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THE ULTIMATE GUIDE TO PRIOR AUTHORIZATION

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PRIOR AUTHORIZATION - THE BASICS

WHAT IS A PRIOR AUTHORIZATION?

Prior authorization — also frequently referred to as preauthorization — is a utilization management practice used by health insurance companies that requires certain procedures, tests and medications prescribed by healthcare clinicians to first be evaluated to assess the medical necessity and cost-of-care ramifications before they are authorized.

The reasoning behind prior authorization requirements is that a less expensive treatment option may be sufficient rather than simply defaulting to the most expensive option. This is especially true for high ticket procedures and medications like surgeries that can safely occur in the outpatient setting, MRIs, durable medical equipment (DME), and specialty drugs.

For medical services, health plans may steer patients to lower cost physicians or sites of care.

For medication — especially high priced specialty drugs — pharmacy benefit managers (PBMs) often require a step therapy approach which dictates starting with less expensive options before stepping up to more expensive medication.

The decision by a health insurance payer to approve or reject a prescribed course of treatment based on the results of a prior authorization review will affect whether a provider or pharmacy will be reimbursed for a claim and, if so, whether reimbursement will be for a full or partial amount.

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WHAT IS THE DIFFERENCE BETWEEN PREAUTHORIZATION AND PRIOR AUTHORIZATION?

Preauthorization and prior authorization are often used interchangeably and refer to the same thing, as do terms like prior notification and prior review.

WHAT IS THE DIFFERENCE BETWEEN PRIOR AUTHORIZATION AND A REFERRAL?

A referral occurs when a referring provider recommends a patient to another provider to receive care, often in another specialty. This requires that the ordering provider submit paperwork to authorize the appointment.

HOW DOES PRIOR AUTHORIZATION WORK?

The current prior authorization process typically resembles the following flow:

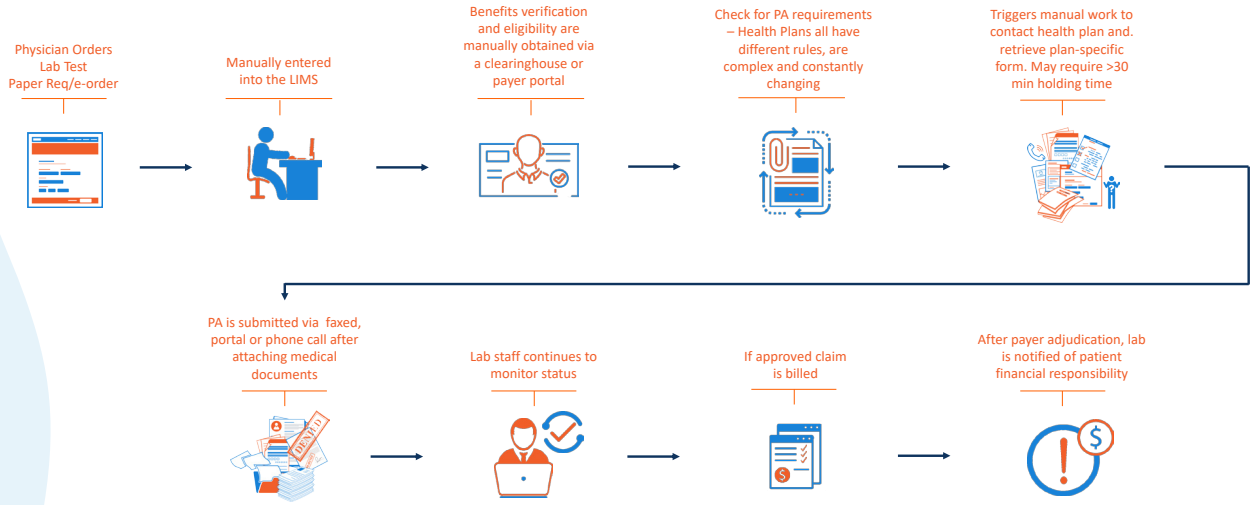
- First, a healthcare provider determines that a patient needs a specific procedure, test, medication or device.

- The onus is on the provider to then check a health plan's policy rules or formulary to determine if a prior authorization is required for the prescribed course of treatment. If it is required, the provider will need to formally submit a prior authorization request form and sign it to attest that the information supporting the medical necessity claim is true and accurate.

