Authorization Playing Catch Up With Technology

While patients are becoming more involved in their own care, providers are increasingly incentivized to secure authorization from payers before procedures are performed to increase their likelihood of receiving payment.

According to a June 2016 survey by HealthLeaders Media, pre-authorization is a consistent pain point that impacts leaders from the C-suite to operations and billing. A total of 158 surveys were completed by the Media Council, which consists of senior, clinical, operations, marketing, and financial leaders representing non-profit (61%) and for-profit (39%) organizations nationwide. The initial survey question asked respondents to rank their pre-service authorization pain points with 1 being most painful and 5 being least painful.

According to the survey, senior leaders ranked the cost of time and resources as their number one pain point (38%). Care delays and risks to patients were ranked as the second highest overall pain point at 29%. The third ranked pain point by a close margin (28%) was up-to-date/complete understanding of payer-specific authorization policies. There was also consistency among respondents on the fifth ranked pain point, the loss of physician goodwill/referrals (48%). Lastly, claim denial risk rounded out the list as the consistently ranked fourth choice overall by respondents (26%).

“Those who are performing well in terms of low authorization-related denials have generally deployed a significant number of people throughout the process,” said David Dyke, Vice-President of Product Management and Business Development at Change Healthcare. “The complexity in the authorization process is continuously changing, and not something that providers can efficiently manage.

Variations in authorization rules between payers are difficult enough to manage, but that is just the beginning. Providers live with significant differences within payer plans and products—and even group levels can have very specific rules of their own.”

While survey responses were somewhat consistent with the priorities representative of each department, some additional commonalities emerge when the results are further segmented. For instance, a higher percentage of senior leaders (45%) than clinical leaders (21%) ranked pre-service authorization cost in time and resources as their number one pain point. The segmented data also showed that...
a higher percentage of physician organizations (56%) than hospital (34%) or health systems (29%) ranked pre-service authorization cost in time and resources as their number one pain point.

“In our discussions with providers across the country, referring physicians bear the brunt of the initial work in determining and securing authorizations for high-volume outpatient and diagnostic services,” Dyke said. “While the survey clearly reflects the prevailing model with significant impacts to referring and ordering physicians, the rendering facilities are by no means immune from the authorization challenge.”

Authorization In Need Of Innovation
Since pre-authorization remains a tedious process with several moving parts and touches several technologies, it’s also an area ripe for innovation such as rules-based process automation and continuous verifications.

According to the second survey question, as many as 63% of respondents still use a combination of the phone and fax machine to obtain pre-authorization. A smaller portion (24%) use a web portal and only 13% use some type of automated technology for pre-service authorization screening and verification.

The main reason pre-authorization is still a significant resource and time drain is because the process has remained largely unchanged for years.

This pain point is echoed by Michelle Fox, director of revenue operations and patient access at Health First, Central Florida’s only fully-integrated health system, including four hospitals and 19 diagnostic centers based in Brevard County, Florida. “We’ve been obtaining authorizations since 2011, and we’ve realized that authorization management is definitely our number one challenge,” Fox said.

Much of what Fox would like to do away with is the amount of time and resources it takes to ensure that claims will be paid. “We have to do a lot of proving to the insurance company that we did have the information that they gave us in order to move forward,” Fox said. “Having to pay for this application is an added expense as well as the time it takes to appeal a denial. Those are all added costs that go along with authorization management due to the requirements that the insurance companies put on the hospital stewardship.”

Fox said she anticipates automating as much of the authorization process as possible given Health First’s continued expansion and the growing demand for care.

Concierge-Style Authorization For Physicians
The final survey question evaluated the extent to which facilities provide concierge-style management of pre-authorization for referring and admitting physicians. About one-quarter of respondents indicated that they were not performing any customized or structured pre-service authorization for physicians (i.e. taking on the process to manage the authorization request, track requirements and obtain approvals). Nearly another quarter (22%) said they were unaware of the level of pre-service authorization that was being done on behalf of or for physicians.

According to respondents, 34% indicated that up to 25% of physicians’ caseload was being performed by some type of concierge-style authorization submissions. A total of 7% said they were managing pre-service authorization for 26-75% of physicians. Only 12% said that pre-authorization service was being handled for 76-100% of their admitting physicians’ caseload.

Due in large part to the shift that has taken place since the reform era began, hospitals are recognizing that they are increasingly the risk-bearing entity when it comes to authorizations. Which might explain why organizations are beginning to take the initiative to engage in obtaining authorizations for both employed and affiliated physicians.

Despite keeping up with a near-constant rate of change, there could be some relief for providers who are trying to better maintain their revenue cycle by proactively managing authorization services.

Overcoming the perception that pre-authorization will remain a manual and therefore tedious and time-consuming process could be an important first step toward better management and more streamlined solutions. Dyke sees considerable
correlations to how ‘seemingly impossible’ problems have been solved by innovations in the past, such as with electronic billing.

“There are a lot of correlations to the move from paper-based claim processes to the advent of electronic billing,” said Dyke. “When the original claims management systems were introduced, providers balanced the savings opportunities from process efficiency with the concerns of confidence in getting rule accuracy. As we’ve evolved, claim rule ‘edits’ and ‘scrubbing’ processes are now well established, and while never quite perfected, have reached advanced levels of being both predictable and proactive. Likewise, bringing technology to the authorization process seems obvious to ensure evidence-based rules are both known and applied in advance.

Layering in end-to-end integration, workflow automation, tracking and reconciliation to the process is happening much faster with authorization than it did with claims, as we have a proven working model to emulate. While the route to improving authorization is incremental, applying technology in targeted and high-quality ways is a vital next step.”