SAN DIEGO: AUDIT & MANAGEMENT ADVISORY SERVICES
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October 4, 2016

LAURA HANDY OLDHAM
Executive Director, Revenue Cycle
UC San Diego Health
8911

Subject: ***Authorization Management Processes***
Report 2016-19

The final report for Authorization Management Processes Report 2016-19, is attached. We would like to thank all members of the department for their cooperation and assistance during the review.

Because we were able to reach agreement regarding management action plans in response to the audit recommendations, a formal response to the report is not requested. The findings included in this report will be added to our follow-up system. We will contact you at the appropriate time to evaluate the status of the management action plans.

UC wide policy requires that all draft reports be destroyed after the final report is issued. We also request that draft reports not be photocopied or otherwise redistributed.

David Meier
Director
Audit & Management Advisory Services

Attachment

cc: Margarita Baggett
David Brenner
Judy Bruner
Lori Donaldson
Chris Longhurst
Patty Maysent
Pierre Ouillet
Cheryl Ross
Sheryl Vacca
Keri Whitehead

UC San Diego

AUDIT & MANAGEMENT ADVISORY SERVICES

Authorization Management Processes
Report No. 2016-19
October 2016

FINAL REPORT

Performed By:

Mareline Godfrey, Auditor
Christa Perkins, Manager

Approved By:

David Meier, Director

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I. EXECUTIVE SUMMARY

Audit & Management Advisory Services (AMAS) has completed a review of Authorization Management Processes as part of the approved audit plan for Fiscal Year 2015-16. The objective of our review was to determine whether internal controls provide reasonable assurance that processes for obtaining authorizations for medical services are effective, in compliance with policy, and support downstream revenue cycle functions

We concluded that internal controls in certain UCSDH authorization units provided reasonable assurance that processes for obtaining authorizations for medical services were effective to support downstream revenue cycle functions. However, due to varying operational needs and demands of departments and specialty clinics, the structure and processes for securing authorization for services varied widely among clinics and medical specialties, which contributed to inconsistencies in obtaining and documenting information necessary in the financial clearance process. It did not appear that the *Patient Financial Policy* requirement for standardized processes was fully achieved.

The variation in processes for obtaining authorizations results in various operational inefficiencies. Downstream, the impact of inefficient or ineffective processes for obtaining authorizations is noted in the revenue cycle, in particular in denied claims. The establishment of standards on workflow and documentation requirements, and increased training for units processing authorizations, could help standardize UCSDH practices to achieve compliance with policy. We also noted that FCC implemented several best practices that would be beneficial if adopted by other authorization units at UCSDH.

Management Action Plans to address these findings are summarized below:

A. Volume and Aged Referrals or Auth/Certs in Work Queues

1. FCC management will coordinate with Information Systems (IS) and department management to assign resources as appropriate to review WQs and clean up Referrals or Auth/Cert cases that have remained in WQs for longer than intended.
2. FCC management is in the process of developing standardized processes, optimizing Epic workflows, and creating efficient staffing models, for UCSDH authorization units. This should include practices for managing WQ volume and standards for number of days a Referral or Auth/Cert should remain active or pending in a WQ.

B. Documentation Standards

Revenue Cycle and FCC Management will incorporate standards for documentation in the initiative to develop standardized processes for all Referrals and Auth/Certs.

C. Inconsistent Use of Assigned Authorization WQ

FCC management is in the process of developing standardized processes, optimizing Epic workflows, and creating efficient staffing models, for UCSDH authorization units.

D. Definition of Responsibility For Obtaining Authorizations

1. FCC Patient Access Management is working on redesigning WQs and process work flows for

specialty areas that are currently transitioning to the FCC Centralized Authorization. The redesign is aimed at providing clarity and definition in the assignment and monitoring of responsibilities.

2. FCC Patient Access management has assembled a workgroup that is currently in the process of prioritizing departments for evaluation of authorization work flows at the department level. The workgroup also assists in standardizing and optimizing work flow and WQ design that would generally meet the goal of securing and appropriately documenting authorization by the responsible department authorization specialists prior to scheduled service.

Observations and related management action plans are described in greater detail in section V. of this report.

II. BACKGROUND

Audit & Management Advisory Services (AMAS) has completed a review of Authorization Management Processes as part of the approved audit plan for Fiscal Year 2015-16. This report summarizes the results of our review.