- Because clinical and healthcare billing systems are rarely integrated, provider staff will often start by manually reviewing prior authorization rules for the specific insurance plan associated with the patient. The rules may often be found in paper documentation, PDFs, or payer web portals.

- These payer rules are not standardized and differ from health plan to health plan. It is not uncommon for the rules to even differ from plan to plan within a specific payer. These payer rules also change frequently, so a provider's administrative staff may be referencing out of date rules.

- If the provider confirms that prior authorization is not required, it can submit the claim to the payer. This does not mean that the claim will necessarily be approved.



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- However, if the provider confirms that prior authorization is required, it will need to track down more specifics pertaining to each CPT code that is applicable to the prescribed course of treatment. It will also need to obtain a number assigned by the payer that corresponds to the prior auth request and include it when the final claim is submitted. These steps are usually done manually, often through a cascade of phone calls, faxes and emails between payer and provider.

- The responsibility falls on the provider to continue to follow up with the insurance company until there is resolution of the prior authorization request — an approval, redirection, or denial. This part of the process is unstructured and often improvised, which often leads to significant wasted time and effort.

WHY IS THE PRIOR AUTHORIZATION PROCESS SO COMPLEX?

The prior authorization process is often complicated by a combination of factors, including:

- Lots of required steps, each introducing the potential for delays and errors.

- Participation by both payers and providers, each of whom have different motivations, workflows, and infrastructure.

- Lack of standards, particularly when it comes to payer rules.

- Fluctuating payer rules which need to be constantly monitored and revised.
- Thousands of payers and health plans.
- Manual review of prior auth requests and medical charts by clinicians.

HOW LONG DOES A PRIOR AUTHORIZATION TAKE?

Depending on the complexity of the prior authorization request, the level of manual work involved, and the requirements stipulated by the payer, a prior authorization can take anywhere from one day to a month to process. The 2018 American Medical Association (AMA) Prior Authorization Physician Survey revealed that 26% of providers report waiting 3 days or more for a prior auth decision from health plans.

This delay can cause problems for both patients and the healthcare professionals attending to them. Patient adherence to medication and treatment often declines when obstacles like postponements or additional steps are introduced. It also siphons off time from clinicians — and the revenue cycle team that supports them — that could be better spent on patient care. As an unintended side effect of delayed care while a preauthorization is reviewed, some patients will seek treatment at an emergency room; a decision that will often result in them receiving a large, unexpected bill not covered by their health plan.

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IS IT POSSIBLE TO SPEED UP PRIOR AUTHORIZATION?

One of the primary reasons that prior authorizations take so long to resolve is that incomplete or incorrect information is submitted to the health plan, which triggers a denial and lot of manual rework on the provider side.

Any errors contained in the prior authorization form, from egregious to innocuous, may flag it for denial. A number on a patient's health ID card may be transposed. A middle initial may be incorrectly input. An address may be incomplete.

Errors often arise because the prior authorization process can be overly complicated and often involve a lot of manual steps and stakeholders, which can make it ripe for mistakes. Information about the patient, the ordering provider, the requested service, and the medical scenario are required and if any of it is amiss, it will precipitate a denial. Once a denial has been rendered, it is difficult to reverse.

Even when there are no errors, lengthy medical reviews associated with prior authorization can delay care and introduce uncertainty into the process for both providers and patients. This is especially true when benefit managers are involved.

Automating the end-to-end prior authorization process as early in the revenue cycle as possible reduces the likelihood for errors, lessens the amount of manual work wasted on tedious tasks, and accelerates patient care.

Read: Why Automation is the Key to Fixing Prior Authorization

WHO IS RESPONSIBLE FOR OBTAINING PRIOR AUTHORIZATIONS?

The healthcare provider is usually responsible for initiating prior authorization by submitting a request form to a patient's insurance provider. As mentioned in the "How does prior authorization work?" section above, this will then often prompt a time-consuming back and forth between the provider and payer. In many cases, the licensed provider is required to sign the order, referral, or requisition before the payer will accept the authorization request.

It is also incumbent on patients to understand if preauthorization is required and if it has been approved before services are rendered.

WHAT IS THE DIFFERENCE BETWEEN A RENDERING VS. ORDERING PROVIDER?

A rendering provider is a person or facility which actually performs the care. An ordering provider is a clinician who refers some type of care to be performed by the rendering provider.

