AN APPROACH TO INSURANCE REFERRALS AND PRIOR-AUTHORIZATIONS: CENTRALIZATION

A CASE STUDY

By

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INTRODUCTION:

Physicians and advanced practice professionals working in the vast majority of the traditional medicine practice specialties in the United States today have a need to refer patients to other specialty providers and also for additional ancillary services and other diagnostic testing. These specialty referrals and diagnostic tests provide vital health information to the ordering provider in order to aid in diagnosis and treatment of the patient’s condition and provide their patients the highest quality of medical care.

In the past physicians could and would order any referral, medication or diagnostic test that the practitioner felt the patient needed, and the insurance companies would pay the bills. The costs for medications and diagnostic tests skyrocketed, due in part to escalating research and technology investments needed to bring new medical innovation to market. In addition, the quantity of exams ordered also increased. The increase was partially attributed to practitioners ordering the tests to rule out all possible ailments, as the exams were being paid. Additionally, ordering diagnostic exams offered a layer of protection from malpractice suits due to missing a diagnosis on their patients. These are some of the factors that led insurance companies to begin to require referrals, pre-certifications and prior authorizations, prior to a physician ordering a more costly exam or medication. The growth in these requirements has been exponential over the last ten years.

The majority of commercial insurance payers in the United States are requiring some form of pre-notification and/or prior authorization be completed prior to the patient being seen for certain lab, ancillary testing or medications being prescribed. CMS (Center for Medicare and Medicaid Services) is also considering requiring pre-authorization for some repetitive diagnostic exams. In some cases patients can’t even schedule an appointment or order the medication without the authorization number. The process for obtaining these “pre-auth” and “pre-certs” varies vastly from insurer to insurer.

The process can take many shapes, such as an on-line form, fax form or telephone notification process. The requests may be processed through the insurance company itself or through a benefits management clearinghouse agency contracted by the insurers to administer the pre-
notification process on their behalf. In order for patients to receive the care and health services that the patient’s condition requires, it may take seventy-two to ninety-six hours or longer during the typical business week for approval to be received. A request made on Friday may not be returned until Thursday of the next week, as the weekends do not typically count as a working day. At a minimum, the majority of insurer’s are requiring a referral form be completed prior to sending a patient to a specialist for evaluation. The more complex prior authorizations may require entire complex medical decision pathways to be completed and multiple questions regarding the patient’s condition be answered. In addition, the insurance companies and benefit management organizations often alter the requirements for the prior certification and/or decision tree pathways without notice.

The continuously changing rules often burden these physicians and their practice staff with time consuming, confusing and onerous processes. These cumbersome and often lengthy forms or telephone requirements lead to intolerable delays in patient care, as well as frustration and dissatisfaction for all stakeholders involved. Some insurers threaten to penalize the referring provider for not obtaining authorization. This may take the form of a decrease in contractual reimbursements, or other financial withhold of payment. Others deny the referred to service provider’s claim, creating potential animosities between provider and patient, when the patient may become responsible for the denied claim’s balance.

**STATEMENT OF THE PROBLEM:**

A large multi-specialty practice with over twenty office locations in the Northeast was continually struggling with the approval process itself and the amount of time it was taking to receive prior authorizations. This was leading to dissatisfaction on the part of all stakeholders. The practice embarked on a process improvement initiative to improve the turnaround time for referrals and prior authorizations. In the absence of improvement, there would be several impacts. The lack of improvement would directly affect the quality of patient care and satisfaction. Patients did not like the long delays to receive care, and some had to suffer through additional days of pain and discomfort while they were waiting for approval. In addition, the practice income and provider and staff satisfaction was impacted negatively by fee schedule cuts, write-offs for denials and generalized frustration with the complicated and divergent processes.

**BACKGROUND:**
The Senior Practice Administrator from a large multi-specialty practice had fielded frequent complaints from many sources with regards to insurance prior authorizations. Numerous patients registered complaints of significant delays waiting for the procedures they needed to be authorized. Physicians complained of these same delays and the perceived impact on quality of care, the unreimbursed burdens on their office practices, as well as to the process of having to do physician to physician review of medical necessity. The practice managers and office staff complained of confusing and cumbersome processes, significant delays “on hold” on the telephone and lack of staff resources to complete the authorization process. These themes and the escalating number of complaints initiated the Administrator’s investigation into the problems.

