Prior Authorizations and Medical Necessity

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Prior Authorization vs Referrals

Prior Authorization

Payer process of reviewing a physician order or referral to ensure

- Medical Necessity
- Signs and Symptoms support the Service Ordered
- Appropriateness of Care
  - Prior to Treatment
  - Based on clinical decision – conservative treatment

Referral

An order or request for a patient to see another MD or Specialist

- PCP - Specialist
- Specialist to Specialist

In the Payer World - HMO - PCP Driven

Understanding Prior Authorizations

Prior Authorization

- Common Services:
  - Radiology – High End Services
  - Sleep
  - GI-Endo
  - Cardiology
  - Drugs
  - Rehab
  - Surgery

Key

- Understanding Payer plan policies
- Monitoring as they change often
- CPT to Diagnosis
- Service Location - alternative sites
- Understanding the payers' decision tree

Understanding the Process

- Referral Order
- Validating the Insurance – avoid rework
- Determining if there is a 3rd party vendor
- Actual Service – Diagnosis and Medical Necessity
- Payer Rules - Conservative Treatment
- Medicare Advantage - usually follow commercial rules
- Understanding the requirements at the Payer Level
  - Subject experts per Specialty

Patient Centric – Authorization Process

- How often is patient treatment delayed or not performed because of authorization?
- Is accurate insurance information being obtained?
- Feedback loop to the patient and the physician.
- 3 outcomes
  - approval
  - pending
  - denial
- Peer to Peer Process
- Appeals
- Alternative care - Site of Service
- Ensure Operational Workflows for all Outcomes

Barriers

- Known Delays with Certain Payers
- PCP vs. Specialist
  - understanding the rules
- Understanding terms of your Facilities' Contract
- CPT ordered vs. CPT performed
- Protocols for checking status of Authorizations

Denial Trending

- Lost reimbursement
  - Formal mechanism to track payer/ plan denials
  - Separate stats for Referrals vs Authorization
  - Tracking of denials at the Service Location and/or Practice

- Service by CPT requirements
  - CPT requested does not match CPT performed
  - Inability to operationalize workflows per specialty

Process for an Easy Win with the Payers

Radiology

- Order Changes
  - Real time notification to Pre-Service Team
  - Flag within Epic (or your system)
  - Pre-Service Work Queue
    - Contact Payer Immediately
    - Notify of Status Change

More Challenging

Surgery

- Coding of the Account prior to service being rendered
- Real-time Validation of CPT Codes
- Optime Schedule – Narrative to a CPT code
- Appeal your Denials

Keys to Success

- Automation
- Education
- Denial Tracking
  - Feedback Loop to Practices
- Patient Centric
- Understanding what workflow works best

Critical Roles

- Revenue Liaisons
  - Hospital and Physician Denials
- Pre-Service
  - Validation that authorization was obtained prior to service
  - Counting of Treatments
    - Is it working?
    - Payer Issues?
    - CPT add-ons?

Share KPIs

- Track denials by specialty, dollars, and volume
- Tracking of number of days to obtain authorization and schedule patient
- Track reason for delays and cancellations
- Constant monitoring, training and education
- Team approach Physician Offices, Ancillary Services, Scheduling and Revenue Cycle

Questions