Best Practices:
Authorization/Preventing Denials

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Introduction

- Presenter introduction and background
- Basis of presentation materials
- Scope of presentation – Authorization stakeholders
- Technology
- Next steps
U.S. Healthcare Efficiency Index (USHEI)

- Consortium of industry experts to measure the administrative efficiency of the U.S. healthcare system.
- Compared to clinical efficiency, administrative efficiency is low-hanging fruit.
- Industry’s track record is poor.
- Half-measures won’t work, everyone has to participate.
- Operating rules that support standard electronic transactions are the undisputed solution.
- Conforming disparate data to the standard is a $30 billion opportunity.

http://www.ushealthcareindex.com/
Key Stakeholders

- Physician
- Patient Access
- Managed Care
- Case Mgmt/Ancillary Dept
- Business Office
- Payer/Network

Secondary Support: IT and internal audit

Authorization Circle of influence
Primary Participant - Physician

- Scheduling:
  - Patient demographic
  - Patient insurance(s)
  - Specific order information and diagnosis
  - Payer authorization number

- Payer compliance:
  - Provide insurance with necessary clinical data
  - Address PCP, Specialist and IPA referrals
  - Initiate specific payer documents (MediCal TAR, sterilization, etc.)
OR Scheduling, Patient Access & Ancillary Departments

• Scheduling:
  • Document specific services and diagnosis
• Verify eligibility, Insurance plan & Auth information
  • Commercial, Managed Care HMO/PPO/POS, Gov’t FFS
  • Document authorization company, requirements and phone/fax #
  • Inpatients – obtain and document approved LOS (*Alert – if no auth required)
• Monitor and review concurrent report for Auth status
  • Include departments without online scheduling
• Monitor patient type change reports
  • Consider adding patient type behind existing auth status to quickly identify accounts that need action
• Monitor maternity and newborn LOS and service level changes
• P&P for scheduled accounts without necessary authorization
  • Consider adopting a facility specific “Notice of Non-coverage”
Case Management/Ancillary Departments

• Address and communicate patient type changes - *timely*
  • Take responsibility to obtain authorizations on retroactivity
  • Resolve and communicate delay-in-service denials

• Worklist to monitor and address when additional auth required:
  • Patients with additional/on-going auth requirements
    • Payer, floor, physician or service
    • Document insurance rep and next review date in worklist
    • Confirm LOS AND Level of Service approval
  • Extended observation
  • 1 Day Inpatient stays

• P&P to address Level of Service, Patient Type variances
  • Scope should include HIM, Billing, Collections and Logging depts
Business Office

• Post $0 payment codes to accounts
• Create and use Reason codes:
  • Denials
  • Payment reductions
  • Line item non-coverage (Aetna – experimental)
• Specific adjustment codes for denials and payment reductions
• Create and/or maintain payment exception database
• Track, report and communicate exceptions - *timely*
• Document and record all insurance correspondence
• Resources for clinical appeals
• Resources for legal payment demands and action

“The single biggest problem in communication is the illusion it has taken place” – George Bernard Shaw
Administration/Managed Care Dept

- Provide necessary resources to be successful
- Obtain input from internal depts. – before signing contract
- Initiate dialogue and timeframes to automated communication
  - Possible rate incentives or hikes
- Encourage and promote integration between entities
- Appeal for Medical Necessity of service
  - Move away from no phone call – no payment
- Define authorization responsibilities in the contract
- Denial Committee
  - Review reports – Internal and External: Physician and Payers/Networks
  - What are the man hours dedicated hospital wide?
  - Timeframe constraints
Payer Participation

• Authorization rules should be published and accessible
  • Guidelines for updates – communication and effective dates
• Payer’s Provider Relations/Marketing department should meet with physician community on responsibilities and guidelines
• Adopt Family CPT codes for approval vs. CPT specific
• Adopt and embrace electronic communication of patient information and activity
Situational workflow considerations

- COBRA
- Secondary/Tertiary – Split primary coverage
- Newborn – Mother or Father’s coverage – both?
- Service Level variances
- Delay in care
- Non-contracted payers
Technology
Leveraging Technology

Physician Office

MPI/Scheduling

Payers

278

EMR (clinical data)

ADT integration
• 278(N)
• e-mail
• census
• fax

Business Office

835

OCR

Hospital

Standardized Payment Exception Database
Integration and Automation

- Look beyond existing HIS capabilities
- Understand payer communication options
- Front-load processes to reduce downstream re-work
- Availability of solutions through SaaS model
- Collaborate with IT&S to understand automation options
- Leverage automated rules architectures to process and manage your workload
Stop deliberating…make a decision and take action
Next steps….

- Determine your baseline, this will make it easier to measure a program’s success
- Engage your stakeholders
- Develop a plan, including milestones and responsibility
- Assess and leverage technology…it is out there
- Leverage existing resources – trade associations, state hospital association, CORE, WEDI, others….
- Take action
For additional information regarding today’s presentation please contact Jonathan Hendricks at 270-256-8129 or e-mail to jonathan.hendricks@recondotech.com