Indiana University Health

Current Medication Prior Authorization Process

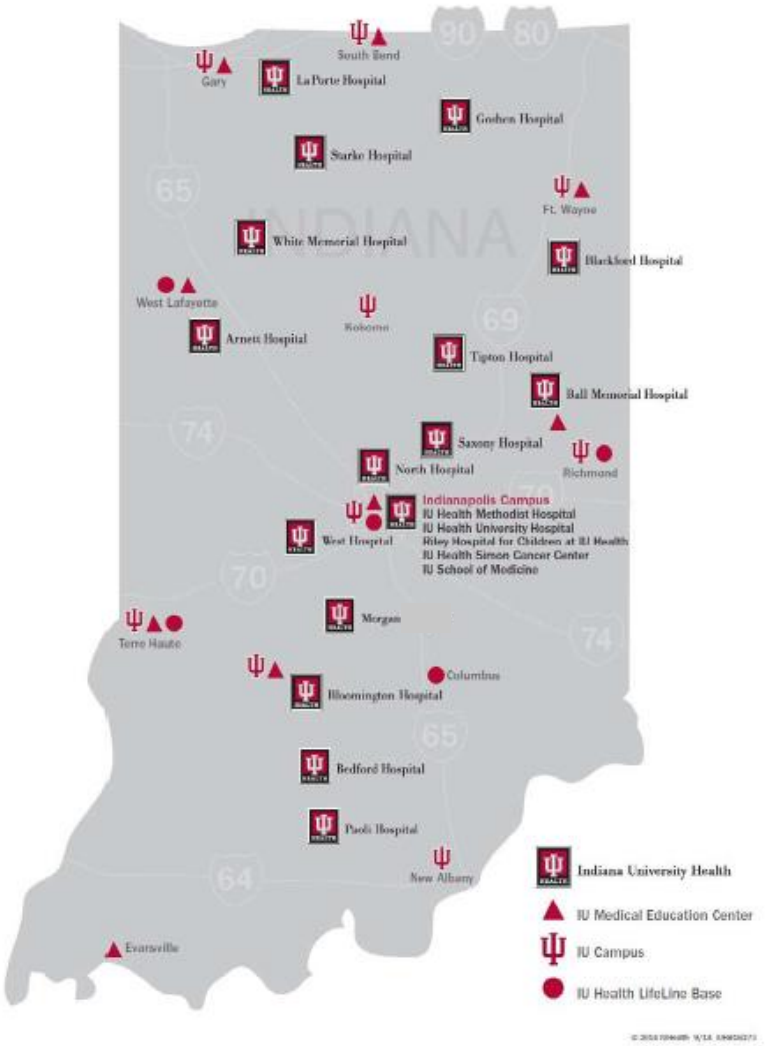
Jennifer Alvey, Chief Financial Officer and
Maria English, Director of Patient Financial Navigation

Organization background

Comprehensive healthcare system

- 17 hospitals
- 3,000 beds
- 2,000 physicians
- 200 physician locations
- 30,000 employees
- 137,000 admissions
- 2.6M outpatient visits
- $13B in revenue
- Over $500 million in community benefit

serving more than 1.4M community members



Pharmacy and therapy technology advances

Advances in drug discovery and development in technologies are leading to very expensive therapies

- These drugs (e.g., biologics) are new and always emerging
  - Technology and treatment modalities are developing faster than ever before, and often faster than medical policy can keep up
- Patients are hopeful these new therapies offer better or extended quality of life
- Providers are eager to improve patient outcomes
- Payers continuously evaluate their medical policies to ensure new advances in drug therapy are used in a payer-supported manner

Why is prior authorization important?

- Obtaining prior authorization:
  - ensures patient care is covered in advance
  - reduces the risk of costly denials by focusing team member resources on insurance verification and authorization
  - provides patients with an opportunity to make decisions regarding their care when services are not covered
  - the authorization process can have a material impact on patient satisfaction

What is the authorization process?

