CLIENT SUCCESS STORY

PROBLEM

Health Plan is a payer organization in New York that manages Medicaid and Medicare programs.

Management was concerned because they had an overworked utilization management staff that was always scrambling to meet turnaround times and provider abrasion.

When inquiring about provider frustration, the main factor was the excessive prior authorization requirements.

SOLUTION

- Conducted interviews with the client's Medical, Claims, and Utilization Management Leads.
- Partnered with the UM staff to identify and pull data samples from the claims system to identify rejected claims due to low-cost procedure codes requiring prior authorization.
- Our subject matter experts analyzed claims data for a six-month period where reimbursement was impacted because of the prior authorization guidelines.
- Pulled the current prior authorization code list, representing over 18,000 codes.

RESULTS

- A streamlined code list better aligned with current industry practices. At the end of this assessment, we eliminated approximately 16,000 codes that previously required prior authorization.
- Identified procedure codes billed at a low dollar threshold should not be required to have authorization because they were overturned upon appeal 82% of the time.
- The client established a new policy of not requiring prior authorization for services billed at a determined low dollar threshold, saving hundreds of labor hours per month within the Clinical / UM department.