WHITEPAPER

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Streamlining the Authorization Process Using HSR 278 Transactions

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Abstract

Since 2014, athenahealth has partnered with Humana, a national commercial and Medicare and Medicaid payer, to pilot the Health Services Review (HSR) 278-215 and HSR 278-217 Electronic Data Interchange (EDI) transactions. These HSR EDI transactions enable the electronic initiation of new precertifications and referrals between providers and payers and the electronic inquiry into a payer's system about an existing precertification or referral.

Over the course of the pilot, athenahealth and Humana have realized the following monetary, time, and quality benefits from adopting the HSR EDI transactions:

- Significantly reduced the number of precertification and referral-related calls to Humana's call center, resulting in estimated cost savings of $100,000 per year
- Reduced the average time from initiation to notification of determination for pre-certifications by 11.9%
- Reduced the number of provider-initiated authorization appeals by 34.8% by standardizing and automating the data transmission process

Given the immediate and significant cost, time, and effort that payers could save, coupled with the relative ease of implementation, athenahealth strongly recommends that payers consider the adoption and use of HSR EDI transactions.

Background

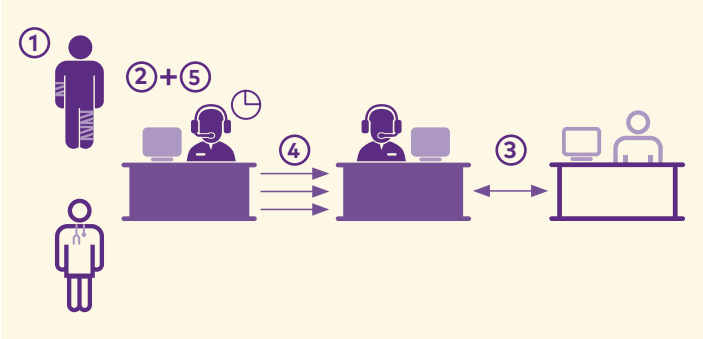
Authorizations cost the US health system $23 to $31 billion a year[1] in administrative costs alone. Providers and their staff spend 20 hours per week per MD providing necessary paperwork to payers[1] – and that doesn't include the time spent retrieving and preparing those documents. These are only a few numbers that point to a fact evident to any provider – the current process for obtaining authorizations is broken. Every party in the process is impacted by the long phone hold times; complex requirements and adjudication; and back-and-forth exchange of clinical information; however, no party is impacted more than the one with the least power in the process – the patient. Patients can only wait and hope that a determination will be made before their critical surgery can be performed. This process will only become more common in the future as healthcare costs rise, the market moves toward risk-based models, and payers look to control utilization and costs.

However, a solution to simplify and streamline the process exists – the Health Services Review (HSR) 278 Electronic Data Interchange (EDI) transactions. As part of the Health Insurance Portability and Accountability Act of 1996, the 278-217 request transaction was mandated for initiating new precertifications and referrals between providers and payers. The 278-215 inquiry transaction, which allows for the inquiry into a payer's system about an existing precertification or referral, was not included in the mandate. Neither transaction has been widely adopted or used in the industry.

From 2014 to 2016, athenahealth, a network-enabled provider of practice management and electronic health record solutions to over 80,000 providers, has partnered with Humana, a national payer of health plans including Medicare and Medicaid Supplemental plans and commercial plans, to pilot the two HSR transactions. The following paper examines the benefits of HSR transactions and presents a case study on the monetary, time, and quality benefits that HSR transactions brought to Humana's prior authorization process. We found that HSR reduced costs, streamlined processes, and improved quality for all parties in the healthcare system when compared to non-automated processes.

Obtaining Authorizations Today

An example process for requesting and obtaining a prior authorization is typically as follows:



1. A specialist, such as an orthopedist, determines a patient requires some service such as a knee surgery and puts in the order for one.
2. The specialist's staff calls the patient's insurance company to verify benefits and whether precertification is necessary. If so, they initiate the request giving the necessary information such as diagnosis code, procedure code, proposed dates of service, and rendering facility information.
3. The payer takes in all this information and sends the precertification to be reviewed by staff.
4. While the payer is reviewing the precertification, the provider's office or patient may repeatedly call or log into a portal to check on its status as the only way to find out if an authorization has been completed.
5. If additional clinical documentation is necessary, the provider gathers the requested documentation and returns it to the payer. They will continue to call the payer or check the portal until a determination has been made (which often takes multiple days).

The process is similar but abbreviated for referrals as most referrals can be determined during the initial request phone call and do not require clinical information.