It was noted by the Senior Practice Administrator that there was no consistency in the requests from the insurance companies regarding prior certification and referral information. Some insurers utilized online forms; some required phone calls and some fax methods for authorization. Some payers processed the requests themselves; some utilized a third party benefits manager. The time that was spent to obtain the authorization in the practice sites could be as little as five minutes, to as long as numerous hours that would span over several days.

To complicate matters, the Administrator observed that cumbersome, confusing and time-consuming processes for obtaining specialty referrals, pre-notifications and prior authorizations existed within all of the practices. Each office manager had developed their own methods for obtaining the authorizations, with varying degrees of success and expediency.

Other considerations contributing to the serious need for improvement observed by the Senior Administrator included the following:

a. Each office handles prior authorizations by the staff in a different manner. Some offices utilized clerical, some clinical staff, and some a combination of staff, including in some cases the practice manager themselves.

b. Documentation of the process to obtain the pre-authorizations varied from simply jotting down the authorization number to a thorough documentation of every interaction. The results of prior authorization attempts and determinations were inconsistent from office to office and in some cases staff member to staff member within the same office. If
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someone attempted to pick up where another staff member left off, it was often nearly impossible to follow the prior work.

c. The volume of prior authorizations generated in each individual office was insufficient for the staff to gain the needed familiarity and proficiency. For example, they may be five authorizations requested, but that may represent five different insurance companies or benefit managers, representing five different processes.

d. There existed a wide range of overall turnaround time. The reasons for this included the lack of available staff members or staff time, as well as confusion with the many different pathways. The Administrator noted that the many attempts to simply reach the insurance company or benefits management company exacerbated the delays.

e. Frustration with delays and process was felt by all parties. This included both primary care physicians and referring physicians waiting on documentation, as well as patients frustrated with waiting for treatment and the office staff, who were frustrated by the process and determination results.

f. Physicians and staff felt that the patients’ quality of care was being impacted by the layering on of additional processes to accommodate the requirements for obtaining prior authorizations.

g. Financial impact on the practice in the form of denials for payment when prior authorization was not obtained timely for procedures performed in office. Other financial considerations noted by the Administrator included the potential for reduction of fee schedules or the fee or portion thereof being transferred to the patient, causing patient dissatisfaction.

After consultation with other senior executives in the practice, the Senior Practice Administrator was charged with leading a task force to improve the process of obtaining prior authorizations and pre-certifications group wide.

A committee was formed and initially met on seven occasions over approximately a nine week period. In addition to the Senior Practice Administrator, the committee consisted of two senior level executives (Chief Operating and Chief Medical Officers), four representative practice managers (two from primary care and two from specialist offices) and four staff members (two clinical and two clerical). The staff members chosen had been directly involved in performing the
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pre-certification activities. The leaders felt that the staff contribution to the improvement journey would be vital to understanding all of the nuances of the process. The first phase was to determine the scope of work. The team determined the following criteria would be documented and reviewed. The committee would then re-convene and the options for remediation would then be considered.

SCOPE OF WORK:
At the time this project was undertaken, the multi-specialty practice consisted of twelve primary care and fourteen specialist offices. The specialty offices consisted of obstetrics and gynecology, general surgery, urology, pain medicine, neurology, orthopedics, sleep medicine, dermatology, endocrinology, rheumatology and physical medicine and rehabilitation. The committee charged each office with the initial review of process and data collection over a three week period.

DATA COLLECTION AND RESULTS:

a. Determine average number of referrals, pre certifications and prior authorizations organization-wide on a weekly basis. For primary care this averaged twelve specialist referrals, three pre medication certifications and three prior authorizations per office, over twelve offices. Over the fourteen specialty offices, this averaged five medication pre-certifications and ten advanced imaging, lab, or procedural prior authorizations per day, per office, with very few referrals to another specialty.

b. Document the staff member completing the work and the average staff time. The staff member varied; primary care offices would often utilize clerical staff to perform the duties, while the specialties utilized primarily clinical staff. Average time for a referral: five to ten minutes to complete the documentation, compile medical information and submit. Pre-medications certifications required ten to thirty minutes of staff time per interaction. Prior authorizations for advanced imaging, surgery and other procedures required the most time at anywhere from ten to over four hundred minutes of time from initiation to completion.

