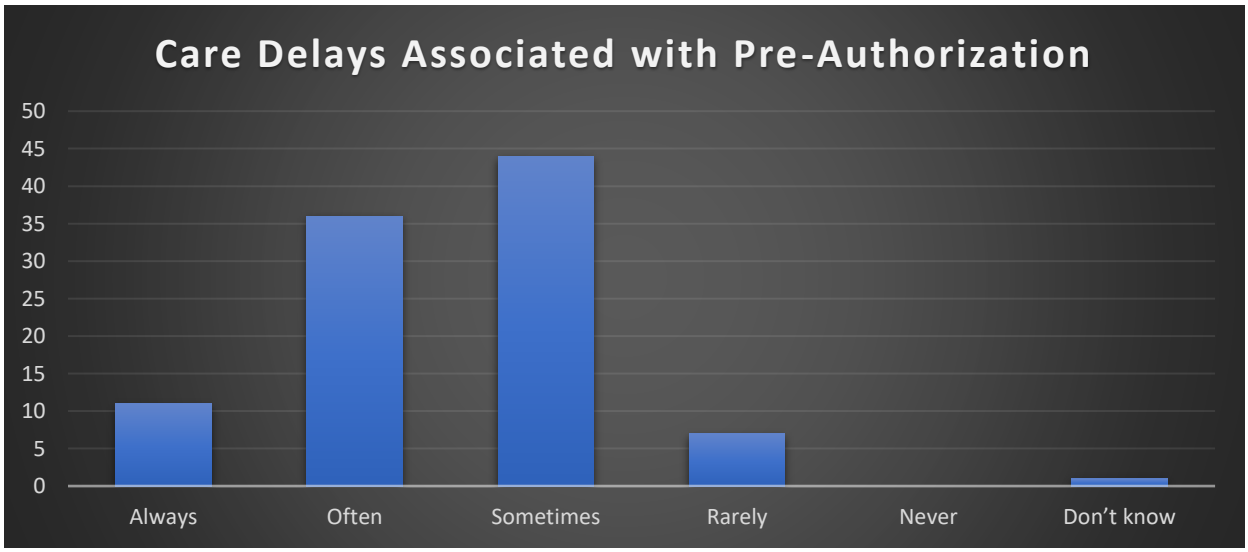

AVERGAE WAITING TIME FOR PRE-AUTHORIZATION RESPONSES
25%
20%
15%
10%
5%
0%
5%
12%
11%
20%
19%
19%
7%
7%
Under 1 hour
A few hours
More than a few hours but less than 1 business day
1 business day
2 business days
3-5 business days
More than 5 business days
Don't know

TABLE 8: CARE DELAYS ASSOCIATED WITH PRE-AUTHORIZATION

ACTIVITY/OBSERVATION	TOTAL (%)
Always	11
Often	36
Sometimes	44
Rarely	7
Never	0
Don't know	1
TOTAL	100



8. RESULTS:

- There are very few organizations who have staff dedicated for monitoring pre-authorization changes.
- Eligibility and benefit verification is the most common function performed by most of the organization's Pre-authorization staff
- Only 60% of the organizations have set pre-authorization performance benchmarks by service line or service setting
- Nearly, 56% organizations have a centralized denial management team
- In 39% of organizations, Staff of Revenue cycle denials team is responsible for providing Physician Education Based on Identified denial trends
- According to the survey by American Medical Association (AMA),20% patients have to wait at least for 1 business day for the pre-authorization from health plans
- According to the survey by American Medical Association (AMA), 44% patients say that "sometimes" the process of pre-authorization gets delayed due to which their necessary care gets delayed.

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