

White Paper

# Fixing Healthcare's Broken Pre-Authorization Screening & Verification Model

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Among the processes that influence the healthcare revenue cycle, pre-authorization stands out—but not in a good way.

It lacks the foundation of a widely-adopted electronic data exchange, resulting in repeated manual, ad hoc methods of securing and confirming payer approval for non-emergency medical services.

And, all too often, there's no centralized responsibility for obtaining pre-authorizations, with the necessary tasks scattered across even the most integrated of care delivery networks and, within those networks, even across various types of service.

It's time to take a closer look at the current state of pre-authorization and ways in which existing obstacles can be overcome.

## Where Pre-Authorization Breaks Down

Understanding payer-specific pre-authorization requirements and monitoring for confirmation of payer decisions are a few of the core activities that suffer from a lack of consistency. They rely on

disjointed, manual processes that are costly—in both time and money. But they don't need to be so complicated and inefficient, and can benefit from process improvement and automation.

So, what can healthcare providers expect to gain from automating pre-authorization screening and verification? Here are some of the problem areas and ways they can be improved with new technology and processes.

### **Problem: Lack of Centralization**

When it comes to pre-authorization and who handles the function, many hospitals and health systems lack clearly defined roles—or even the departments responsible. Just as Patient Access was once the responsibility of whoever was at reception (even a Candy Stripper, back in the day), authorization is too often a rudderless, ill-defined function. The process of pre-authorization varies across both institutions and specific services—from inpatient to outpatient, from imaging to discharge planning.

While acute facilities often find themselves financially “on the hook” when required

authorizations are not obtained prior to service delivery, they are not generally responsible for actually securing the authorization. Referring physicians—often outside of the hospital’s control—are responsible for initiating the authorization process. Hospital staff review schedules for upcoming visits, determine whether an authorization is required, and then follow up to ensure that the physician’s office has completed this all-important task. Some hospitals have centralized this pre-service activity, but many times the responsibility is passed to multiple departments. This lack of centralized process and visibility can result in delays in care and claim denials.

### **Solution: Clearly Defined Roles**

The first step in getting on track with pre-authorization screening and verification is to clearly define the roles and responsibilities of the individuals involved. Centralized responsibility addresses the lack of consistency; therefore, a designated team or department (e.g., Patient Access) should own the process to ensure a reliable and stable approach.

Clear lines of communication also must be established with physicians regarding expectations for authorizations to be in place prior to patient scheduling. Providers can take advantage of an automated “trust-but-verify” toolset to screen for authorization requirements and confirm that an authorization has been secured before treatment. This approach allows measurement of physician compliance—and management of those who fall outside of guidelines.

### **Problem: Inconsistent, Disjointed Processes**

Pre-authorization screening and verification have been dominated by inconsistent processes for years—to the point that many providers essentially rely on methods that more closely resemble “urban legends” than consistent, repeatable processes. Consider the ways many providers manage the pre-authorization screening and verification process: sticky notes, annotated Rolodexes, mammoth in-house procedure binders, or personal knowledge held by a single staffer. These are just a few common workarounds to what should be an automated,

centralized process.

Determining the actual authorization “source of truth” can also represent a challenge for providers. With increasing frequency, payers are outsourcing pieces of their medical benefit management process to third party utilization management organizations (UMOs). These UMOs manage the authorization requirements and determination for specific sets of services such as radiology, home health, and others. Providers must understand when to look beyond the core payer for authorization requirements and specific answers. The complexity adds to the challenge of a manual, decentralized process.

### **Solution: Centralized Teams with Technology-Enabled Processes**

Automating components of pre-authorization enables providers to screen and verify consistently across the organization while supporting the centralized pre-authorization function. Automated screening and verification embedded in workflow can help drive higher reimbursement, fewer denials and rework, and greater provider satisfaction.

Such a solution ideally integrates with scheduling to actually initiate the pre-authorization process. It determines whether a pre-authorization is required and on file with the payer, and identifies accounts needing intervention by providing an exception list. Outstanding requirements can be addressed before the account reaches pre-registration. As a result, the “urban legend” factor is eliminated and manual processes are replaced with easy, repeatable—and automated—screening and verification.

Process redesign can include real-time scheduling and EHR integration to enable instant pre-authorization decision-making. Further, automated monitoring of payer decisions and immediate confirmation or exception handling can drive significant improvements in staff productivity and morale. Just as billing manuals and “cheat sheets” gave way to today’s claim scrubbing and workflow, pre-authorization workarounds can be vetted, defined, and continuously updated.

