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

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HBI Healthcare Business Insights

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Introduction : U.S. Healthcare

- **U.S. Healthcare coverage is provided by the combination of private health insurance and public health coverage.**
- **Healthcare facilities are largely owned and operated by private sector.**
- **According to Center of Medicare and Medicaid Services (CMS) U.S. healthcare spending grew 3.9 percent in 2017, reaching $3.5 trillion. As a share of nation's GDP, health spending accounts for 17.9 percent.**
- **U.S. does not have universal health program, unlike other developed countries.**
- **Most of the citizens in U.S. are covered by private insurance or various federal and state programs**

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Decision Resource Group (DRG)

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.

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Healthcare Business Insights

- **HBI is the part of DRG which turns insights into action.**
- **HBI has four research academies:**

Academy	Topics
Revenue Cycle	Authorization, insurance verification, patient collections, preventing insurance denials, coding, clinical documentation, patient out-of-pocket estimates
Cost & Quality	Reducing readmissions, infection control, care coordination, chronic illness management, preventing hospital-acquired conditions
Supply Chain	Value analysis, inventory management, product review, logistics, environmental services
Information Technology	Data analytics, cyber security, encryption, electronic health records, disaster recovery, cloud computing

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Healthcare Business Insights

- **Revenue Cycle: The process used by healthcare systems in the United States to collect revenue from patients and third-party payers. The revenue cycle includes administrative and clinical functions that occur from the time services are scheduled to final account resolution.**
- **The three parts of the revenue cycle are:**

Patient Access

- Scheduling
- Patient Information Collection
- Insurance Verification
- Authorization
- Residual Collections
- Patient Estimates
- Financial Clearance

Mid-Cycle (also called Health Information Management)

- Charge Capture
- Coding
- Clinical Documentation
- Medical Records

Billing and Collections

- Billing
- Denials and Underpayments
- Vendor Management
- Collections

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Authorization

- **Authorization is a process used by some health insurance companies in the United States to determine if they will cover a prescribed procedure, service, or medication. The process is intended to act as a safety and cost-saving measure.**
- **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 a number of 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.**

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Research Question

Q1. What are the best practices that can be implemented to avoid authorization-related denials?

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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**

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Methodology:

- **Study Design:** Descriptive Observation study design
- **Setting:** The research work will be 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

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Review of Literature

Author	Study Title	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.
Charleed a 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	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.

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Author	Study Title	Result	Reference
Karen Craig	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.
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.

Contd.

Author	Study Title	Result	Reference
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*

Contd.

Author	Study Title	Result	Reference
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 Accuracy Through Efficient Workflows and Proactive	77% of organizations ranking Authorization issues as Top-Five Denial Root Cause	Facility, O. (2016). Promoting Financial Clearance and Authorization Accuracy Through Efficient Workflows

Current Prior Authorization Process

Physician orders lab test

Lab receives order, starts prior auth

Check for PA requirements, health plans all have different rules

Contact health plan
May require > 30 min holding time

Retrieve plan specific form as forms vary by each plan

PA is **faxed** out after attaching medical documents

Clean approval 1-10 days

Rejection/Appeal cycle
2 days – 2 months

Insurance Agent reviews PA

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Common Procedures that Require Pre-Authorization

- **Imaging studies like MRIs and CT scans often require pre-authorization**
- **The brand name of a medication is available as a generic. For example, Drug A (cheaper) and Drug B (expensive) are both able to treat your condition. If the doctor prescribes Drug B, your health plan may want to know why Drug A won't work just as well.**
- **An expensive drug (as with psoriasis and rheumatoid arthritis medications)**
- **Medication used for cosmetic reasons (such as hair growth)**
- **Higher doses of medication than normal**
- **Medication that treats non-life threatening conditions**
- **Medication not usually covered by the insurance company, but is deemed medically necessary by the physician (who must also inform the insurance company that no other covered medications will be effective)**
- **Drugs that are intended for certain age groups or conditions only**
- **Drugs that have dangerous side effects**

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What If Authorization is not done?