In many cases the rendering and ordering provider may be the same. There are exceptions where the rendering and ordering providers differ, however, such as when dealing with some alternative sites of care.

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A good example of this dynamic is the common practice by ordering providers to refer diagnostic tests — blood, tissue, urine and so forth — to labs, which render the service.

WHO DECIDES THE OUTCOMES OF A PRIOR AUTHORIZATION REQUEST?

The ultimate decision on a prior authorization request rests with a clinician — a physician or nurse — who works for the health plan to which the request was submitted. All final denials or redirects commonly are decided by a clinician at the insurance carrier.

DO ALL MEDICAL SERVICES PERFORMED REQUIRE PRIOR AUTHORIZATION?

No.

Prior authorizations are usually only required for more costly, involved treatments where an alternative is available. For instance, if a physician prescribes an invasive procedure such as orthopedic surgery, it will likely require preauthorization. An alternative therapy, like injecting the patient with Cortisone to reduce pain and inflammation, is less likely to require payer review.

IS THE OCCURENCE OF PRIOR AUTHORIZATION INCREASING?

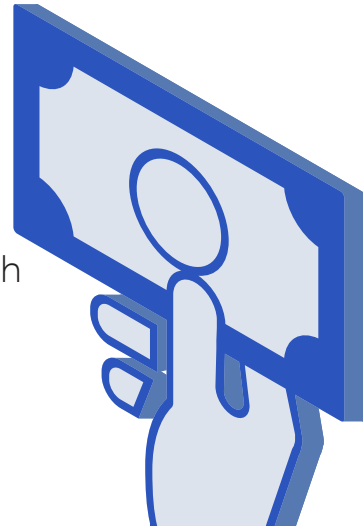
Yes.

The volume of medical procedures and prescribed medications requiring prior authorization is increasing significantly. This is driven largely by insurance companies searching for ways to control spiraling healthcare costs, especially those associated with innovative new specialty drugs or emerging technologies. While these medications or services can demonstrably improve patient outcomes, they usually come with outsized costs and are often too new to have a proven track record. This is especially true of specialty pharmacy drugs that are patent protected.

The American Medical Association (AMA) has projected that use of prior authorization for prescription drugs will increase 20% per year.

CAN DOCTORS CHARGE FOR PRIOR AUTHORIZATIONS?

Physicians and other healthcare providers do not usually charge for prior authorizations. Even if they wanted to, most contracts between providers and payers forbid such practices.



However, there are some instances — such as when a patient is out of network — that it may be appropriate to charge for a prior auth. In this scenario, the physician would not have a contract with the patient's health plan and could theoretically charge for the preauthorization.

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WHAT ARE THE DIFFERENT OUTCOMES OF A PRIOR AUTHORIZATION REQUEST?

There are three different possible outcomes:

1. A denial.

2. A redirection. This might occur when a prescribed treatment is denied from one site of care like a hospital-based surgery center and redirected to a lower acuity outpatient site of care.

3. A withdrawal of the prior authorization from the ordering provider.

WHAT IS A DENIAL OF REQUESTED SERVICES DUE TO MEDICAL NECESSITY REVIEW VERSUS AN ADMINISTRATIVE DENIAL?

If a requested treatment by a provider on behalf of a patient is not found to be medically necessary, it will be denied by the health plan on those grounds. If, however, the reason for the denial is due to incomplete member benefit or clinical information, it may result in an administrative denial.

WHAT ARE THE DIFFERENT CHANNELS THAT CAN BE USED TO SUBMIT A PRIOR AUTHORIZATION?

Traditional channels for submitting prior authorization requests have been by phone, fax or a web portal.

PRIOR AUTHORIZATION - INTERMEDIATE

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WHAT TYPE OF MEDICAL INFORMATION IS COMMONLY REQUESTED WHEN SUBMITTING A PRIOR AUTHORIZATION FORM?

While the format and requested information for a prior authorization form may differ from health plan to health plan, they will generally require that healthcare professionals provide the information below. Here is a sample prior authorization request form.

Identifying information for the member/patient such as:

- Name, gender, date of birth, address, health insurance ID number and other contact information

Identifying information for the referring provider and servicing provider. This can include contextual information such as:

- Referring provider information, including the name, NPI number and relationship to the patient (i.e. PCP or specialist, whether they are in network or out of network).
- Servicing provider information, including the name and NPI number.

