

Inside Cleveland Clinic's \$10 million prior authorization price tag

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Hundreds of times each month, insurance companies put highly trained staff at the Cleveland Clinic on hold for more than 10 minutes at a time.

About 250 times a month, or roughly 3,000 times a year, payers make Cleveland Clinic staffers wait on hold for more than 10 minutes during the processing of a prior-authorization (PA) request, according to information provided by Susan Milheim, senior director of revenue cycle management at the preeminent Ohio health system.

The Cleveland Clinic expects to process 900,000 outpatient PA cases in 2018, she added.

PA is a process that requires physicians and hospitals to obtain approval from an insurance company or other payer to qualify for payment before they can deliver the prescribed treatment or ordered service their patients need. It is used by payers as a utilization-management tool to control costs and, traditionally, was applied mainly to newer or more expensive services and medications.

But physicians participating in an AMA-sponsored survey reported an increase in prior-authorization burdens in recent years. This may in part be due to payers placing PA requirements on commonly prescribed drugs and services that are neither new nor costly.

Back at the Cleveland Clinic, staffers send about 520 repeat PA-related faxes a month, including some that are retransmitted as often as six times.

The cost of prior authorization has also grown. Cleveland Clinic spent \$9 million in 2015 on processing PA cases with 175 "caregivers" doing the work. Expenses grew to \$9.7 million in 2017 and they expect to spend \$10.7 million this year, Milheim said.

\$4 million spent fighting denials

Cleveland Clinic spent \$4 million fighting prior-authorization denials in 2017 and \$4 million will also be spent in 2018. The \$4 million figure represents administrative expenses—including employee and vendor resources—used in the attempt to overturn PA denials.

Besides these denials, there are other ways that Cleveland Clinic loses income due to PA, Milheim said. For example, authorization may have been secured for an MRI of a patient’s pelvis and, while it is being performed, the radiologist can see the need to also do a study of the abdomen. Getting paid for such additional services can be problematic, as many insurers won’t permit a retro authorization, Milheim said.

Similar cases arise during surgery where a specific procedure has been authorized. The surgeon may spot an additional issue that needs be addressed during the operation. Even though the additional procedure is beneficial to the patient, the surgeon may have trouble getting paid for the additional procedure.

Ohio passed a PA-reform in 2016 and includes provisions that took effect this year. These include mandates that a web-based system be used rather than faxes and that there be a 10-day turnaround on requests. Milheim said their cases are averaging 11 days, with some payers routinely taking as long as 13 days.

She said the Cleveland Clinic is calling for “adherence and enforcement” of these and other provisions in the new law. That sentiment was echoed by Ohio State Medical Association spokesman Reggie Fields.

“We feel very confident with the new provisions in the process,” he said. “The key is to get them enforced.”

OSMA encourages “members to report any problems to us or directly to the Ohio Department of Insurance,” Fields said.