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Revenue Cycle:
Reimagining for a
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How to Play Ball with Prior Authorizations

Thursday, January 17th, 2019
Gillette Stadium Clubhouse

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Principal
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AGENDA

- Huddle Up!
- Finding the Root Cause
- Common Scenarios
  1. Starting Out Behind
  2. Payers take too long to respond
  3. Pre-Auth'ed Service Denied Anyway
  4. We can't keep up!
  5. Denials are YOUR problem

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Huddle up!

Historically, responsibility for authorizations has been distributed across many players – physician offices, case management, patient access, etc. This decentralization makes it a struggle to keep track of the rules and guidelines.

Payers create new prior authorization requirements by adding levels of complexity and various turn around time requirements that are difficult to navigate.

Being on losing side of the final score means administrative burdens, loss of revenue, and poor patient experience due to delays in care.

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New interest in the problem

As the trend in cost containment on the payer side continues to increase, time and resource demands on Physicians is impacting their ability to deliver care. Key stakeholders such as the American Medical Association (AMA) and the American Academy of Family Physicians (AAFP) have gotten involved in calling for reform, validating what Patient Access departments have struggled with for more than a decade!!

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AMA and AAFP

"The AMA believes that prior authorization is overused and that existing processes are costly, inefficient, opaque and responsible for patient care delays"

-AMA

"The very manual, time-consuming processes used in prior authorization programs burden family physicians, divert valuable resources away from direct patient care and can inadvertently lead to negative patient outcomes."

-AAFP

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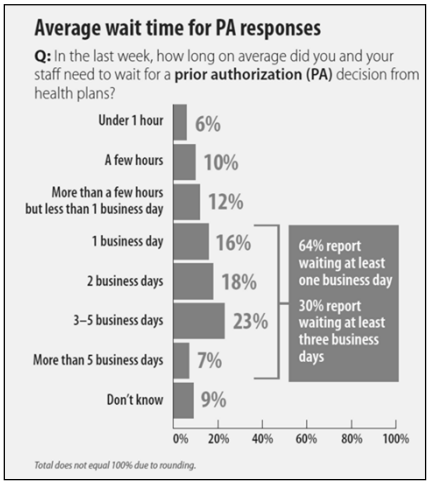
Prior Authorizations – Response Time

AMA gathered meaningful statistics on the impact to patient care.

- The average hospital scheduling process can add anywhere from 1 to 3 additional days to the process.
- The average days out scheduling is approximately 72 hours in many facilities.



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Source:
2017 AMA Prior Authorization Physician Survey

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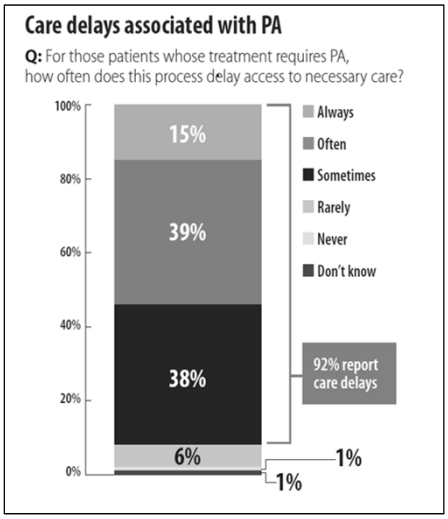
Prior Authorizations – Care Delays

- Care delays are not new!
- The alternative = significant financial drain, ultimately costing the servicing healthcare organization.
- ***Question:*** What is your Delay/deny policy?



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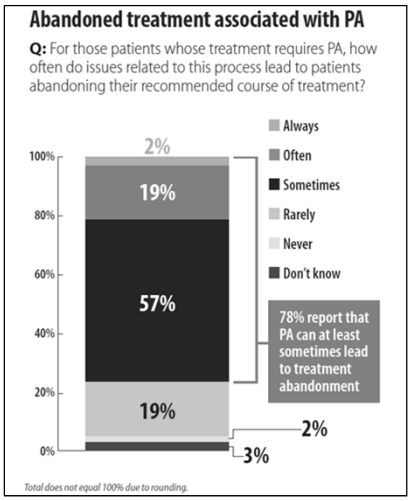
Prior Authorizations - Treatment

- Cancellations and re-scheduling
- Tracking physician orders
- Denied prior-authorizations and the use of Waivers