Clinical information specific to the treatment requested that the payer can use to establish medical necessity, such as:

- Service type requiring authorization. This could include categories like ambulatory, acute, home health, dental, outpatient therapy, or durable medical equipment.
- Service start date
- CPT and ICD codes

WHAT ARE THE NEGATIVE EFFECTS OF PRIOR AUTHORIZATION?

- Perhaps the most significant negative effect is that prior authorization delays patient access to care. It adds a speed bump to the patient journey, and can lead some patients to forgo treatment.

  In fact, 75% of physicians participating in an AMA survey reported that issues related to the prior authorization process can cause patients to abandon their recommended course of treatment. In that same survey, 28% of physicians reported that preauthorization has led to a serious adverse event for a patient in their care.

- The administrative burden from prior authorization distracts clinicians from practicing medicine and contributes to the growing epidemic of "physician burnout."

- The unstructured and unpredictable nature of preauthorizations can wreak havoc on the normal administrative workflow of a practice. In fact, many practices have to add or repurpose staff expressly to deal with prior auths. These inefficiencies and the additional overhead required to deal with them can strain already dwindling margins and overextend office personnel.

Sometimes prior authorization requirements are not determined until after treatment is complete. This results in payers withholding some or all of an expected reimbursement. If this is the case, providers will often have to pursue payment from patients directly, a strategy that often results in practices writing off uncollectible revenue as bad debt.

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HOW CAN ADMINISTRATIVE BURDEN AND PHYSICIAN ABRASION BE REDUCED?

Healthcare providers often bristle at the idea of having to justify a prescribed treatment with insurance companies. That, in and of itself, creates friction between providers and payers.

Adding the "paper chase" that ensues when a prior authorization request kicks in only intensifies this friction, compounds the administrative burden that falls on the revenue cycle team, and worsens the abrasion between providers and payers. There are ways to change this scenario, however.

One of the best means to preempt the problem is to fully automate the prior authorization process so that the administrative burden of faxes, phone tag and emailing is removed, and clinicians are less likely to be consumed by the process.

The American Medical Association (AMA) has reported that physicians spend 16 hours per week on authorizations, with almost 90% stating that authorizations delay access to care. Giving doctors back those hours to spend on patient care can improve outcomes, reduce the administrative burden and lessen abrasion with payers.

WHAT IS ELECTRONIC PRIOR AUTHORIZATION?

Electronic prior authorizations (ePAs) refer to those instances where some or all of a prior auth determination is processed electronically.

What constitutes an ePA is up for interpretation. Manual keystroke entries to a payer portal or an eFax might technically count as ePA, as would more sophisticated computer-to-computer information exchange using electronic data interchange (EDI) or clearinghouse transmissions.

To more legitimately lay claim to offering an electronic prior authorization solution typically requires the following:

- EDI capabilities, particularly the capability to send a 278 transaction. This is the standard protocol to electronically transmit patient data pertaining to authorizations and referrals between providers and payers.
- Integration with EHRs, LIMS, and other clinical and financial management systems.
- Direct connections with health plans.
- Rule sets that automate the submission and tracking of prior auth requests.
- Use of multiple web-based prior authorization applications for each payer/PBM with their own username and password requirements.

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HOW ARE CLAIMS EDITS DIFFERENT FROM PRIOR AUTHORIZATIONS?

Payers can create electronic claims processing rules to enable automated determinations. For instance, if treatment associated with childbirth is recommended for a male patient, it can be easily flagged as erroneous and be denied. This would be an example of a claims edit.

However, medical decisions can be complex and not easily distilled into an "if this, then that" computational query. For the many care decisions that fall within a gray area, a claims edit will not suffice. These scenarios, where a determination of medical necessity is more nuanced, will often require prior authorization.

ARE ALL PRIOR AUTHORIZATION REQUESTS REVIEWED BY A CLINICIAN ON THE PAYER SIDE?

No.

Some prior authorization requests submitted electronically can be adjudicated algorithmically, especially for simple, lower cost procedures and medication. If a prior auth request appears to be heading for denial after being vetted computationally, it can then be escalated to non-clinician administrative personnel at a payer for further review.

More complex, higher cost treatments usually require clinician review or peer-to-peer discussions at the insurer, however.