As a component of the financial clearance process, authorization for services, if applicable, must be obtained in accordance with the UCSD Health (UCSDH) Patient Financial Policy (Medical Center Policy (MCP) 750.1). Authorizations may be obtained prior to services, during an admission, or retroactively for services rendered. The Authorization function at UCSDH is largely decentralized due to varying operational needs of the different departments and medical specialty services. Authorizations are generally obtained as follows:

- Patient Access Financial Clearance Center (FCC) processes authorizations primarily for hospital inpatient admits (including General Surgery, and Burn unit) and Radiology.
- Clinical Practice Organization (CPO)[1] Central Authorization[2] processes authorizations primarily for follow-up consults and some outpatient visits and laboratory services for Medicine specialties and a few other departments (such as Dermatology, Gynecology, Neurology, and Ophthalmology);
- Various departments have centralized authorization functions internally (examples include Cardiology, Interventional Radiology, Orthopaedics and Surgery)
- Other departments have decentralized authorization functions, where the authorization is obtained by administrative staff in each clinic location as a component of the patient registration and appointment scheduling process, performed by one or more individual specialists, or coordinated with another group. Authorization for initial consult services are usually performed by the referring clinic or specialty.

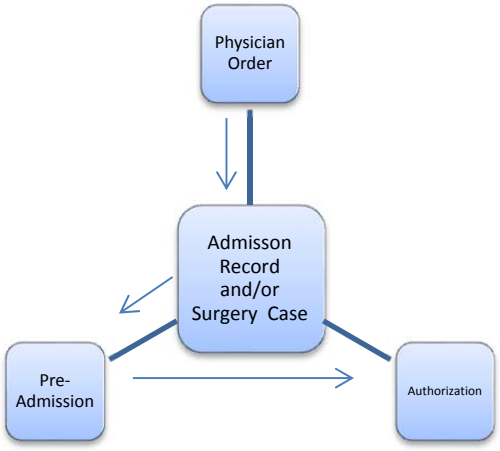
Several process improvement efforts have been initiated in recent years. An external consultant assisted Radiology in improving authorization processes, and in 2015 FCC initiated a process improvement project with special focus on identifying and eliminating inefficiencies and improving process flow for obtaining authorizations. New guidelines and standards were established which now serve as baseline and model for the FCC centralized authorization function. The authorization function for some decentralized units is being transitioned to FCC management.

In general, an authorization for services is generated from physician orders. Authorization Certification for Pre-admission and Surgical procedures[3] (Auth/Cert) begins from the patient admission record[4] where the Auth/Cert record is created for processing and documenting authorization. Prior to the

[1] Previously referred to as Medical Group Business Services.
[2] A separate CPO authorization team also processes authorization for Managed Care. The CPO Authorization unit is currently in transition to the FCC Central Authorization.
[3] For Surgical Procedures and/or Inpatient Services, a physician Order automatically creates the Surgery Case and/or Admission record in Epic. The Admission record is not dependent on the appointment. Surgical Procedures may also be Inpatient or Outpatient.
[4] The existence of a patient admission record in Epic does not mean the patient is currently admitted.

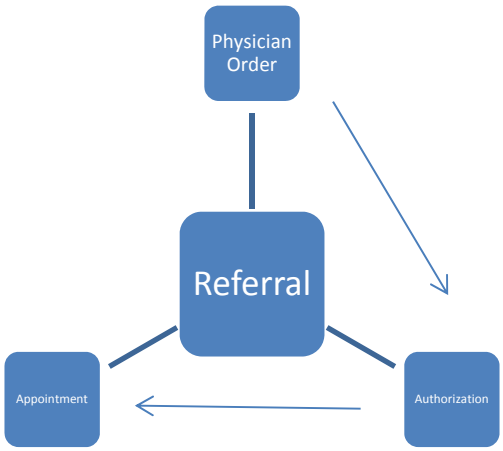
processing of an authorization and completion of the Auth/Cert, pre-admission needs to be confirmed[5] (see Figure 1 below). The Authorization result is documented as pre-cert status, which dictates the need for an Authorization number[6]. For example, if the surgery or admission is authorized as "Approved (e.g. inpatient, outpatient, or observation)" the pre-cert status should indicate this, which will require an authorization number.

Figure 1



For Outpatient visits and Consult services (Referrals), a physician order is required, and once authorization is secured, the appointment scheduling process can begin (see Figure 2 below).