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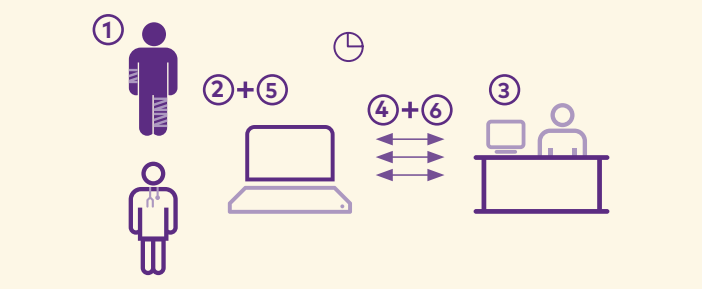
An Overview of HSR 278 Transactions

There are two HSR 278 transactions. The first, the 278-217 request transaction, allows for the electronic transmittance of a new request for an authorization for a patient. Patient insurance and procedure information is sent to the payer in an ANSI standard transaction available in real-time or batch, and payers respond to providers with confirmation of authorization requirement, case numbers, and status of the request. The second transaction, the 278-215 inquiry transaction, allows for the follow-up and retrieval of information on an existing request opened with the payer.

With the power of these two transactions, Humana and athenahealth established the following streamlined process:



1. An orthopedist determines a patient requires some service such as a knee surgery, and puts in the order for one.
2. The practice management system, using the information from the order, auto-generates a 278-217 request transaction with the patient's insurance information, diagnosis code, procedure code, facility, and dates of service requested and sends it to the payer. The payer responds real-time with confirmation of whether or not a precertification is required, and if so, generates a case number for the request within seconds. The payer may also respond directly in the transaction with a request for more clinical documentation.
3. The payer sends the precertification to be reviewed by staff. If necessary, they contact the provider through fax or phone to request additional documentation to make a determination. In the meantime, the provider can follow-up at any time with the 278-215 inquiry transaction and retrieve the status of the case within seconds. athena's practice management system schedules these inquiry transactions to run every hour and updates the provider whenever new information is returned.
4. If necessary, the provider gathers the requested documentation and sends it to the payer.
5. Using the inquiry transaction, the provider is updated once the authorization has been determined. The payer returns either the authorization number needed for billing or a reason code and message with a denial in the inquiry transaction response.

The referrals process with HSR replaces the initial phone call with a request transaction and an inquiry transaction follow-up if needed to complete the process.

Study Methodology

For this case study, Humana and athenahealth compared data from the authorization process with HSR to the process without the transaction over the span of five months (January to May 2016) and analyzed how the two processes compared on a number of measures. The measures are grouped into three major categories – process, costs, and quality – and we found that on every measure, HSR performed better than its alternatives. Humana, as a payer, processes 645,000 authorizations a day by web portal and HSR. Humana supports the use of both the 278-217 request and 278-215 inquiry transactions for all precertifications procedure codes and referrals. athenahealth is piloting a process where they are working about 2,500 authorizations a day for providers by transaction or through agents who use payer phone lines, web portals, or Interactive Voice Response (IVR) to complete authorization requests. It is worth noting that, as a pilot effort, athenahealth sent transactions to Humana for only a subset of their clients and had not fully optimized their transaction generation and processing logic. This suggests that the results presented here represent only a baseline of the potential for HSR to improve the authorization process. At the time of the case study, Humana and athenahealth had yet to exchange referral transactions due to the limited clients with whom athenahealth was piloting the transaction. However, athenahealth did pilot the referral transaction with two other regional payers. Humana and athenahealth analyzed data from their respective referrals processes with and without HSR and found results consistent with their data for prior authorizations.

As there are many terms used across the industry, this case study will use the following terms and definitions to discuss prior authorizations:

- **Precertification –** the process of obtaining approval from a health plan before a procedure or hospital admission is performed
- **Referral –** the process of obtaining approval from a health plan before sending a patient to a specialist for a consult
- **Prior Authorization –** the general term used to refer to precertifications and referrals

Study Results

1. Streamlined Processes

When compared to the turnaround time of precertifications initiated and completed by phone, precertifications completed by HSR had a lower average turnaround time by 11.9%. Precertifications made and followed-up by HSR took an average of 3.7 days from initiation to receipt of determination compared to 4.2 days through phone or portal. For cases sent to Humana, even if the case was not initiated by HSR, an inquiry transaction was sent every hour – a frequency unsustainable and impractical by human means – to follow up and retrieve the status of the case. Any time a new status (i.e., approved, denied, no precertification required, clinical information required, etc.) was received, the system would automatically update the case and send the status to the provider. This meant that providers found out sooner when they needed to send more clinical information and sooner when the patient was approved and ready to be scheduled. This automation was only possible with Humana's support of the inquiry transaction in real-time with robust responses.