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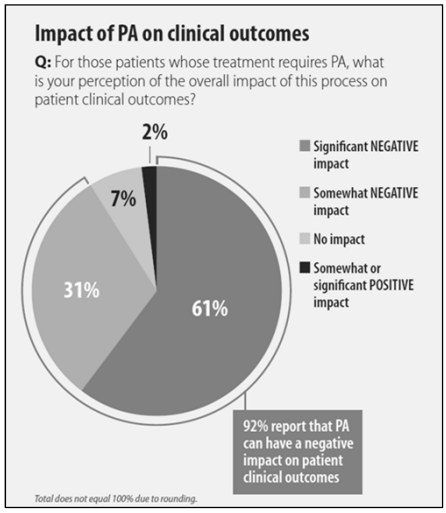
Prior Authorizations – Clinical Outcomes

- If not diagnosed now … then when?
- Inability to carry out treatment as initially prescribed
- Impact of delayed 'elective' surgical procedures



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Prior Authorizations – Recognition of costs

The GOOD news here is … that we all agree! Navigating prior authorizations is painful at best. Everyone wants to improve the practice and the new buzzword is REFORM!

The current practice of securing prior-authorizations:

- Is costly to organizations by way of administrative costs
- Is costly to everyone involved by way of lost revenue
- Is delaying patient care and degrades health outcomes
- Is costly to overall patient experience

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Reform might be on the way

BUT WAIT!! Reform takes time. It ***COULD*** happen…

but about the same time Brady gives up his avocado ice cream...

or Gronk decides to keep his shirt on.

In the meantime, there are more timely steps to take towards expediting performance improvement:

- Know where to look for gaps & process deficiencies
- Take immediate action diagnose and repair any fractures
- Get a line of site on best practice and create a plan to move towards it

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Finding the Root Cause

The only way to change the performance is to isolate the root causes which are creating bad outcomes before attempting to improve.

The following are five common examples of gaps found in prior-authorization departments, but the list is not all inclusive.

Much like football, financial clearance is a team effort but also requires leadership.

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Finding the Root Cause

Stages of performance improvement:

- Getting your hands on the right data is a completed pass
- Analyzing it is a first down
- A good working theory or conclusion is reaching the goal line
- Better performance is the TOUCHDOWN!!!

A few mistakes to avoid in this phase…

DON'T

- Look to technology & vendor ROI to solve all of your problems
- Leave out the financials: what is impact & cost?
- Hand off the problem if "it isn't your department"

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Finding the Root Cause

Looking at only data for your root cause could put you back on the bench without scoring. Take time to size up the issue and be hands on before giving your problem a name.

Good habits to have include…

DO

- Review data in different ways: payer trends etc., (80/20)
- Observe/walk through the process: beginning to end
- Take ample time to REVIEW barriers with front line staff in detail
- Perform and assign account reviews: understand what you are seeing
- Include upstream & downstream in financial impact calculations

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Scenario 1
Starting Out Behind

Financial Clearance staff do not have sufficient time to obtain timely prior-authorizations.

Common Scenario:

Financial Clearance staff consistently struggle to achieve their "days out" metric. Disconnected scheduling departments focus on "filling open blocks" & TAT times. Ultimately patients are cancelled, rescheduled and even provided service without proper prior-authorization in place.

- Scheduling department routinely schedules patients in "first available" time slots
- Not enough insight into prior-authorization requirements
- Poor patient demographic/insurance capture squeezes turn around times
- Financial clearance staff become inefficient

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Starting Out Behind

Need to manage the timing of scheduling and expedite clearance where necessary

Solution	Ease	Cost	Time
• Develop a Matrix detailing payer/service prior-authorization requirements & turn around times • Educate schedulers on correct demographic entry	●	●	●
• Look for integration between scheduling system and registration system • Update job description from 'scheduler' to 'schegistrar'	◗	●	○
• Centralize scheduling staff under Patient Access leadership	○	◗	○

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Scenario 2
Payers take too long to respond

Prior-authorization requests are being denied and delayed.

Common Scenario:

The prior-authorization department is meeting the "days out" goal of 5 days, however, patients are consistently being cancelled and rescheduled for their services.

Gaps/area of deficiency:

- Payers are returning higher than average requests for Peer to Peer reviews
- Prior-authorization requests are coming back as denied

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Payers take too long to respond

Educate and Communicate about prior authorization requirements

Solution	Ease	Cost	Time
• Track prior-authorization requests & status outcomes • Review payer's contractual obligation • Sit down with Contract Management team & Payer Rep	○	●	○
• Centralize effort of starting & obtaining prior-authorizations (VERSUS verifying if they are on file) • Employ clinical/coding credentialed staff	○	◗	○
• Procure & implement Prior-authorization software that will map payer clinical requirements	○	◗	○

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Scenario 3
Pre-Auth'ed Service Denied anyway

Services performed do not match prior-authorization on file…

Common Scenario:

The Business office is reporting a trend of adjusted accounts for the lack of prior-authorization. A patient account review reveals that authorization numbers & details are noted in the system as they should be. Further review reveals that the services ordered and authorized prior to service are different than the services rendered.