Authorization must be obtained for certain services per various health insurances or plan medical policies:

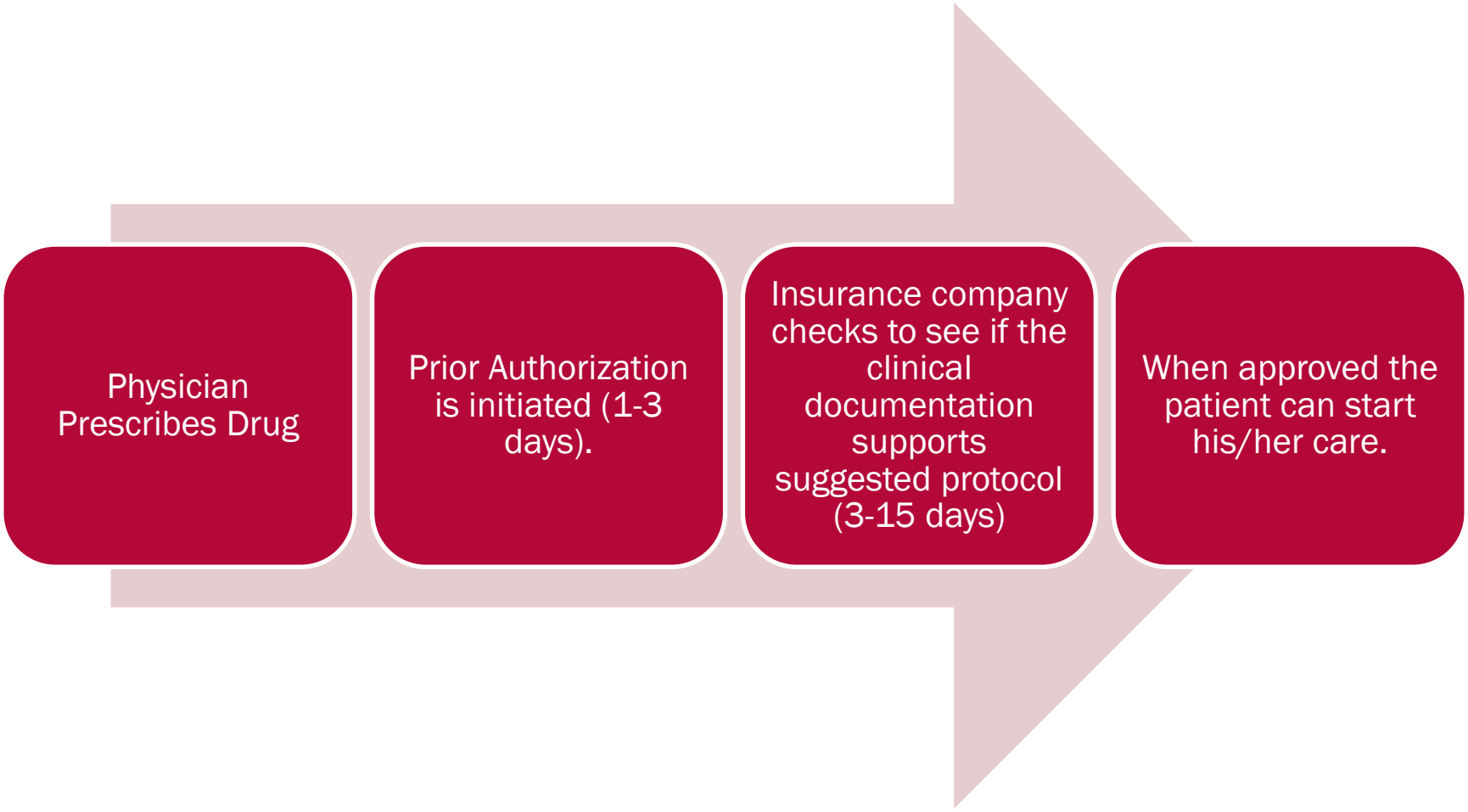
- **Prior Authorization:**
  - Decision by health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary.
  - Health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency.
  - *Pre-authorization isn't a promise your health insurance or plan will cover the cost.*
  - 3 to 15 days[1]