c. Determine the average number of requests for physician to physician (peer to peer) reviews for additional clinical information and the number of denials per week. The
committee noted that this metric varied drastically from office to office. Some reported no denials or requests for physician to physician review. Other offices reported as many as twenty denials and as many peer to peer interactions per week.

d. The baseline current overall turnaround time from order/request to authorization per office was compiled. Referrals averaged thirty minutes, pre-medication or other pre-certifications two hours and prior-authorizations average time was seventy-two hours. Some however, took as long as ten days to receive a definitive answer or approval.

ALTERNATIVE SOLUTIONS CONSIDERED:

Review of data collected was completed by the committee over three sessions spanning a two week timeframe.

a. Retain the current fractionated process that each office developed. This was immediately rejected by the Administrator and the committee as being unsustainable both from a human resource and financial perspective, based on the reasons already described.

b. Remain decentralized with modifications to current process. Some of the improvements would include clear assignment of staff and secondary staff in each office, standardized policy and definitive documentation. This option was ultimately rejected as creating too much duplication of service and there existed insufficient volumes of each type of request and insurance brand for the staff assigned to develop familiarity and proficiency in the process.

c. The third alternative explored by the project committee was mini-centralization as well as standardization of process and forms as documented above. This would entail setting up three to four sites for assigned employees to work from. This alternative was rejected for several reasons. Adequate space with the necessary infrastructure was hard to identify. Duplicating both human and equipment (phones, computers, office furniture etc.) resources would also add unnecessary expense to a process that was unreimbursed.

d. The fourth alternative and the solution chosen by the committee after thorough review and consideration was to centralize the insurance notification process into one location. Though some of the employees needed to staff the center may need to travel from remote
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locations, it was felt by the team that the economies of scale and efficiencies gained outweighed any of the other options.

PROCEDURAL ANALYSIS:

The policy and procedural following steps were outlined and approved. These were determined to be the essentials to an efficient cost-effective prior-authorization process.

a. Develop the manual for obtaining referrals, pre-notifications and prior authorizations to include outlines of process and steps needed to obtain the required approval or authorization number. The manual would include the procedures and requirements (as known) for each insurance payer, indexed by insurance company.

b. Document the where, what and how's of recording the approval, pending, or denial. Determine the standard information needed for each request. This included name of patient, insurance information, test ordered and medical documentation of the patient’s condition. Create a standard form for the staff member to utilize for recording interactions with the insurance companies and benefit management organizations.(Appendix 1)

c. Implement the process and evaluate. Some of the evaluation points chosen by the leaders included improvement in turnaround time, lessening of the financial implications as well as satisfaction with the process by all stakeholders. (Patient, physician and staff). Re-engineer as appropriate.

SOLUTION CHOSEN:

The committee chose to centralize all referral and prior authorization to one location across all practices and specialties. This process was guided by principles from Hayes Healthcare Management and Emdeon centralized workflow publications. This was felt to produce the largest economies of scale for an unreimbursed process and to allow for the development of subject matter experts that could assist with any questions or data requests. The first step that the Senior Administrator and the committee took after outlining the policy and procedure manual was to
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select an adequate site and determine approximately how many staff full time equivalents (FTE) would be needed to begin the project.

It was determined that the site should be able to house up to six authorization specialists, as the practices were growing and the insurance companies were also adding new procedures and clinical pathways to the process, thus more FTEs were forecasted to be warranted. Initially it was determined to hire three full time FTEs, as it was anticipated that streamlining process and familiarity would produce economies of scale. The site also needed to have reliable, full connectivity to the Electronic Health Record (EHR), as well as telephone access and relative privacy for telephone interactions to occur. The Facility Director for the practice was added to assist with appropriate site selection. The site was outfitted in one month’s time, as simultaneously the staff was recruited. All of the staff initially involved was recruited from existing offices and were already performing the prior authorization duties. The offices from where the employees were selected to man the pre-authorization process were able to back-fill these employees with other duties. All remaining offices split the salaries and benefits evenly. This represented a small financial outlay for the offices that was easily recouped. Examples of the benefits included increased patient and provider satisfaction and the decrease in denials and write-offs for denials.