Gaps/area of deficiency:

Services ordered and authorized prior to service are different than the services rendered.

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Pre-Auth'ed Service Denied anyway

Need to develop a process to minimize mismatches or identify them as soon as possible

Solution	Ease	Cost	Time
• Gather stakeholders to review samples of the issue and develop charter for future prevention	◗	●	○
• Work with internal IT resources to develop a report that enables manual reconciliation between ordered vs. performed services	○	●	○
• Procure & implement Prior-authorization software that includes reconciling ordered vs. performed services	○	◗	○

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Scenario 4
We can't keep up!

Under resourcing leads to backlogs, poor quality and lost revenue …

Common Scenario:

The prior-authorization department struggles to keep up with their workload. The Manager of the team is consistently moving staff work assignments to cover the work and approving overtime. Staff work out of multiple systems, not all of the team members are equally equipped to complete all types of accounts due to access and training. There is no room to add staff or upgrade software.

Gaps/area of deficiency:

The department is lacking resources

Staff do not have the training or the tools to complete their jobs.

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We can't keep up!

In-house IT solutions: utilizing extensions currently available within your existing registration technology

PROS

Can save time & cost

Customizable

Limited results

CONS

Success with this type of strategy can be "trial & error"
Mapping & dictionary dependent w/variable success

Examples:
GE Centricity/IDX: Enterprise Task Manager (ETM)
McKesson STAR: Financial Clearance Workstation

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We can't keep up!

Automation: Going to market to procure & implement automation technology

PROS

Increased visibility/reconciliation

Increased process efficiency

Decreased payroll cost

Results may vary

No 'all in one' solution in the market … YE

Integration can be tricky

CONS

BEWARE!
The sales pitch ALWAYS sounds AMAZING!!!
Allocate the right expertise & resources to project
Ask for current client demos with same ADT system

Examples:
PriorAuth Now
Experian Passport
Availity

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We can't keep up!

Outsourcing: Partnering with a vendor to take on the management & outcome of the process

PROS

Frees up Management team to drive results
Gives access to enhanced reporting & metrics
Opportunity for better performance

Can be controversial

Ability to 'customize' service is limited
Can be time consuming
'Perfection' comes over time

CONS

BEWARE!
Customization is not necessarily a GOOD thing
Registration foundation could = trouble
Turn over rates are the silent killer

Examples:
Key Pro
R1
Athena

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Scenario 5
Denials are YOUR problem

Inadequate insight to denials delays true performance improvement and puts further reimbursement at risk.

Common Scenario:

There is a lack of clear performance indicators for prior-authorization work. Stakeholder departments (such as radiology and surgery) are reaching out for answers to denied pharmacy charges, were the other services on the account paid? The Surgeons and Radiologists state that they are being denied payment for their professional fees.

Gaps/area of deficiency:

Not enough focus around denial prevention and performance

Preventable denials are undetected until write off is imminent

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Denials are YOUR problem

	Solution	Ease	Cost	Time
	• Obtain and use 835 denial data to analyze and prioritize areas of opportunity • Implement formal patient access denials policy that requires approval to adjust fatal denials	◗	●	◗
	• Attend and participate with organization's denial committee • If there is no denials committee, be an advocate and start the conversation	◗	●	◗
	• Use a business intelligence software package for reporting and visualization	○	◗	◗

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Denials are YOUR problem

Denials Committee

- The committee is typically established by the RC director and facilitated by the billing office.
- Meets on a regular monthly basis
- Measure against Industry Standards when it comes to assessing performance
- Have a goal established for each category

Example of Measuring to Industry …

Denial Category	Baseline	Current	Benchmark (25th Percentile)
Billing	0.00%	0.00%	0.03%
CoordinationofBenefits	1.00%	1.05%	0.87%
Diagnosis	0.13%	0.17%	0.06%
DuplicateClaim	2.96%	2.31%	1.13%
Eligibility	1.86%	1.95%	0.93%
LacksInformation	2.07%	1.55%	2.51%
MedicalNecessity	3.83%	4.04%	1.04%
Non-Convered	3.78%	3.15%	1.34%
NoPresert/Auth/Referral	57.00%	0.53%	0.44%
Procedure	37.00%	0.51%	1.53%
Provider	2.90%	2.47%	0.02%
TimelyFiling	61.00%	0.32%	0.17%
All Denials	19.21%	17.19%	10.07%

*Note: Columns don't total because "All" is d-duplicated - it is possible to have 2 denials on one remit

