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Improving the Prior Authorization Process through Operating Rules

NCVHS Subcommittee on Standards
Hearing on Proposed CAQH CORE Operating Rules
August 25-26, 2020

Overview

- Prior authorization background
- Overview of problems
- Value of proposed rules
- Opportunities for improvement

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Prior Authorization Overview

- Prior Authorization: Utilization management method requiring claims for services to be reviewed and approved by a health care payer before services are rendered to patients.
- According to America's Health Insurance Plans (AHIP), prior authorization is implemented by health plans to help ensure patients receive optimal care based on well-established evidence of efficacy and safety, while providing benefit to the individual patient.
    - The AHA philosophically agrees with this concept and recognizes that prior authorization, when utilized appropriately and effectively, can accomplish these goals

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Current Problems with Prior Authorization

(1) Delays caused by inefficient implementation

(2) Differences in requirements and submission methods between health plans

(3) Questionable application

(4) Inappropriate denials

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Delays and burdens caused by inefficient implementation

- **Documentation preparation and submission**
  - Most methods of requesting prior authorization require significant manual work (including electronic portals)
  - Requires significant staff and resources that could otherwise be spent on patient care
- **Slow processing times delay patient care**
- **Unavailable outside of business hours**

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Differences in insurer requirements and submission methods

- **Is prior authorization required for a particular service?**
  - Specific treatments requiring authorization differs between health plans (even those issued by the same insurer).
  - Prior authorization list (and frequent updates) are often posted on a website or included in a monthly bulletin
- **What information/documentation required for approval?**
  - Prior authorization forms and clinical criteria used to evaluate requests varies
- **How should the request and supporting documentation be sent to the payer?**
  - Fax
  - Phone call
  - Portal
  - 278 transaction

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CAQH-CORE Prior Authorization Infrastructure Operating Rule: Anticipated Value

- **Reduces delays**
  - **Plans required to:**
    - respond to completed prior authorization within 2 business days of receipt
    - request additional information within 2 business days of receipt
    - acknowledge real-time prior authorization within 20 seconds of receipt
- **Streamlines process**
  - Promotes usable electronic method that can be used with across various payers
    - Helps address the “pended” roadblock of some 278 implementations

CAQH-CORE Prior Authorization Data Content Operating Rule: Anticipated Value

- **Increases transparency and eliminates variability**
  - Plans required to use standardized code sets (PWK01 or Logical Identifiers Names and Codes) to identify additional clinical information needed for PA requests.
  - Requires plans to send Health Care Decision Reason Codes

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Opportunities for Improvement: Operating Rules

1. Removal of “Business Day” Concept

- Providers are caring for patients 24/7, plans seeking to insert steps in this process should abide by the same timeframes

2. Increased Compliance Requirements

- Plans only required to meet the operating rule requirements 90% of the time over the course of a month
  - Insufficient for prior authorization, as it limits a provider’s ability to establish reliable timeframe expectations for their patients

Opportunities for Improvement: NCVHS Subcommittee on Standards

Attachment Standard

- There is currently no standard method of sending clinical information and other documentation required by plans to complete prior authorizations
  - Health plans vary in how they accept/prefer this information to be sent
  - Often results in inefficient, manual processes (mail, fax, telephone)

Conclusion

The AHA recommends that NCVHS approve the proposed prior authorization operating rules, which establish necessary process improvements that increase revenue cycle efficiencies and improve patient care.

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