In October 2022, the healthXchange Patient Financial Services online meeting included a lively discussion focused on a critical step in the patient and hospital reimbursement journey, securing prior-authorization for care. Led by Makeyta Love, Enterprise Manager, Prior Authorization – Patient Access at the Mayo Clinic, and Stephen Schapp, Senior Manager, Patient Financial Services at Massachusetts General Hospital, the discussion ranged across six broad issues:

- Managing Timelines for Securing Authorization
- Increasing Payer Documentation Requirements
- Conducting Peer-to-Peers & Facilitating Appeals
- Structuring Teams & Managing Work Queues
- Authorization with Unlisted Codes or Experimental
- Focus on the Pro's and Con's of Technology

Read on for a full summary of this enlightening discussion, featuring comments, questions, and feedback from the panelists as well as audience members.

HEALTH X change

Session Summary: Securing Prior Authorization for Care

Session Leaders:

Makeyta Love
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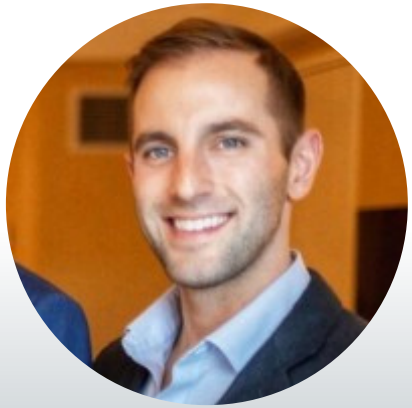

Steven Schapp
Senior Manager, Patient Financial Services
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Managing Timelines for Securing Prior Authorization

Consensus across the group was that 12-15 days is the current amount of time required to secure prior authorization, with 14-15 days being the most common, and the universal goal of securing a positive determination prior to the service date. Several challenges were described in meeting these timelines:

- Urgent or late add-on's
- Same or next day requests
- CPT changes or switches
- Documentation requests
- Delays in payer responses

For some organizations, such as the Mayo Clinic, where patients frequently travel in from considerable distances to secure specialized treatment, there is a desire to conduct as many tests, services, or procedures while the patient is in the area; often resulting in a need for expediting requests with payers.

Situations where prior authorization appears to be secured more quickly are those where treatment plans clearly align with a specific set of diagnosis codes, and where medical appropriateness is a match. Panelists noted that payers are often approving based on a checklist which confirms against medical policies, and where there is an alignment, approval is secured more quickly, while moving outside of the box there are more challenges presented.

Late add-on's and same or next day requests for authorization were noted as challenging for everyone to facilitate, with some organizations dedicating teams to specifically tackling these expedited authorization needs. Escalating the cases, having comprehensive documentation to hand, and using urgency focused on medical necessity were all mentioned as ways to handle these situations.

CPT switches also posed a considerable risk, with executives noting the need to consider the situation, whether part of the procedure had been approved compared to the part that had been changed.

Panelists and audience members also noted that payer delays and requests for additional documentation are slowing authorizations, causing ripple effects with scheduling and patient satisfaction. Knowing the payer requirements and meeting those demands up-front was the primary solution to securing authorization in the timeline required.

"No Authorization Required doesn't actually mean it's covered."

Increasing Payer Documentation Requests

A common reply from payers is that there is "lacking, missing, or incomplete data," resulting in an authorization delay or denial, as additional documentation is gathered and resubmitted for approval.

Industry consensus was that more documentation needs to be submitted to payers in order to secure authorization, requiring a heightened level of collaboration with medical staff who must provide clarity on planned procedures, outline the conservative treatments that have been attempted, provide previous imaging, and very clearly outline previous results.

As payers often outline criteria for approval, submitting this information in a complete state will smooth the authorization process, and providing the data and documents in an order that a reviewer can quickly work through and make the appropriate checks is advised. Some participants noted that working with physicians to incorporate specific keywords that can help prevent denials or delays has been successful.

Focusing on medical appropriateness and medical necessity and working with physicians to ensure a comprehensive capture of the patients medical history is provided will help to smooth prior authorization and reduce the need for peer-to-peer reviews and appeals.