Example of Goals …

Front End Denials	Orig Baseline Average	Goal	
COB	1.00%	0.90%	(10% reduction)
Elig	1.86%	1.67%	(10% reduction)
Med Nec	3.83%	3.44%	(25% reduction)
Auth	0.57%	0.51%	(25% reduction)

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Denials are YOUR problem

Best Practice: Utilize 835 denial data to analyze and prioritize areas of opportunity

Outpatient Week Ending	3-Mar		10-Mar		17-Mar		24-Mar		31-Mar			
Denial Category	#	$	#	$	#	$	#	$	#	$	Total #	Total $
Billing											-	$ -
CoordinationofBenefits	23	$ 30,043	9	$ 15,671	5	$ 2,074	11	$ 12,916	18	$ 19,346	66	$ 80,050
Diagnosis	1	$ 155	0	$ -	1	$ 568	1	$ 465	1	$ 465	4	$ 1,656
DuplicateClaim	12	$ 27,454	2	$ 4,564	2	$ 4,142	9	$ 14,965	7	$ 12,315	32	$ 63,440
Eligibility	22	$ 22,996	17	$ 6,314	7	$ 13,750	13	$ 24,927	11	$ 15,528	70	$ 83,515
LacksInformation	3	$ 20,863	1	$ 5,497	2	$ 12,384	5	$ 15,139	2	$ 6,119	13	$ 60,002
MedicalNecessity	25	$ 6,021	13	$ 2,879	42	$ 9,991	3	$ 778	23	$ 4,984	106	$ 24,643
Non-Convered	1	$ 12,591	18	$ 6,395	13	$ 3,591	21	$ 8,018	4	$ 6,836	57	$ 37,431
NoPrecert/Auth/Referral	10	$ 77,006	4	$ 38,936	2	$ 20,457	1	$ 28,084	1	$ 46,176	18	$ 210,659
Procedure	7	$ 6,970	1	$ 270	4	$ 8,630	11	$ 12,947	2	$ 10,499	25	$ 39,326
Provider	0	$ -	0	$ -	0	$ -	0	$ -	0	$ 182	-	$ 182
TimelyFiling	1	$ 3,038	1	$ 89	0	$ -	1	$ 3,930	0	$ -	3	$ 7,059
Grand Total		$ 207,137		$ 80,615		$ 75,587		$ 122,169		$ 122,450	394	$ 607,963

First Step: analyze by denial category to provide insight to the scope of the issue and assist in prioritization

→ In this example, authorization denials account for 4% of the overall account population and 35% of the total dollars
→ It is the priority for FE denials over eligibility and coordination of benefits

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Denials are YOUR problem

Best Practice: Utilize 835 denial data to analyze and prioritize areas of opportunity

Next Step: take the biggest opportunity (authorizations) and drill down to the next biggest opportunity to analyze further …

March Outpatient	Authorization		CoB		Eligibilty		Grand Total	
Payer	#	$	#	$	#	$	#	$
Advantage by Buckeye								
Aetna	1	$ 23,489	9	$ 3,274	4	$ 6,710	6	$ 33,473
Aetna Better Health of Ohio					3	$ 3,778	3	$ 3,778
Ambetter from Buckeye Community HP								
Buckeye Community Health - Ohio								
Caresource of Ohio								
Cigna Health Plans								
Humana	2	$ 27,295	7	$ 2,873	9	$ 12,912	12	$ 43,080
Medical Mutual of Ohio								
Molina Healthcare of Ohio					11	$ 15,598	11	$ 15,598
Ohio Blue Cross	15	$ 159,875	18	$ 22,762	24	$ 34,551	40	$ 217,188
Ohio Medicaid					12	$ 7,611	12	$ 7,611
Ohio Medicare			32	$ 51,141	7	$ 2,355	13	$ 53,496
Paramount								
Grand Total	**18**	**$ 210,659**	**66**	**$ 80,050**	**70**	**$ 83,515**	**97**	**$ 374,224**

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Best Practice: Utilize 835 denial data to analyze and prioritize areas of opportunity

Last step: Perform & record account review data to get to & follow up on Finding the Root Cause …

Ohio Blue Cross Account Review Finding: No Auth	#	$
Authorization is on file & approved	12	$ 111,520
CPT performed NOT CPT ordered	5	$ 22,834
Auth denied pre-service: not xld	1	$ 25,521
Pre-service team failure	0	
Grand Total	**18**	**$ 159,875**

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Conclusions

- Technology, vendors, and data must fit with process
- Be hands on – observe for yourself, dig into detailed operations
- Follow root causes to identify the gaps
- Make a conscious decision on good/better/best strategies for improving operations
- Be data driven in identifying opportunities and working with stakeholders

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Questions?

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