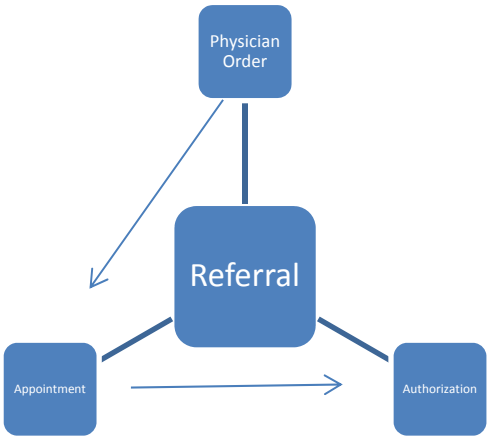
Figure 2[7]



[5] To confirm pre-admission requires that registration is complete and a hospital account is created. Any error or missing registration information needs to be corrected/completed.
[6] The Authorization number can be entered in the Authorization Number field, or Pre-Cert Number field.
[7] Patient registration record is created/completed during the appointment scheduling.

For certain specialties that do not use Epic, an interface is required to communicate data and process back and forth, or the interface requires a different route. As an example, Radiology work flow (Figure 3) requires that appointment scheduling takes place prior to securing service authorization.

Figure 3[8]



Authorization work flows at UCSDH are currently designed based on various factors, including insurance type, visit type, system workflow interface, clinic location, billing area, and even by physician, or type of patients. For instance, the type of visit – whether it is a return, follow up, or new visit – may have a different work flow that would dictate whether authorization is required. Some clinic specialties have work flows set up based on billing area which does not indicate when the authorization is required, but where it is processed.

Because the authorization process is connected to another function, such as scheduling, how each component is carried out also affects the work flow. For example, one department may have specialists that work all those components, and others may have specialists dedicated to only work one or more functions. User knowledge and understanding of the relationship between each record linked, and importance of the information entered in the data fields are key to ensuring records flow to the intended recipient for the next part or completion of the process.

The *Patient Financial Policy* states "The ability to complete the financial clearance process (which may result in the patient being financially cleared or not prior to service) depends in part on the physician (or designee) and the patient working with the Financial Clearance staff to provide necessary information timely. This process may change over the course of a patients care and may need to be repeated throughout a course of therapy."

The policy further states that appropriate UCSDH staff, including hospital assistants, medical assistants, and authorization specialists, designated to secure authorization for services will attempt to secure authorization, either pre-service, during an admission or retroactive to the services rendered or to be rendered. While this function is not centralized, the policy states it is also the expectation that securing of the authorization is standardized across UCSDH.

[8] For Referrals, a physician Order automatically creates a Referral record. In this work flow, however Referrals could also be created from Appointment schedule.

III. AUDIT OBJECTIVE, SCOPE, AND PROCEDURES

The objective of our review was to determine whether internal controls provide reasonable assurance that processes for obtaining authorizations for medical services are effective, in compliance with policy, and support downstream revenue cycle functions.

In order to achieve our objective, we performed the following:

- Reviewed a matrix for summarizing functional areas of responsibility obtained from Patient Access to identify centralized and decentralized units performing authorization and related functions;
- Reviewed Patient Financial Policy (MCP) 750.1;
- Interviewed the following to gain an understanding of the processes related to authorizations:
  - FCC Patient Access Unit Manager for FCC Central Authorization,
  - CPO Centralized Authorization Unit Manager,
  - Clinic Managers for certain areas with centralized departmental authorization units, including Cardiology, Interventional Radiology, Orthopaedics, and Surgery
  - Clinical Director for Pulmonary which is one of the areas with decentralized departmental authorization units and Specialists performing full spectrum of clinic administrative functions such as registration, appointment scheduling, and authorization,
  - Information Systems Programmer Analyst involved with Authorization Work Queue (WQ) design;
- Performed process walk-through for authorization functions performed by assigned coordinators or individuals in selected centralized and decentralized authorization units specified above;
- Reviewed training and training materials provided to individuals with authorization responsibilities for Authorization/Certification for Inpatient and Surgical Procedures, as well as Referral Authorization for Outpatient and Consults;
- Evaluated a sample of 46 WQs used by the units above to evaluate volume and number of days a Referral or Auth/Cert stays in the WQ;
- Evaluated a sample of 21 authorization cases completed and closed in January 2016, 25 deferred cases, and 13 cases that were pre-authorized in June 2016; and
- Examined WQ history for selected completed, deferred, and pre-authorized work queues.

IV. CONCLUSION

Based on our review, we concluded that internal controls in certain UCSDH authorization units provided reasonable assurance that processes for obtaining authorizations for medical services were effective to support downstream revenue cycle functions. However, due to varying operational needs and demands of departments and specialty clinics, the structure and processes for securing authorization for services varied widely among clinics and medical specialties, which contributed to inconsistencies in obtaining and documenting information necessary in the financial clearance process. It did not appear that the *Patient Financial Policy* requirement for standardized processes was fully achieved.