The committee members again reviewed the process, documented and approved processes. Flowcharts were created to outline the procedures for obtaining needed referral or authorization were also completed during the timeframe the site was being outfitted.

A reference manual was created and a copy made for each employee. Each insurance company had a tab in the reference manual with the most common questions required and clinical or decision pathways were documented. The initial documentation sheet that the prior-authorization department utilized for each patient request was developed on paper (example attached). The top portion was completed by the requesting office and faxed to the centralized location, along with any needed medical information. When the approval or denial was obtained, the form was faxed back to the requesting office. (Appendix 2)

The process and forms were integrated into the Practice Management System and the prior-authorization staff was granted access to the practice’s EHR to retrieve any needed medical
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information to document medical necessity to the insurance representatives. This occurred approximately two months into the centralization project, once all staff was felt to be comfortable with the workflow as initially established. This move to the electronic world kept documentation accessible to all interested parties and the staff back in the offices could readily review the status and communicate to the patient and provider as needed.

Initially, the newly dubbed central prior-auth department was staffed with three clerical members. It was quickly determined three clerical and one clinical staff (medical assistant) was the appropriate staff mix. This mix was selected as it was determined that the clinical staff’s medical knowledge base was needed. This was due to the clinical’s additional knowledge of conditions and diagnostics when travelling down some of the insurance companies’ medical necessity and decision determining pathways.

LESSONS LEARNED:

The Senior Practice Administrator discovered several things in the process of transformation to a centralized prior authorization department. Developing relationships with the agents at the insurance companies and benefit management organizations by the staff aided in achieving success when they needed an urgent authorization or had a complex case to get approval for.

Some of the other components that were noted by the committee were noted as follows:
The site needed to be technology-able. Appropriate number of telephones and computers that have the ability to access the EHR, insurance eligibility clearinghouses and insurance company authorization or benefit management portals needed to be in place and be reliable. Although the team felt that by involving the Facilities Director they were ensuring success, the challenges of running computer cable to the selected office nearly cost the opening to delay. Space needs to be adequate to allow conversations on telephone without impacting HIPAA or being a distraction to co-workers. The room was designed for six employees, each given four feet of desktop space. Small dividers were placed between the stations, which were u-shaped. The u-shape was selected as the optimal shape to provide adequate space to work and organize, as well as provide ergonomics. After several weeks, it was determined that headsets were deemed optimal to aid the staff. The staff could communicate over the phone without disturbing others, provide a reduction
in neck strain, and the sets allowed employees to utilize both hands to type or write while speaking.

Selection of staff is vital. Not only does the staff need to be able to navigate the process effectively, they need to be equally comfortable on the telephone for long periods of time. Accurate documentation of varying lengths and complexity is essential. Medical knowledge is beneficial for some of the clinical decision trees that must be navigated. A combination of clinical and non-clinical was the most optimal configuration, both for skill set and salary reasons. If staff assigned to the process was not engaged in the process, the delays may continue to mount. Staff must be organized and have the ability to multi-task. At times, the process may get interrupted by the need for more information or data and staff may need to start on another prior-authorization.

Repetition was one of the keys that were discovered by the Practice Administrator and the team. It is recommended to keep staff in one pre-notification “arena” (diagnostics or referrals for example) prior to cross training in other areas as much as volume/structure allow. Comfort and competence led to shorter times to “yes” or approval. There were less need for providers to perform 1:1 peer reviews, as requests did not go to physician to physician peer review as often when the staff were comfortable and familiar with the process and the clinical documentation that would be required. This comfort came primarily from performing the duties on a daily basis. Documentation was essential for all stakeholders. Examples of the types of documentation include the following:

Clear and complete provider documentation in the EHR is essential for conveyance of medical necessity and the physicians thought process to the prior authorization vendor. This aids in a reduction of peer to peer review and denials.

Clear and timely referral and prior-auth documentation provided by the staff working in the central prior-authorization department - i.e. who did the department member speak with, what is the authorization number, if it is pending why, and when will the staff member be checking back to see if the authorization is valid or denied?
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Don’t be penny wise and pound foolish when approaching the referral, pre-certification and prior authorization process. Though the process and employee time are not reimbursed per se, there can be penalties associated with reduced fee schedules and denials on the practice’s financials. The time an office practice spends obtaining referrals and prior-authorizations can be significant. These processes become especially time-consuming and error prone if the staff only needs to perform these duties sporadically. Centralization was a wise investment. The team noted that in the first six months of operations, turnaround time was decreased by nearly 35% and peer to peer provider requests decreased by almost half. Approval at first touch increased from 60% prior to centralization to 90% post centralization.