CAN A PRIOR AUTHORIZATION DECISION EVER BE OVERTURNED?

Yes.

If a health plan denies treatment or medication requested as part of the prior authorization process, the provider has the right to appeal on behalf of their patient.

The denial will often be communicated by phone from payer to provider first. A letter from the payer to provider will then follow. An Explanation of Benefits (EOB) document will typically be sent from the payer to the patient.

The provider can then follow a formal appeals process specific to each payer. This can be a protracted, multi-step process that requires a material amount of time from providers and insurers alike.

- **Level One**: The initial phase begins with the doctor and patient contacting the payer to demonstrate that the requested treatment is medically necessary, and to request that the health plan re-evaluate the denial.

- **Level Two**: If the initial phase does not resolve the issue, the appeal is then escalated to a medical director at the carrier who has not yet been involved in the adjudication process. The medical director will evaluate whether the denial was properly assessed.

- **Level Three**: If the previous steps do not yield a satisfactory result for the provider and patient, the appeal may be taken to a more neutral party for review; often a physician with a similar specialty as the appealing doctor, and an intermediary from the insurance company.

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CAN A PRIOR AUTHORIZATION REQUEST BE WITHDRAWN?

Yes. A prior authorization request can be canceled once it is submitted.

Often this will occur when a prior authorization request is pending. While waiting for approval, the provider may learn of an alternative treatment that doesn't require preauthorization. For instance, a physician may cancel a prior auth request for back surgery and prescribe physical therapy instead.

WHAT IS ORDERING PROVIDER ATTESTATION?

As part of the prior authorization process, the ordering provider must certify that the information supporting the medical necessity claim is true and accurate. This may include the need to substantiate why a more expensive treatment is necessary when a lesser cost alternative is available.

HOW ARE HEALTH PLAN MEDICAL POLICIES RELATED TO PRIOR AUTHORIZATIONS?

Medical policies determine what procedures, medication and equipment are eligible for reimbursement. These payer rules govern — on a health plan by health plan basis — when prior authorization is required.

DOES MEDICARE REQUIRE PRIOR AUTHORIZATION?

Medical policies determine what procedures, medication and equipment are eligible for reimbursement. These payer rules govern — on a health plan by health plan basis — when prior authorization is required.

PRIOR AUTHORIZATION - ADVANCED

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HOW DOES MEDICAL NECESSITY IMPACT PRIOR AUTHORIZATION?

Medical necessity is a legal principle that applies to clinical situations, and provides a lens through which to evaluate the care provided by a physician or other provider to a patient. It is used in accordance with generally accepted medical standards to assess specific diagnostic and treatment recommendations. If prescribed care does not meet the threshold of being medically necessary, it will not be reimbursed by insurance carriers.

Demonstrating medical necessity is generally required to receive payer approval of care requiring prior authorization.

ARE THERE EXCEPTIONS WHERE A PRIOR AUTHORIZATION REQUEST CAN BE DISREGARDED?

Yes. Certain providers are exempt from prior authorization.

Some providers with a track record of high prior authorization approval rates are given "gold card" status and do not need to adhere to the same prior auth rules required of others. The same goes for hospitals and healthcare systems with marquee brand names that health plans covet for their networks. Emergency rooms and other trauma-based care are also exempt from prior authorization since the stakes are too high to wait for payer approval.

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CAN CASES WITH A DENIED DECISION BE RECONSIDERED WITHOUT GOING THROUGH THE APPEALS PROCESS?

Yes.

Prior authorization cases that have been closed can be reopened if the reason for the denial was administrative in nature, such as missing or inaccurate information. A new form with corrected information can be submitted for reconsideration.

CAN A NEW PRIOR AUTHORIZATION REQUEST BE SUBMITTED FOR THE SAME PATIENT AND SERVICE FOLLOWING A PREVIOUS DENIAL?

Yes.

Prior notification requests that were previously denied can be resubmitted and potentially be authorized. Sometimes the timing of the submittal plays a role. For instance, if a patient's condition worsens or the current treatment regimen is ineffective, the payer may be more inclined to approve the prior authorization request.

WHAT HAPPENS WHEN A PRIOR AUTHORIZATION REQUEST IS APPROVED BUT THE PATIENT NEVER RECEIVES THE SERVICE?

It is fairly common for a prior auth request to be approved, only to have the patient forgo the procedure or medication. In this case, the payer does not need to reimburse the provider.