Conducting Peer-to-Peers and Promptly Facilitating Appeals

All participants noted the challenge in ensuring peer-to-peers are conducted prior to the scheduled service in order to secure approval, with many noting the difficulty in scheduling the peer-to-peers between medical teams and payer reviewers. As one participant noted, the "terribly small window" in which teams can make the peer-to-peers happen, the compressed time frames for conducting the meeting, was noted as the largest issue.

Solutions to facilitating peer-to-peers ranged from working to avoid them in the first place, to creating stronger relationships with clinical staff, and ensuring an open dialogue between authorization teams and medical staff.

Several anecdotal examples shared included peer-to-peers being conducted when small documentation errors had been made; for example one participant shared being asked to facilitate a peer-to-peer so that the physician could confirm that patient was not a smoker. In another instance, a surgeon was asked to provide additional documentation during the peer-to-peer that had already been included, but overlooked, during the initial requests. These types of inefficiencies are a cause of considerable consternation for not only authorization teams, but also for physicians who find administrative tasks an increasing burden.

Structuring Teams & Optimizing Work Queues

Throughout the discussion, with a focus on creating efficiencies in securing prior authorization, many questions were submitted from the audience focused on the nature and structure of authorization teams. In particular, one participant asked whether the authorization teams were centralized or decentralized, which led to a robust conversation regarding the benefits and drawbacks of each structure, as well as challenges that many had experienced in making a transition from decentralized to a centralized approach.

Overall, those that had transitioned into a centralized authorization team noted the benefits of the structure, but the difficulty in removing responsibility from service lines that had traditionally facilitated their own authorizations, which had unique requirements. In nearly all instances, decentralized teams perceived their authorization requirements as unique and specialized; while in actuality, the authorizations were often quite similar in process.

Participants also noted that despite having centralized authorization teams, executives were very much specialized in their authorizations, learning their payers, documentation requirements and procedures, so that a level of efficiency and knowledge is achieved.

When considering work queues, the primary focus was on the prioritization of work to support authorizations and to identify common denials and trends in order to prevent future difficulties. Some common examples shared included:

- Coding mismatches
- Notice of admission
- Outpatient to inpatient

While one individual noted that there are perhaps too many, an almost over-abundance of work queues, ultimately the audience agreed that using work queues effectively helps to support the authorization team in meeting benchmarks, particularly in days out and timelines scores.

Unlisted Codes, Experimental & Investigational Procedures

Another challenge discussed during the panel was the use of unlisted codes; and a common trend of payers indicating at first pass that no authorization is required, but then denying the procedure on the back end. The general consensus from the discussion was that payers largely do not know how to handle unlisted codes, as they do not meet the checklist criteria that other procedures follow.

Consensus with the group was that moving forward with a pre-determination in situations where unlisted codes are being leveraged is important in ultimately ensuring the procedure is covered. In facilitating the pre-determination, panelists noted that extensive documentation should be submitted, outlining in detail the procedure, supporting medical necessity and benefits that the procedure will provide, and that a peer-to-peer is often also helpful in supporting the determination.

When addressing experimental or investigational procedures, many noted that their payers do not typically cover these types of procedures, while others noted that to a limited extent, they are covered. In the case of an experimental or investigational procedure, a pre-determination was seen as a requirement, with letters and documentation submitted by the provider underscoring the medical necessity. Again, the audience agreed that "knowing your payers" was essential.

Technology: Pro's and Con's

As technology continues to rapidly advance, many executives are considering how and where to implement tools such as robotic process automation (RPA) and other supporting artificial intelligence to create efficiencies in workflows.

Positive aspects of technology implementation included:

- Increasing efficiency
- Streamlining tasks
- Supporting employees
- Lifting productivity
- Increasing quality
- Reducing costs

At the same time, participants noted some negative aspects:

- Overreliance on technology
- Need for human monitoring
- Identification of errors
- Workforce reductions / layoffs
- Security risks, cyber threats

Overall, the audience felt supportive of the introduction of new technology, but at the same time focused on the need to investigate potential return on investment to ensure technology ultimately lifts processes.