From: Josie Ives
To: OIC Rules Coordinator
Cc: Teri Mayo, LMP; soapsage@comcast.net; manager@mayotherapy.com
Subject: Comments on Prior Authorization
Date: Friday, June 17, 2016 10:40:05 AM

Dear Jim,

Thank you for asking for comments regarding rulemaking for the prior authorization process of insurance companies in Washington State. I have been helping massage therapists in Washington bill insurance for 5 years, and I would like to offer the following feedback:

What has not worked in streamlining prior authorization?

At times, Regence and Care Core National do not keep their benefit information in sync. I have seen several cases where the Care Core site says the patient does not require prior authorization; but the claim gets denied later because it turned out that they actually did need authorization, but Care Core and/or Regence did not keep their benefit and eligibility information up to date on the Care Core website. This places an undue burden on providers, because they have to maintain a database of evidence that they did try to obtain prior authorization, in the form of screenshots and printouts; in addition to the extra time it takes for an appeal to be reviewed and processed.

When a claim is denied for this reason, the provider must go through the appeals process. I believe that this rule should be changed. A provider should not have to go through the appeals process and wait 60-90 days for payment because the insurance company and third party authorization administrator failed to communicate information. The appeals process can be lengthy and result in up to a 90 day waiting period for claims processing. The rule should be changed for the following reasons:

Most providers who accept insurance are extending credit to their patients for around 60 days on average, and this is the best case scenario for clean claims. This 60 days includes the 1-2 weeks it takes to bill the insurance, then wait 30 days for the claim to be processed, and then the patient to be billed for their responsibility. This turnaround time is already lengthy, but a denial and appeal represents an additional 60-90 days. This means it could take a provider up to 120-150 days to recover an accounts receivable, in the form of a deductible amount or copay, from a patient.

I have seen in my billing practice, and I think many providers would agree, that the recovery rate for an accounts receivable decreases drastically after 90 days. Patients who receive a bill 120 days after the date of service are more likely to question the credibility of the provider than that of the insurance company. It is a matter of perception, but it does create a barrier to providers in getting paid; providers who are relying heavily on their ability to collect accounts receivable in order to stay in business. There is also the additional administrative cost to consider.

My suggested solution is that those claims that have been denied for lack of pre authorization, where the provider can produce evidence that an attempt to obtain pre authorization was made, and it was stated by the Care Core website that pre authorization was not required, must be able to bypass the appeals process and be expedited to match the typical claims

proccessing time of 30 days from filing. There should be a system in place for reprocessing where customer service reps can access the provider's evidence without having to send the provider through the appeals process. There should also be stiffer penalties for the insurance company who does not keep their benefit information up to date, or fails to facilitate the transfer of information where it results in an undue financial and administrative burden on the provider.

I can provide specific cases that went to the appeals department at Regence Blue Shield if neccessary.

Thank you very much for your attention to this letter.

Sincerely,

Josie Parkhurst
Empower Billing

empowerbilling.com