Beware of Prior Authorization Demands When Working with MA Plans

by: Sarah Schock, HHL Mar 7, 2024

It's important for agencies to get the authorization practice streamlined, especially with the increase of Medicare Advantage (MA) plans. An ability to navigate this challenge can make or break your success with alternative payors and put you in a better position to adapt as the payor mix continues to evolve.

Most MA plans require prior authorization, so this will increase the workload in the authorization department, stresses Ashley Michael, senior manager at SimiTree Health Care Consulting in Hamden, Conn.

"Without this authorization, the MA plan is unlikely to pay for services," she explains.

The authorization staff should be looking closely at these MA contracts to ensure prior authorization requests are handled appropriately. It isn't one-size-fits-all. Each different MA plan is likely to have different requirements around authorizations.

It's not just MA plans that need to be watched out for though. Any alternative payor could come with requirements for prior authorization, so agencies need to be diligent when looking over payor requirements for any patient.

Watch out for common mistakes

There are several areas where agencies commonly trip up around prior authorizations, Michael says:

- **Incorrect insurance selected at verification.** If this field in initial documentation is incorrect, it will cause prior authorization requests to be denied. To avoid this, staff should double check this field against the patient's insurance card. If the wrong insurance company/plan is selected initially, all insurance information submitted later will be denied.
- **Untimely requests.** This usually stems from having a backlog of patient paperwork to get through, staff responsible for handling authorizations taking PTO or when an agency lacks a standard process for requesting and tracking prior authorization requests.
- **Lack of clinical documentation.** Agencies may need to educate clinical staff on documentation guidelines to ensure necessary documentation is ready to submit with authorization requests.
- **Changing payor requirements.** Denials for authorization often happen when the agency is not up to date on the constantly changing payor requirements. If the agency does not have someone dedicated to keeping up with those changes, the agency could get denials due to lack of required information needed by the payor, Michael warns.

Set up a process around authorizations

To curb prior authorization denials, agencies should have operational processes in place to address these issues.

Agencies struggling with denials should do the following:

Educate and train clinicians around verification. Clinicians typically aren't aware of all payor nuances, but agencies should educate staff on payor-specific requirements about prior authorization, Michael warns. The fact is, if a clinician doesn't know that prior authorization is required for certain services on a patient's insurance, they will likely move ahead without requesting it, meaning that the agency may not be reimbursed later, she explains.

Monitor denials. Agencies should consistently monitor denials and the reason for them. Often agencies will see that claims are being denied for the same reasons, such as missing signatures, meaning that the agency needs to update their processes in that area, Michael says.

Agencies should also dig into which clinicians provided the care when an authorization request is denied. If certain clinicians have more denials than others, the agency must act.

"Hold clinicians accountable for visits made without authorization," Michael recommends.

Discuss denials with operational staff. The agency should have dedicated authorization staff responsible for addressing denials. The number of staff would depend on the payor mix and the number of patients that will require authorization, Michael says.

"Everyone on the operational team should be involved in communication around authorization issues and denials," she adds.

Operational staff that should be educated on denials include intake, liaisons, clinical management, billing and compliance, says Michael Puskarich, director of advisory consulting at McBee of Wayne, Pa.

The staff responsible for authorizations should have access to payor portals and know how to utilize them.

The authorization staff should also be responsible for discussing issues pertaining to authorization denials with operational staff so that everybody is on the same page.

Be familiar with the payor's provider manual. Knowing the process and having an updated pro-vider manual or access to the payor site will go a long way, Puskarich says. "This will allow intake to get any information they need to assure the agency is gathering what they should be," he explains.

Agencies often trip up here, Puskarich warns. Typically, it's related to communication around the contract and whether intake has what they need on the details or access to files and links they need, he says.

Standardize EMR documentation. All documentation regarding authorizations should be standardized in the EMR. This includes documentation detailing what has been requested, the start and end date of the requests, visits dates and services performed at the visits.

“Best practice is to utilize the EMR to track all initial and ongoing authorizations,” Michael says.

Staff then need to follow all workflow specific to authorizations within the EMR. This shouldn’t be a difficult task if the agency has implemented standardized documentation procedures in the EMR.

Agencies can also utilize payor portals, if available, for all authorization requests, Michael adds.