RECOMMENDATIONS:

After review and consideration of the central authorization journey, the team made some recommendations based on the experience of establishing a central prior authorization department.

After the initial meetings, follow-up meetings should be scheduled to evaluate and refine the process. The committee held meetings at one, two, six and twelve months post implementation. Any changes to the insurance company requirements were reviewed and the manual was updated, for example.

A centralized referral and prior authorization department can improve the efficiency and turnaround time for obtaining the insurance company permission, especially in a mid to large size practice. It can increase satisfaction with the process for all parties involved by making it an easier process to navigate and can lead to efficiencies as a familiarity with navigating the system develops.

Thoughtful planning and execution of the plan can decrease cost (less staff as centralized process removed duplication of efforts), and increases patient and provider satisfaction. Patients often can receive the needed diagnostic exams in an expedited manner. Having staff that only concentrate on prior authorizations has shown to improve efficiencies and decrease turnaround time.

Even small practices may wish to develop a smaller, even part time version of central prior authorization. This can be accomplished by setting aside a work area and telephone dedicated to prior authorization and training a primary and relief staff member in the process. A manual can be
developed to fit the practice type, as well as the insurance companies and third party benefit management vendors unique to their geographic region and practice.

SUMMARY:

All parties involved in the healthcare system have a desire to be financially sound and to render and receive outstanding medical care. Patients desire prompt treatment for their ailments and high quality medical care. Patients are often dismayed and lacking in understanding of the lengthy documentation processes that the medical practice must perform in order to render said care. The constantly changing world of prior-notifications for impending medical treatment has practices scrambling to meet the requirements being imposed on them by the companies that insure the vast majority of their patients. Medical practices must be nimble and forward thinking in order to meet these challenges and maintain financial stability, while still rendering high quality care and ensuring a satisfied patient base.
Pre-authorization request:

Office: ___________________ Provider requesting: ___________________ Today’s Date: ___

Patient name: ___________________
DOB: _______________ MRN: _______________

Insurance Plan and subscriber number: _______________________________

DIAGNOSIS OR OTHER DATA:
______________________________________________________________________________
______________________________________________________________________________

TEST OR PROCEDURE REQUESTED:
______________________________________________________________________________

TIMEFRAME FOR COMPLETION: TODAY (STAT): __________ 48-72 hours: ______
At Patients Convenience___________ Other: _______________

For Central Authorization Department:
Date received: ______________ Date and Time of Initial start: ___________________

Approved ____ Denied ____________ If Denied, Appeal? _______________________
PEER to PEER _____________ Date/Time MD contacted: _______________________
Date contacted office _______________

Prior Authorization number: ___________ Date Valid until: ___________________
Agent: _________________________________

Request worked by: ______________________
EXAMPLE FLOW CHART FOR ADVANCED IMAGING PRE AUTHORIZATION
REQUEST RECEIVED VIA ELECTRONIC IN-BOX (APPENDIX 2)

Is all demographic, insurance and medical information present?

YES, Refer to manual for insurance, select proper form and complete. Emergent orders take precedence.

NO, send electronic message to office for additional information. When information received begin authorization pathway.

Authorization approved. Note auth number, date and contact information and contact patient. Electronically file form in patient chart.

Authorization denied. Message office for additional information or alternative exam.

Authorization requires peer to peer. Message office for physician availability to complete.
SUMMARY:
The constantly changing world of prior-notifications for impending medical treatment has practices scrambling to meet the requirements being imposed on them by the companies that insure the vast majority of their patients. Medical practices must be nimble and forward thinking in order to meet these challenges and maintain financial stability, while still rendering high quality care and ensuring a satisfied patient base. Streamlining and centralizing the process for obtaining pre-notification is a fiscally responsible option to meet the growing demand for pre-notification of patients’ diagnostic exams.

KEYWORDS:
Prior-authorization, pre-notification, centralization,