

Prior Authorization: An Adversary to Timely Patient Care

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Abstract: The timeliness of patient care is often subject to the requirements of the prior authorization process for health insurance. From the perspective of insurance denials and administrative burdens, each stakeholder, including the patient, healthcare organization, and the payor, experience a degree of risk that requires the need to remove barriers affecting the prior authorization process. These challenges, however, can be combatted by seeking to enhance the communication between all stakeholders and integrating technology in a manner that creates a more efficient and effective prior authorization process.

I. INTRODUCTION

Patients seeking medical care often delay or forego care when they are required to cover the cost of that care. This often occurs when patients are required to undergo the prior authorization (PA) review process. Currently, when a patient needs healthcare services, elective or necessary, the health plan will require a verification of benefits to ensure the procedure will be covered. If the plan requires information to determine necessity of such procedure the health organization providing care will task a staff member to submit a request for prior authorization.

The process is standard, there exist various challenges that lead to patient care delays and foregone treatment. If the insurance company denies that patient coverage, then the patient is left to pay for the service out of pocket, spend time trying to meet the criteria on which they were denied, or request the physician prescribe an alternative treatment for which they might be considered eligible by the insurance plan. The questions to be asked then are “who is really determining the patient’s treatment plan?” and “how can this process be improved?”

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II. CURRENT PRIOR AUTHORIZATION PROCESS

The process of seeking prior authorization is when an insurance company reviews pertinent patient documents, reviews previous medical history and treatments, and in many cases requests a peer-to-peer review with the prescribing physician to discuss their reasons for proposing such care to the patient in an effort to determine if the service is reasonable and will be covered in part by the insurer. This authorization process requires that patients complete specific criteria established by the payor organization, including imaging tests, physical therapy for a specified duration, medication treatment, or any other clinical therapies. However, the requirement is not that they only complete the course of care but also fail to receive benefit in order to justify alternative care. Payor organizations have implemented the requirement of prior authorization in efforts to control cost through the practice of utilization management (UM) techniques. These techniques have been effective in reducing costs within healthcare but have caused various negative externalities that are affecting the patient's ability to receive care in a timely manner.

III. EXISTING PRIOR AUTHORIZATION CHALLENGES

Treatment delays often are due to the challenges that present during the prior authorization process and the time it takes to resolve those challenges. A key contributor in this process is the lack of standardization. Each payor has prior authorization requirements for each procedure they cover, which varies by payor. The challenge being that each payor has different criteria that needs to be met before approving care. This illustrates the issue of standardization in that not all payors require the same criteria for a patient or healthcare provider to meet and receive authorization. A common issue of standardization is the lack of EMR integration with insurance PA systems. This affects standardized processes and timely care. As each provider meets with a patient and discusses next steps for care, they do so without knowing the requirements for which a patient must satisfy and receive care. Suggesting that if a provider had already known, via EMR integration, what documentation was required and PA criteria to be met by the patient then that knowledge would allow for timely care and a clearer indication of steps in the patients care plan. However, due to such lack of authorization capabilities in any given EMR system, this information is often unknown to the patient or provider in advance. Thus, creating barriers that cause the patient to often return for more appointments and experience further delays to "qualify" the patient for care.

Care delays may also result from poor communication from the EMR regarding authorization status, between staff, between the staff and patient, between the patient and payor, and between the payor and healthcare organization. The more individuals or groups that are involved in the authorization process the longer and less effective it can become. When an order is sent from the physician to their staff, that staff is then required to request authorization from the insurance company. In some cases, staff must spend more time calling the patient to clarify prior health history for the payor prior to submitting the authorization request. When the authorization has been approved, often having waited two days to several weeks, the authorizer informs the patient, the physician, the scheduling team, the nurses involved, or any other pertinent stakeholders in the process. If the authorization is miscommunicated in any way or the authorization was denied, the process of informing occurs again, the care plan is revised, and then another authorization request is submitted. This simple example illustrates the lengthy process of informing individuals of the authorization prior to care. Such patient experiences lead to longer wait times for care, worsened conditions, and poorer satisfaction. Furthermore, it affects the staff and frustrates those involved.