A common area of added complication in the precertification process is the group of determinations overseen by third-party utilization management organizations (UMO). Although not fully robust, HSR has been able to handle and improve the precertification for these procedures as well. Humana takes in all requests through the same connection and routes them either to their internal UMO department or to their third-party UMO, HealthHelp. After receiving a response that the case is with HealthHelp, athena will generate all inquiry transactions for the case with a specific segment identifying HealthHelp, which enables Humana to return the status for the case despite it being in process with HealthHelp. Case status can only be returned through the inquiry transaction as Humana receives updates from HealthHelp. Therefore, within the span of a few hours, a phone representative at HealthHelp may be able to present more up-to-date information than a transaction sent from the practice management to Humana; even so, the turnaround time improvement above includes HealthHelp cases and allows third-party UMO cases to be automated in the overall process by HSR.

For referral requests, the real-time, full responses sent are essential for full automation of the process. For referrals, 99.6% of requests receive an approved, denied, or "No Referral Required" response and can be closed out in the same day. While phone calls to complete a referral request take an average of seven minutes, the turnaround time of a real-time HSR transaction is 20 seconds. For a mid-size 10-doctor practice with 300 referrals and 500 precertifications per month, the practice would save 35 hours on referral calls and 79 hours on pre-cert request calls every month without even factoring in follow-up pre-cert calls.

The immediate determination of referrals may seem to make the inquiry transaction irrelevant for referrals, but the opposite is true. The inquiry transaction is extremely valuable for specialists. Under the increasingly prevalent managed care plans, many payers require patients to get a referral from their primary care provider to see a specialist for consults. For specialists, these consults are abundant, but the work and resources necessary to secure referral information for every single appointment leave many specialists opting to risk non-payment rather than attempt to undertake the burdensome process. However, with the inquiry transaction, practice management systems can easily automate "referral checks" that will retrieve from a payer's system the relevant referral information and number necessary for each consult to secure payment or alert the provider that a referral will be required where none has been obtained. What once burdened providers to the point of forgoing payment for their work can be automated at little cost to the provider.

Attachment Automation

A common concern raised about the implementation of the HSR transactions is the dependency of many precertifications on clinical documentation for which there is yet to be created an industry-wide automated method and standards. Much work has been done this year alone in reaching consensus on the 275 transaction; however, it is still far from being implemented widely.

For precertifications that require clinical documentation, full automation is not possible with the HSR transactions. However, it is still able to automate and improve all the steps leading up to and immediately following the submission of clinical documentation. With or without attachment automation, case initiation and follow up has to be done regardless. With the HSR transactions implemented, the entire process for both payers and providers can be established and ready for 275 automation when the standards are determined and mandated. In fact, drafts of the current standards for the 275 already provide integration points with HSR to allow for full automation end to end when necessary.

2. Reduced Costs

HSR reduces costs for all parties involved by eliminating many of the phone calls necessary in the authorization management process. Phone calls are costly for both payers and providers. As mentioned in the previous section, HSR is able to essentially eliminate phone calls necessary for referrals and significantly reduce the calls necessary for precertifications. Every follow-up call can be eliminated through the use of the inquiry transaction. Procedures that don't require precertification or clinical documentation can also be completed with one request transaction. In our case study, "No Precertification Required" accounted for 32.0% of responses received by request transactions. This percentage does not include cases where no request was sent due to clearly published "No Precertification Required" payer

guidelines. In the study, *7.74%* of precertification requests were approved immediately in the request transaction's response. All of this adds up to 83.9% of all precertification requests that could be completed without any phone calls or manual work with the HSR transaction.

If we take conservative estimates that each phone call costs $1 and that on average each referral requires one call and one procedure takes one request call and ⅓ of a follow-up call, if a mid-size 10-doctor community health practice with 300 referrals and 500 precertification orders per month, both the practice and payer could save $9,000 or more a year by implementing both HSR transactions. A larger orthopedic group of 30 providers with 5,000 precertification orders per month could save payers and their own group $53,000 or more a year. According to the CAQH Index, these savings could be as high as $17,400 and $108,600 per year for payers.[2]

While HSR cannot eliminate all manual work, it eliminates the work that is most time consuming, standardized, and least valuable. This allows practice staff and payer call centers to focus on the work required that varies from case to case – discussing medical history and necessity for procedures.