- **Delayed patient access to necessary therapies**
- **Uncompensated work for physicians and staff, which translates into increased overhead costs for practices—many of which are already financially stressed**
- **Disruptions in practice workflow, resulting in inefficiencies and a reduction in physician time spent providing care**
- **Nonpayment for provided services, as PA requirements are often not identified until after treatment is already completed**
- **Payer rules keep have changed unexpectedly. This will most often result in a "soft" denial remedied by resubmitting forms in accordance with the payer's updated specifications.**
- **The payer is new to the practice, so the payer's preauthorization requirements are unfamiliar. Contact payer or third party administrator to obtain requirements and resubmit request.**
- **Billers and claims managers are simply unable to keep up with changes and additions to so many payer plans precertification rules.**
- **The practice does not have the capacity to handle prior authorizations but cannot find a reliable vendor to outsource to.**

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Types of Queries Received

- How can we implement a paperless authorization process?
- Do others let pre-authorization staff work remotely?
- What are best practices for obtaining authorizations for outpatient services?
- What are productivity benchmarks for pre-authorization staff?
- Are other organizations providing updates to patients about the status of their authorizations?
- Are other organizations working with payers to automate inpatient authorizations?
- What is a good model for outsourcing authorizations?
- What is best practice – securing authorizations for physicians, or letting them do it themselves?
- How many days in advance do other organizations secure authorizations?

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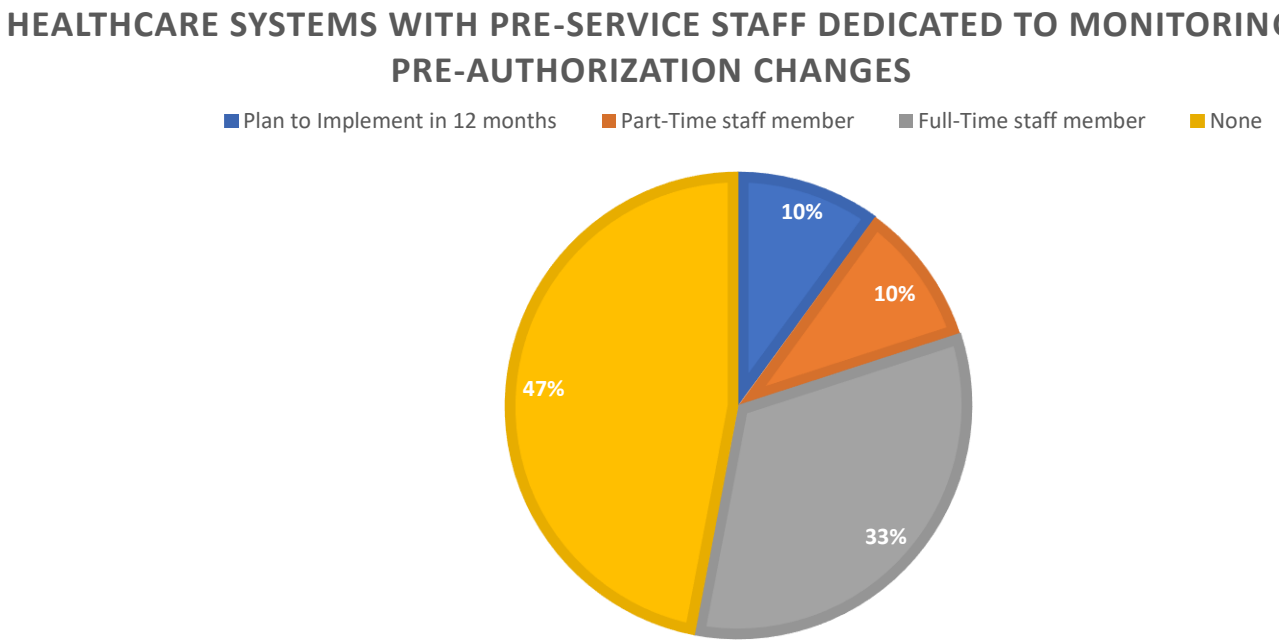
Statistical Analysis