## **Problem: Manual Processes**

Similarly, manual processes are no match for the level of complexity, limited commonality, and frequency of changes and updates found among both payers and plans. For example, an analysis of 1,300 procedure-specific authorization policies among 23 major health plans revealed only eight percent commonality in those policies.<sup>1</sup> Further complicating matters, many sub-plans within health plans have their own independent pre-authorization policies.

In practical terms, manual pre-authorization screening and verification frequently complicates or even delays patient care. Consequently, many providers report that the pre-authorization process often starts with a claim denial. In such cases, the process would more aptly be named “post-authorization.”

## **Solution: Efficient and Repeatable Processes**

Automating the location, capture, and maintenance of payer authorization policies is emerging as an essential capability to help systematically determine whether an authorization is required for a given service prior to provision of the service itself.

Additionally, authorization details generated by a technology-enabled system give providers a clear understanding of whether an upcoming treatment will be covered by the patient’s insurance, thereby aligning physician and hospital pre-authorization objectives. Likewise, providers can make more informed decisions related to rescheduling services when a required pre-authorization has not been secured.

## **Problem: Savings Left on the Table**

Pre-authorization is costly, in the range of \$35 to \$100 per occurrence, according to industry estimates.<sup>2</sup> Expenses add up quickly, with nurses devoting 13 hours or more per doctor each week to the process, and staff members spending up to nine hours on hold weekly waiting for payer responses.<sup>3</sup> Pre-authorization errors account

for a large percentage of denials. Money also drains away through “fatal” denials, when payers refuse to authorize services already delivered, or through reworked denials, which average \$25 per instance.<sup>4</sup> In soft-cost terms, providers lose patient goodwill when appointments must be rescheduled due to authorization problems.

## **Solution: Savings to be Banked**

To put the potential impact of automating pre-authorization screening and verification in perspective, consider what has been achieved through electronic claims filing, where deliberate efforts to drive transition from manual processes have prevailed.

The cost of processing a claim has dropped to just \$0.66 now that 92 percent of providers have implemented electronic processing. Imagine what could happen with pre-authorization costs when electronic processing ramps up from its current level of only seven percent provider adoption.<sup>5</sup> The elimination of duplicative reviews, administrative savings, and fewer denials translate into significant savings.

## **Getting Back on Track with Automation**

Everything outlined above can be changed—now. There are two options: continued reliance on costly manual, labor-intensive processes, or implementing technology to address the challenges.

The good news: there are solutions that automate pre-authorization screening, verification and monitoring. These solutions can also revolutionize pre-authorization by handling the rapid and routine rate of policy change among health plans, as well as regulatory and legal shifts at national and state levels.

An automated pre-authorization screening and verification system monitors payers for pending decisions and updates the practice management system with results, including approval and pre-authorization number.

It enables providers to confirm that payer pre-authorization and admission notification policies

<sup>1</sup> Change Healthcare survey of 23 major health plans

<sup>2</sup> Change Healthcare study conducted in 2014 with CAQH index data

<sup>3</sup> “What Does It Cost Physician Practices To Interact With Health Insurance Plans?” Health Affairs, May 2009

<sup>4</sup> “How to avoid ‘unclean’ claims” MGMA Connection Plus, March 28, 2014

<sup>5</sup> 2014 CAQH Index™ Electronic Administrative Transaction Adoption and Savings

are readily available and consistently addressed. It continually monitors payer authorization rules and request statuses while tightly integrating into any EHR workflow to ensure consistent implementation of authorization requirements. It also provides an audit trail of verification results and dates to help appeal claim denials when necessary (i.e., when verification was obtained, but the related claim was denied).

### **Future Potential**

Automated pre-authorization screening is already connecting providers to hundreds of payers, with hundreds more electronically linked payers expected to activate in coming months.

Every day, repetitive and costly manual tasks are being replaced by codified and callable payer-specific policies, giving providers more control and making the pre-authorization process consistent and replicable.

The effective use of screening and verification rules can slash the time required for research, while arming providers with definitive answers about whether a given service needs a pre-authorization. From all indications, it's time to get onboard with this vital market trend as providers and payers converge on an admission-centric approach with a keen focus on ROI and improved patient outcomes.