3. Improved Quality

The third improvement to the authorization management process is improved quality. As an ANSI standardized, automated format of transmitting data, the HSR transaction requires and validates data for quality. By conforming data to a standardized format, the HSR transactions enforce data quality and consistency between the provider and payer. In addition, ANSI transactions require data validation and surface inconsistencies between provider and payer records in the event of a mismatch whether for patient information, provider information, or other information needed for the authorization through AAA error codes and free text messages. Mistakes due to human error are inevitable – from data entry mistakes to verbal miscommunication over the phone regarding procedure codes or facilities. Any time data entry is manual and two copies of a record exist (one on the payer side, one on the provider side), it is prone to mistakes and getting out of sync. However, using automated transactions not only aligns the two copies of a record without human intervention, it also maintains an easily accessible audit record of the information transmitted.

In our case study, we found that 58% of all Humana appeals were appeals regarding authorizations and that 60% of the provider-initiated authorization appeals through athenahealth were due to confusion or miscommunication between the provider and the payer over whether an authorization was required for a procedure before the service was rendered. However, for cases that were initiated through HSR, athenahealth had no provider-initiated appeals for Humana.

As authorization requirements vary by plan, provider, facility, and specific procedure code, miscommunication on any one of those factors could result in misinformation on whether an authorization is required or not. Through the HSR transaction, every required piece of information is transmitted from provider to payer in a structured way that can be taken in by automated logic to be determined for authorization necessity. As authorization requirements change frequently, this also means that payers can easily access what determination was given to a patient and providers will always receive the most up-to-date authorization requirements. By supporting the HSR transactions' ability to return "No Precertification Required," 34.8% of all appeal work could be eliminated and the remaining work can be more easily managed.

Greater Scalability than Web Portals

Web portals are a common solution many payers currently offer. While web portals may be able to offer similar benefits to the process, portals do not have the same scalability that the HSR transactions do. Every portal requires its own set of logins that often cannot be shared across different users in the same practice. Some payers split plans across different portal platforms each requiring a different set of credentials. For multi-site or multi-department practices, some payer portals require different accounts and logins for each National Provider Identifier (NPI). This means staff not only have to manage multiple logins across payers, but for the same payer as well. We found that athenahealth practices managed anywhere from 20 to over 600 different logins for payer web portals. Aside from credentialing woes, providers are still required to spend time researching whether to log into a payer's portal or a third-party UMO's portal and must manually enter each request every time they want to initiate or follow up on a request. While web portals are a helpful step to moving away from phone calls, they still require a manual touch and pose a significant challenge to automation with practice management systems.

Key Takeaways

1. 83.9% of precerts and 99.6% of referrals can be automated completely with one HSR transaction, allowing staff to focus on getting complex procedures approved.
2. HSR transactions eliminate all manual follow-up work and return determinations in less time.
3. With HSR transactions, 34.8% of all appeal work could be eliminated and the remaining work can be more easily managed.

Conclusion

Humana and athenahealth found that the HSR transaction was able to improve turnaround time, reduce phone calls, improve data quality transferred, and thereby reduce authorization appeals. Although the transactions cannot fully automate the process, it makes significant progress in reducing the cost and manual burden of researching requesting, and following up on authorization requests while improving accuracy of information exchanged. Some may argue that the transaction is not worthwhile until the attachments transaction is standardized and implemented across the industry; however, there is immediate and significant cost, time, and effort that could be saved through using the HSR transactions alone. In addition, by implementing the HSR transactions now, the workflows and system will be established and ready for the attachments transactions to be integrated into when ready.

How to Implement the HSR Transaction

The actual build out of the transaction is similar to other industry-wide EDI transactions such as the eligibility transaction. Following CAQH CORE Phase IV implementation rules, payers build transaction logic for the parsing, storing, and retrieving of data from their authorization case management system. Providers and practice management systems either establish new or leverage existing real-time connections to test the HSR transactions with payers. After testing and validation on both sides is complete, systems can go live to exchange HSR transactions. Some payers may want to use a phased approach in building out groups of procedure codes that are easier to automate until they are able to handle all codes. Third-party utilization management systems should also consider establishing connections to payers or offering connections directly to practices and practice management systems to exchange the HSR transactions.

Although the HSR transactions are only mandated at a high level, two essential factors to the success of the transactions stood out: the real-time nature of the transactions and the full responses returned by the payer. These two pieces were the foundation for automation and value gained through the transactions. Due to the time-sensitive nature of authorizations, the batch format would significantly reduce the effectiveness of the transactions. Without full responses, no automated workflows could be built. (Full responses are defined as a response containing a case number and procedure-specific statuses, message, or authorization number.)

With the rise of risk-based models from CMS, the necessity for authorizations is only going to increase over time. The need for alternative methods of managing the process has already become apparent in the industry and the burden will only grow. As ANSI standardized, partially HIPAA mandated transactions, the HSR transactions offer both immediate relief and long-term potential for automating the process of acquiring authorizations.

Bibliography

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"there is immediate and significant cost, time, and effort that could be saved through using the HSR transactions alone"

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