- **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.
- **GRAPH 1:**



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- **Pre-Authorization Process performed by staff (Graph2) :** 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

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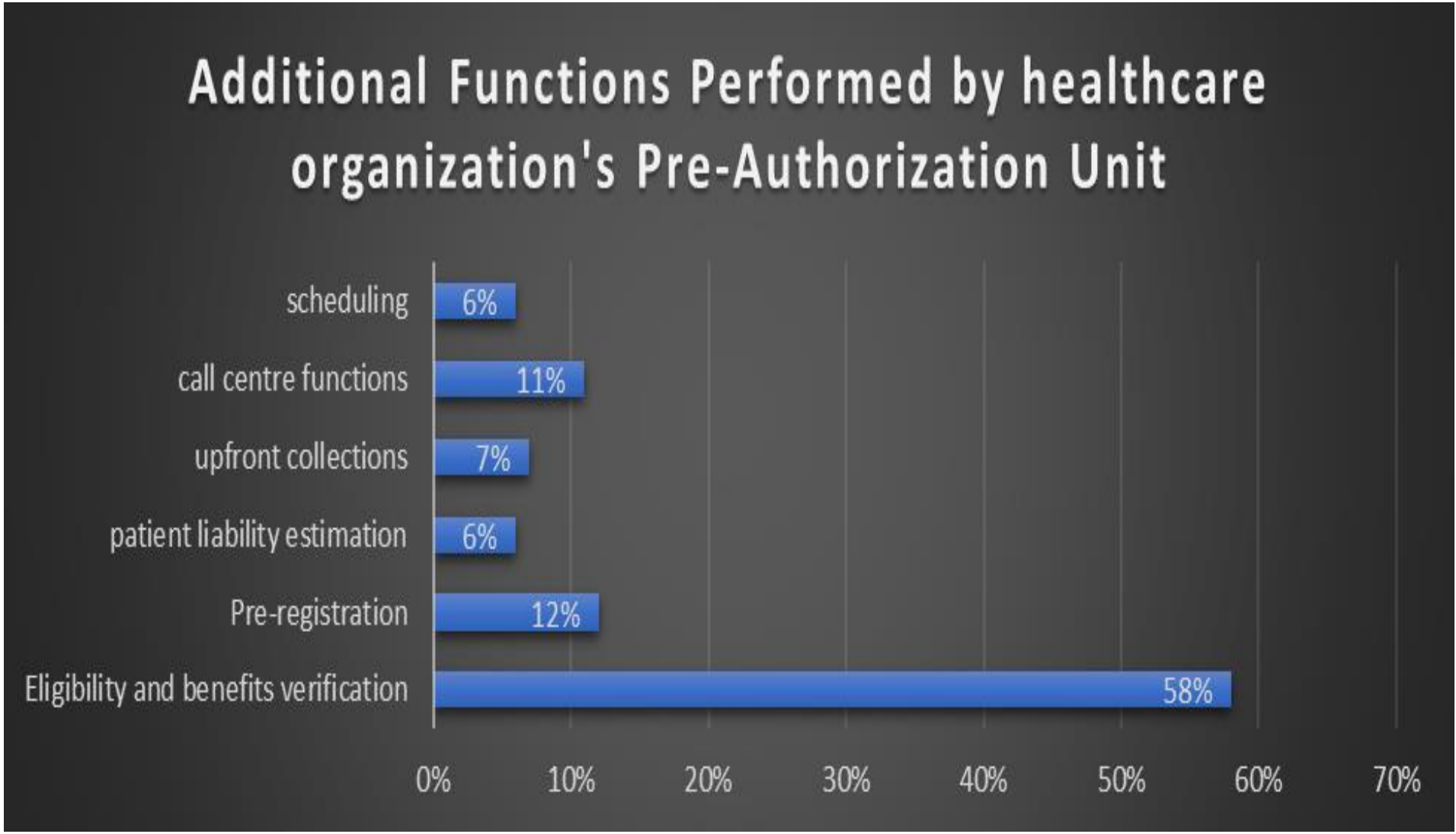