- **Pre-Determination:**
  - For certain medical procedures and drugs, the health insurance company might require a pre-determination letter.
  - Before the service, the physician/ hospital must receive confirmation that this is a covered benefit under the health insurance plan and approved by the insurer.[2]
  - 30-45 days

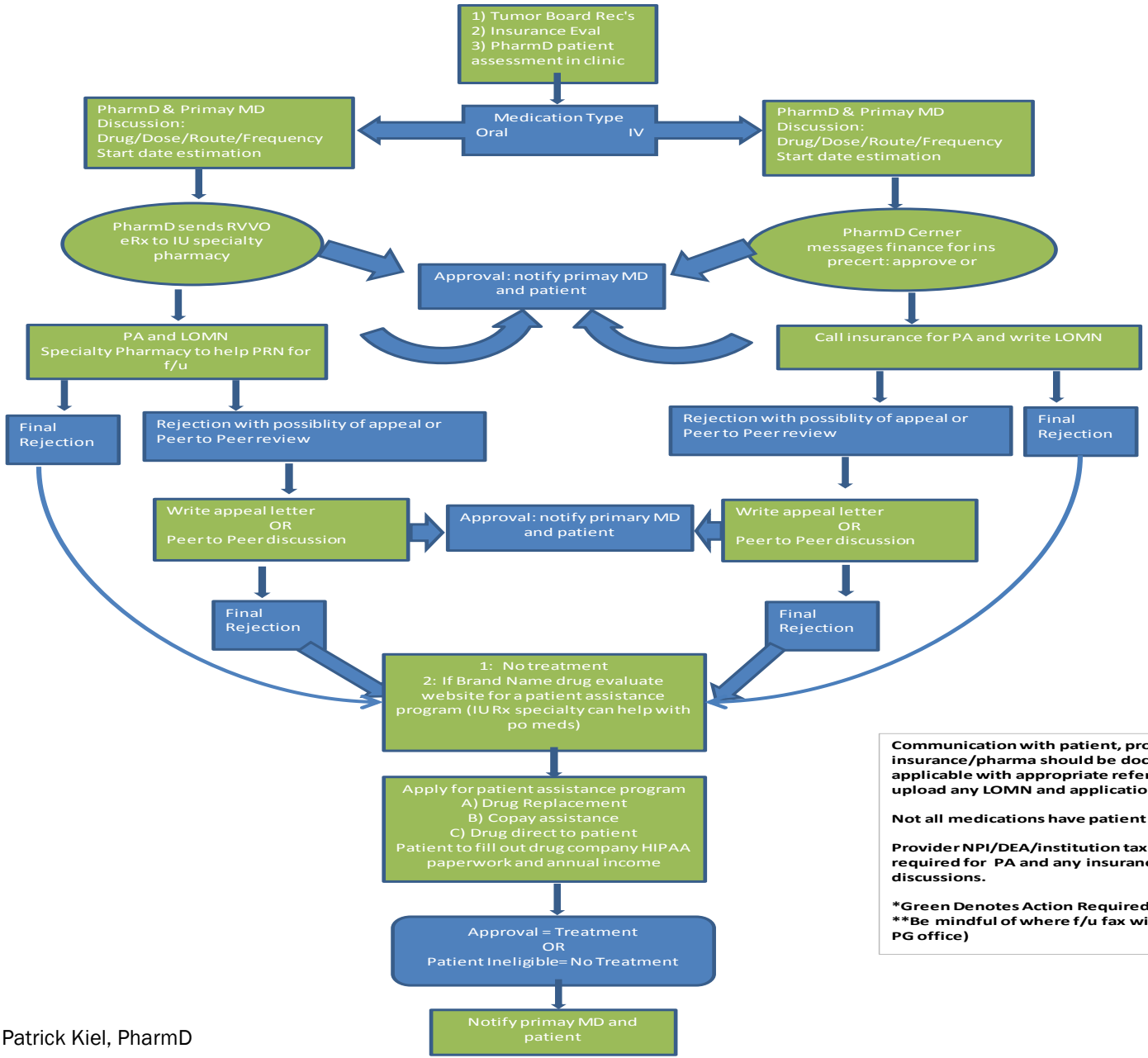
1.Healthcare.gov

2. http://classroom.synonym.com/predetermination-letter-health-insurance-14609.html

Prior authorization for covered drugs



Prior authorization for non-covered drugs



Communication with patient, providers, and insurance/pharma should be documented in Cerner when applicable with appropriate reference numbers. Please upload any LOMN and application paperwork as well.

Not all medications have patient assistance programs.

Provider NPI/DEA/institution tax ID (IV meds only) will be required for PA and any insurance company/pharma discussions.

***Green Denotes Action Required by PharmD**
****Be mindful of where f/u fax will be (ie primary onc office or PG office)**

**Courtesy of Patrick Kiel, PharmD

Challenges to obtaining prior authorization for drug therapies

- Drugs are used for ‘off-label’ therapies
  - Torisol (FDA-approved for renal cell carcinoma (RCC)) prescribed to treat uterine cancer
- Medical policies are ever changing making it difficult to understand what’s covered
  - Lack of awareness from insurance to providers regarding requirements for drug coverage
- Patient and provider confusion regarding insurance coverage and requirements
  - Mixed messaging from insurance companies regarding non-covered benefits and prior authorization
- Procedures and timing to request authorization varies from insurance to insurance
  - phone, fax, online portals, varying levels of access
- Denied Authorizations
  - A properly submitted appeal is necessary to overturn these denials
  - Must resubmit with additional information or change in clinical care plan
- Peer to Peer Justification Process
  - The physician ordering the test must call in to discuss the planned treatment with the medical director at the insurance company
- Non-Covered Services
  - Financial clearance or the physician office must look for alternative measures to get treatment for this patient

What are the problems when prior authorization isn't well managed?

