Why Do Health Insurers Require Prior Authorization?

Health Insurers and Prior Authorization

Like sands through the hourglass, so are the days of prior authorization

"This procedure will require prior authorization." Words that no patient or healthcare provider wants to hear when they are ready to proceed with a doctor-approved procedure for a medical matter. However, **it's one of the utilization management tools that insurance companies have fostered** to decide if specific prescribed procedures, services and medications are medically required or whether there is an equivalent useful treatment existing for the patient. Healthcare.gov defines **prior authorization** as "approval from a health plan that may be required before you get a service or fill a prescription in order for the services or prescription to be covered by your plan."

Importantly, services (medications, imaging studies, etc.) that need prior authorizations require healthcare providers to acquire consent from the patient's health insurance ***before*** the cost of the service is covered by the company.

The process can be lengthy and can frequently put off patients getting the care they need. **These roadblocks can often trigger frustration and apprehension for doctors, hospitals and patients while adding to the mountain of paperwork doctors and hospitals must complete.**

What are the effects of prior authorizations on the medical industry?

It's like being on an un-merry-go-round

Truth is, one of the more irritating tasks for physicians and other healthcare providers is securing prior authorizations for matters such as testing and prescriptions. **In the eyes of some, prior authorizations are not anything more than insurance companies injecting themselves into the provider's decision-making activity, generating glitches for both providers and patients.**

Moreover, **prior authorizations have produced a restraint on the revenue stream of many healthcare provider organizations**. If a treatment procedure doesn't get authorized, the provider can't continue with the service. In some instances, such interruptions bring about a loss of revenue since the patient ultimately decides to proceed without the treatment or because such circumstances compel additional negotiations before the insurance company will sanction the procedure.

The prior authorization process is often **further muddled by a mixture of factors**:

- Plenty of **mandatory steps**, each presenting the possibility for interruptions and mistakes.
- Involvement by **many people** including patients, healthcare professionals, and the patient's health insurance company.
- **Absence of standards**, especially when it comes to payer policies.
- **Shifting payer rules** that must be continuously reviewed and amended.
- **Thousands of payers and health plans** all competing for a rapid response.
- **Manual assessment** of prior authorization requests and medical charts by clinicians.

Depending on the complexity of the prior authorization application, the volume of manual work required, and the prerequisites specified by the insurance company, **a prior authorization can take anywhere from a single day to a month to process.** The AMA's Prior Authorization Physician Survey disclosed that 26 percent of healthcare providers reported waiting three days or more for a decision.

The AMA found, on average, **a medical practice will complete 29.1 prior authorization requests per physician per week that take 14.6 hours to process**. About half of the requests are for medical services, while the other half are for prescriptions.

According to another AMA survey, 75 percent of physicians participating reported that issues related to the prior authorization **process can cause patients to abandon their recommended course of treatment. In the same survey**, 28 percent reported the prior authorization has led to a serious adverse event for a patient in their care. Says Matthew Hahn, MD, author of ***Distracted: How Regulations are Destroying the Practice of Medicine and Preventing True Health-Care Reform***, "The more hoops a doctor or practice has to jump through to obtain care for their patients, the less likely that care will take place." He adds, "**The**

burden created by prior authorizations is extremely taxing to physicians and medical practices, creating minutes to hours of work just to obtain basic care for their patients. This translates into added administrative costs for practices, and incredible distraction from patient care, which is difficult even under optimal conditions."

What can be done about prior authorizations to improve revenue?

Some physicians who have taken it upon themselves to streamline the prior authorization process have suggested **that healthcare practices need to standardize their in-office procedures for processing such authorizations.**

Adds one such physician, "The real challenge is knowing which services will require prior authorization. We realize that it's going to be an administrative burden, but if we can approach it as a team so that the providers are not completely overburdened, it makes it seem more manageable." **There are also technologies that can help**. Says one healthcare professional, a strategy would be to take advantage of any electronic or automated processes a payer may have for receiving requests and returning determinations.

Physicians must also communicate effectively with patients concerning prior authorizations and it's usually best to tackle the situation proactively rather than wait until a treatment is denied. Once it's understood that a prior authorization is required it's important for physicians to educate the patient on the process and the possibility that the authorization might be disallowed. Another physician tells us, "**Patients need to understand, up front, that prior authorizations take time, and it could mean a delay in care."**

Additionally, make sure the **administrative staff are knowledgeable in the coding requirements for the various payers.** From time to time, denials take place when a physician or technician enters data without complying with the coding requirements of the insurer.

Lastly, the staff should **reexamine the prior authorization applications** before submission to steer clear of errors.

How can a coding and billing firm such as Medwave help with the prior authorization process?

Studies show that over **80 percent of reimbursement claims are denied because the healthcare provider did not get the appropriate prior authorization, or the application included errors.** Any errors contained in the prior authorization form, from egregious to trivial, may flag it for a denial. It could be that two different specialists both ordered a CT scan for dissimilar purposes, but the insurance company won't approve both unless a medical necessity is indicated. Or it could be as innocent as a number on a patient's health ID card may be transposed, a middle initial might be keyed inaccurately, or an address may be half finished.

Such a healthcare provider **can slash these errors by employing a coding and billing company to help expedite the approval process.**

Medwave provides a total **medical billing** solution that can be included with your electronic health records to aid you to better manage your income stream. **This makes it possible for healthcare providers to submit claims more promptly, acquire prior authorization quicker so you can provide care straightaway and, of course, get paid sooner.**