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- **Setting of Performance Benchmark Prior to authorization:** Few of the benchmarks which are usually set for the pre-authorizations staff are as follows:
- Specializing Staff by service lines
- Orienting staff performance by time
- Monitoring Account Touches

Healthcare Organizations that set pre-authorization productivity and/or performance benchmarks by service line or service setting

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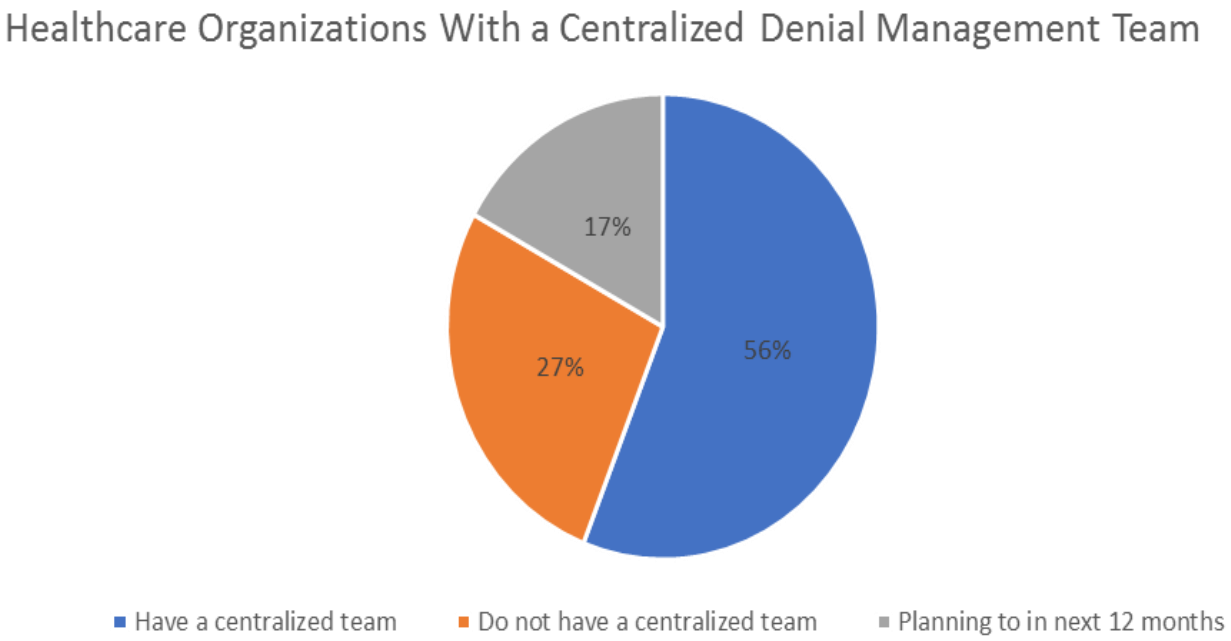
- **Strategy to handle Clinical Denial (Graph 4) -** Centralized Denial Management Team is team which consists of 5-6 members to handle denials related to authorization in a healthcare organization and this team is located centrally in the healthcare organization for the effective and efficient working. 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.