- Patient Satisfaction
  - Patients can see increased wait times before services can be performed and drugs can be procured
  - Patients can often be brought into the discussions between the providers and the payers
  - Patients could be billed where care was not authorized
  - Patients can blame providers, payers, AND EMPLOYERS
- Provider Satisfaction
  - Providers and their support teams can be burdened with additional hoops to jump through to get the patients the care they need
  - Providers may also be involved in the discussions and have to work directly with payers to explain medical necessity
- In-efficiency
  - Physician office teams may have employ team members who aren't updated on current authorization rules or have effective access to payers
  - Physicians and nurses can spend non-value added time dealing with authorization issues instead of caring for patients
  - The billing team could have denials, communication loops, and back-end re-work

How does IUH manage these increased authorization complexities?

- Provider side:
  - Create a one stop shop with a highly integrated patient financial navigation team coordinating registration, scheduling, payer coverage, and financial clearance
  - Centralize authorization process to experienced and highly trained team members keeping current on constantly changing insurance guidelines/medical policies
  - Have a medical escalation process offering provider-to-provider clinical discussions to support financial clearance
  - Have dedicated physician advisors supporting care providers in advocating for patients to ensure they get the care they need
  - Efficiencies have resulted in a 30% decrease in authorization costs
- Payer side:
  - Highly integrated processes between the IU Health Plans and the providers to ensure streamlined processes in many cases eliminating the need for authorizations altogether

Access to non-covered drug therapies after authorization fails

- IU Health pursues financial assistance programs offered by the drug companies for non-covered therapies to support our patients in getting the care they need
- IU Health provides exhaustive searches for possible payment options to help avoid costly patient liabilities
- We value our patients and must be good stewards of the care we provide

Questions?