WHY IS PRIOR AUTHORIZATION PARTICULARLY BURDENSOME FOR DIAGNOSTICS AND GENOMICS LABS?

Alternative sites of care like diagnostics and genomics labs don't usually communicate directly with patients. Instead, they are reliant on an originating provider like a hospital or physician practice to refer them business and to communicate with patients on their behalf. This business relationship, where the lab is one step removed from the patient, introduces an additional level of complexity when it comes to prior authorization.

If there is a single mistake in the prior authorization process then the diagnostics or genomics lab is put in the position of having to work through the referring provider as a go-between and to rely on them to resolve any issues with the insurance carrier. Because rendering providers depend on referrals from the originating providers, they know that they can only push the referring hospitals and physicians so hard or risk losing future business.

For a deeper dive on this subject, read: Diagnostics Lab Execs Reveal Their Biggest Revenue Cycle Challenges

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HOW CAN PRIOR AUTHORIZATION BE AUTOMATED?

As the volume of preauthorizations has spiraled, so too has industry enthusiasm to enact standards and automate the process. With the number of prior auths predicted to only climb higher, there is an urgency to find a way to remove a lot of tedious, time-consuming manual tasks through automation.

There are essentially 3 levels of revenue cycle automation but only one that specifically addresses prior authorization automation.

1. **Digitize the current prior authorization process**

   For those health systems and practices looking to at least free themselves from faxes, phone calls, and endless email loops, digitizing claims management can be a small step forward in automating prior auth and reducing denied claims.

   This might involve something as simple as a web portal that allows providers to create, validate, and submit healthcare claims electronically. The concept of introducing yet another portal that's not integrated with the rest of the systems and workflows is a major drawback, however. With this option, the medical billing team is still left to cut and paste from one portal to another.

   These solutions won't automate prior authorization, often don't have the horsepower to process transactions in real-time nor do they connect directly with payers at scale.

2. **Partially automate the prior authorization process**

   Providers will often begin by automating eligibility checks and benefits verification. That way they can at least begin to determine whether a patient is eligible for a procedure or medication, and patient access personnel can rectify potential conflicts at the point of care which could otherwise trigger a denied claim.

   Some providers may also look to automate the calculation of patient financial responsibility at the point of care. This enables them to inform patients how much the treatment will cost, and collect payment upfront if appropriate.

3. **Fully automate and orchestrate electronic prior authorization**

   Providers can build upon eligibility and patient financial responsibility capabilities by also automating prior authorization. Doing so adds functionality like the ability to automatically identify whether prior authorization is required and to determine the optimal submission route. This requires a fully-integrated, end-to-end approach that includes:

   - A master patient index (MPI) that can identify each unique patient.
   - Direct, real-time connections to most payers.
   - An extensive library of payer rules that synchronizes eligibility and prior auth rules.
   - Integration with workflows and systems like EHRs, LIMS, HIS, and RCM solutions.

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- A self-learning system that uses AI to dynamically update automated workflow and rules engines based on the actual responses and results from submitted prior authorizations.

For a deeper dive on this subject, read: Claims Denial Prevention in an Age of Prior Authorization

WHAT IS THE "HAWTHORNE EFFECT" AND HOW DOES THAT PERTAIN TO PRIOR AUTHORIZATION?

The Hawthorne Effect is a phenomenon in which people modify their behavior based on their level of awareness that they are being observed. It pertains to preauthorization because studies have shown that prior auth modifies provider behavior.

1. When prior authorization is not required, providers are often not as discriminating and price-sensitive in the treatment and medications that they prescribe.

2. When prior authorization is required, the Hawthorne Effect kicks in and changes the behavior of providers to be more conscious of the tradeoffs between patient care and costs.

3. Even if the prior authorization requirement is lifted, provider behavior remains changed thanks to the Sentinel Effect, which posits that performance improves when participants are aware that their behavior is not only being observed but also evaluated.

About Myndshft Technologies

Myndshft is a leading provider of real-time benefit check and prior authorization technology for diagnostics and genomics labs, specialty pharmacies and infusion therapy providers. Our software-as-a-service automates and simplifies time-consuming healthcare administrative tasks associated with prior authorization, eligibility and benefits verification, and patient financial responsibility, freeing providers, and payers to concentrate more fully on patient care.

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