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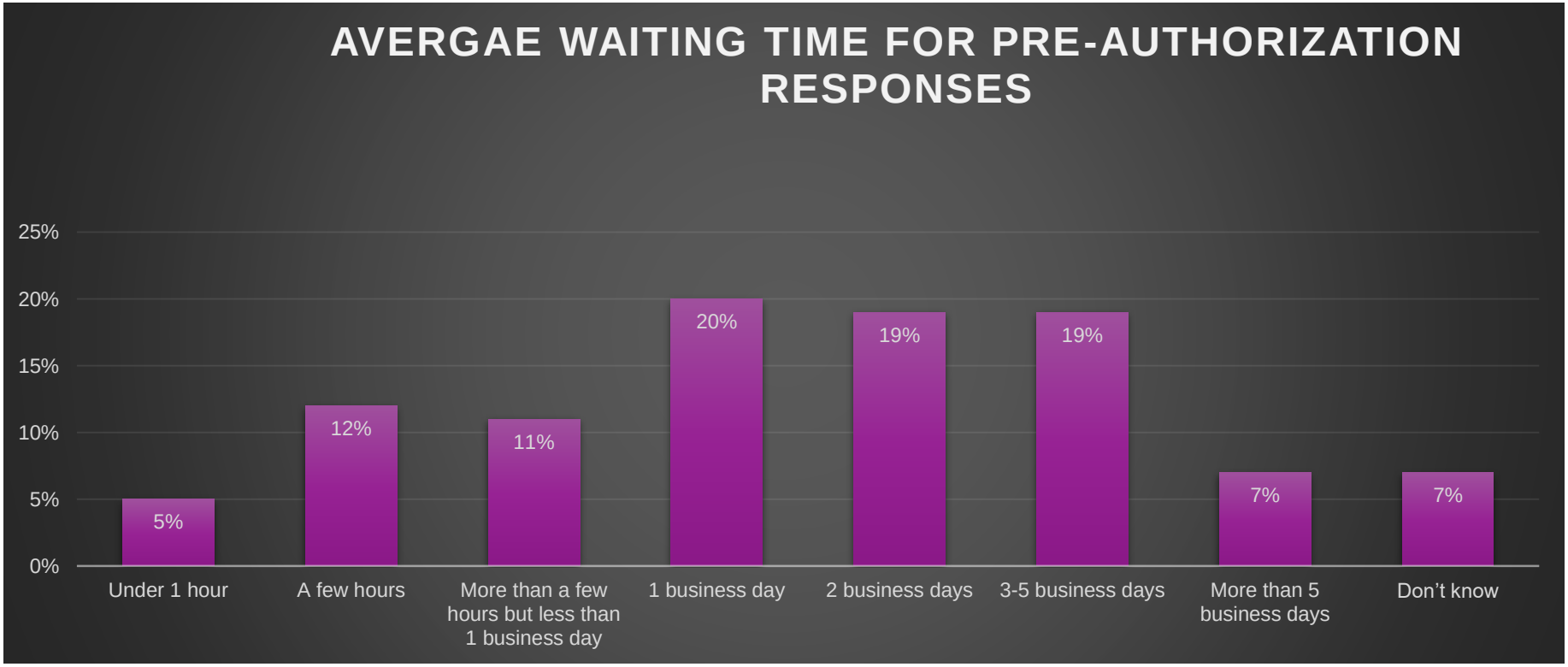
- **Turnaround time for Pre-authorization Responses (Graph 6) -** The standard time approval of pre-authorization process is 1-2 business days and it can get delayed because of the following reasons:
- Incorrect demographic information
- Incorrect insurance information
- Miscommunication between the insurance company and the healthcare organizations
- Delay in getting the information from the patient or physician
- If the procedure has been changed



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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Links :

- https://en.wikipedia.org/wiki/Prior_authorization
- https://members.healthcarebusinessinsights.com/internal/events/eventDetailViewPage/26666/1
- https://members.healthcarebusinessinsights.com/internal/events/eventDetailViewPage/26660/1
- https://members.healthcarebusinessinsights.com/internal/events/eventDetailViewPage/25896/1
- https://www.practicesuite.com/prior-authorization/
- https://www.healthdatamanagement.com/news/ama-survey-finds-prior-authorization-trends-raise-patient-risks
- https://www.grouponehealthsource.com/blog/bid/74087/the-importance-of-preauthorization
- https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/psa/prior-authorization-toolkit_0.pdf
- https://members.healthcarebusinessinsights.com/research/document/61027
- https://members.healthcarebusinessinsights.com/research/document/58243
- https://members.healthcarebusinessinsights.com/research/document/61251

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- **Redman, C. (2015). Structuring a Clinical Denials Department . *Structuring a Clinical Denials Department- A Case Study in Absorbing Appeals from Physicians to Increase Efficiency* (p. 29). Milwaukee: Healthcare Business Insights.**

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QUESTIONS?

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