The next big challenge is administrative burdens that affect and delay patient care. When an authorization is denied the patient and the requesting provider are notified explaining why the request was denied. This denial may be from insufficient documentation in the patient's record. As mentioned, not every provider knows the criteria a patient must meet for each payor. Thus, it is often a challenge for providers to know how to tailor their notes to a specific insurance's requirements of care. This challenge often leads to the authorization specialist or nurse to contact the patient and gather further information or reschedule the patient for another appointment to update the patient record with the required information. There is also the burden of the appeal process. This process requires a fair amount of time from either the provider or the authorization specialist. The provider, in some cases, will contact the payor and complete a peer-to-peer review, in which they are questioned and led to justify why the patient is being prescribed that treatment option. If approved, then the appeal ends, and the patient is able to proceed with the treatment. However, if denied, then the authorizer and patient may pursue one of five main options: submit a new request once the patient has

met the payors approved criteria, do nothing and forego care, request an alternate treatment option, pay for the procedure out of pocket, or request an external review (source external). Unless the patient decides to pay out of pocket, each option requires more time on each stakeholder's behalf and unnecessarily adds risk to the patient's health. In each option, administrative burden is another significant contributor to delayed or foregone patient care.

IV. PATIENT AND ORGANIZATION RISKS

A recent Gallup survey indicated that 33% of patients put off receiving care due to cost they would be expected to pay out of pocket. For patients, the primary concern of delaying or forgoing care is having to experience poorer health outcomes and illness. If a patient chooses to delay or forego, this can challenge a patient's life as well as economic productivity. When an individual is sick, they are forced to undergo a tradeoff by choosing to recover and give up productive time. Through which, they are led to work less and earn lower income in the short run. The patient would likely experience higher healthcare costs and poorer health in the long run. In such event, they begin to feel a lower sense of satisfaction with their healthcare and become less engaged with care coordination.

The risk facing organizations can be significant as well. As mentioned previously, if the patient is unable to receive care, they may begin perceiving the organization as providing low quality. If such occurs, patients will state a lower sense of satisfaction in their ratings of the hospital. Through which, physicians and staff become unhappy as they might lose patients or are forced to care for unsatisfied patients. This can lead to poorer job satisfaction and higher burnout rates in the organization. If an organization undergoes high prior authorization denials, then they risk financial loss. In some cases, if a patient is treated without prior authorization and the patient was not informed of such denial, then the organization will suffer the loss of reimbursement and offer the service as charity care to that patient. In either scenario for patient or organization, both will face risk that may undermine their ability to receive and provide quality care.

V. RECOMMENDATIONS

To first combat the challenges previously discussed, it is recommended to standardize PA processes. We should advocate for established policies that favor care over cost savings. All payors should have a set process by which patients can meet authorization criteria by prescribed procedure. This could be enforced through each U.S. state's policies or made a requirement in value-based care through established authorization pathways for each covered procedure. Through which, it would limit the provider or staff's need to custom tailor their documentation to each payor organization. Second, as the advancements of technology build in Artificial Intelligence to an EMR, automated authorization systems should be integrated within any given EMR. This would allow for health systems to save time in contacting the insurance organization, requesting authorization, and having to track manually the authorization. Furthermore, it would save time for the patient and provider because the authorization criteria would be available for immediate provider review. Such would help the provider ensure authorization by proving the payor sufficient documentation and allow them to address such in their treatment plan and current visits. Lastly, reduce the administrative burdens that affect care. Ensure staff is sufficiently trained to handle appeals efficiently and effectively to prevent long wait times and miscommunicated information. Staff should be trained on coordinating peer-to-peer reviews to save time for the provider. Another simple solution would be to establish system policies that allows for internal coordination of care through the authorization process. Specific pathways should be established that inform who will oversee the authorization, who should be informed of it, and the most efficient methods whereby they may inform each stakeholder. Through which, we will save staff time, improve tracking, and reduce waste.

VI. CONCLUSION

The healthcare prior authorization process has been an insurance utilization management technique for decades, but it requires changes and modifications to reduce delayed or foregone patient care. If healthcare organization can fully implement integrated EMRs that include automated authorizations, designated pathways that educate and train staff to manage the prior authorization process effectively and efficiently, and aid in the standardization of the insurance authorization criteria, then patient care and the organization can be improved to ensure the timely care.

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