The variation in processes for obtaining authorizations results in various operational inefficiencies. We noted that some WQs used in the authorization process had extremely large volume of cases, including some remaining in WQs for over 6 months, which can be difficult to manage. Also, documentation of notes and key information for each account on the Referral or Auth/Cert appeared to be inconsistent. Authorization management can be further complicated by related processes such as patient registration, appointment scheduling, or preadmission requirements in Epic, particularly if not completed appropriately or timely in Epic. We also identified opportunities for improvement in defining ownership and functional responsibility for department's authorization team. The establishment of standards on workflow and documentation requirements, and increased training for units processing authorizations, could help standardize UCSDH practices to achieve compliance with policy.

Downstream, the impact of inefficient or ineffective processes for obtaining authorizations is noted in the revenue cycle, in particular in denied claims. AMAS recently completed a review of Claim Denials Management (project 2016-31), and information obtained during that review indicated that denials due to authorization issues was a significant area of focus under review by Patient Access and Revenue Cycle Continuous Improvement. For example, data from July 2016 indicated that in the previous 6-month period, denials due to authorization issues averaged $4.41 million, approximately 5.5% of total impactable denials.

We also noted that FCC documented standardized procedures and guidelines for authorizations managed by that unit aimed to reduce inefficiencies previously identified with the department authorization function. Some best practices in FCC that would be beneficial if adopted by other authorization units at UCSDH included:

- 72-Hour Notification – Contacting a patient 72 hours in advance of a scheduled service to inform if an authorization has been denied allows time for the clinics or departments to work with the patient to either cancel, reschedule or proceed with the appointment without authorization.

- Quality and Performance Monitoring – FCC Central Authorization monitors and measures productivity based on how many accounts were reviewed/processed by the WQ owner or authorization specialist. Productivity includes accounts submitted to insurance for authorization, or following up on an account that is pending. This data is compared with Healthcare Financial Management Association (HFMA) Industry Best Practice Standards and UC and Industry Average. Productivity measures allow managers/supervisors to identify staff training or support needs.

- Quality Review (QR) – The use of quality data allows managers to analyze and review accounts marked as STAT or Urgent to analyze, address and isolate issues requiring immediate attention. QR allows managers to monitor the volume and type of accounts with STAT or Urgent designation, and also identify issues with false or incorrect STAT or Urgent designation as those accounts would require top priority for the authorization team. Other performance metrics reviewed and regularly monitored by managers and supervisors include authorization secure rates, denials, and days out.

- Payer Guidelines – Payer guidelines have been established which determine how far in advance appointments should be scheduled to allow time for FCC to obtain authorization. While this may not be applicable to certain medical specialty services, aligning the scheduling process with expected payer response timelines could help reduce rescheduling, cancellation and patient complaints when routine appointments were scheduled sooner than payers could provide authorization.

Observations and opportunities for improvement are discussed in the remainder of this report.

V. OBSERVATIONS REQUIRING MANAGEMENT ACTION

A.	Volume and Aged Referrals or Auth/Certs in Work Queues
Several Referral or Auth/Cert cases requiring action and/or update remained in WQs for three months to more than 365 days, which further increased the volume of cases in the WQ.	
Risk Statement/Effect	
Cases remaining in WQ for longer periods could result in unmanageable WQs or unresolved authorization-related issues that affect downstream revenue cycle processes and/or patient satisfaction.	
Management Action Plans	
A.1	FCC management will coordinate with Information Systems (IS) and department management to assign resources as appropriate to review WQs and clean up Referrals or Auth/Cert cases that have remained in WQs for longer than intended.
A.2	FCC management is in the process of developing standardized processes, optimizing Epic workflows, and creating efficient staffing models, for UCSDH authorization units. This should include practices for managing WQ volume and standards for number of days a Referral or Auth/Cert should remain active or pending in a WQ.

A. Volume and Aged Referrals or Auth/Certs in Work Queues – Detailed Discussion

Work Queues are used for tracking, acquiring, and accessing records to create or complete related function. There are different types of WQs used by authorization specialists or team and are designed based on user needs and interface, context and access to records. The most common types are described in the table below:

WQ Type	Description
Referral WQs	Designed for working on scheduled orders (Referral Scheduling WQ) or unscheduled orders (Referral Authorization WQ) requiring review and update or on the status of authorization.

WQ Type	Description
Surgical Pre-Admission WQs	Designed for working on scheduled procedures or surgeries requiring review and update on authorization the status of authorization.
Patient WQs	Designed for working on identifying missing authorizations based on a scheduled visit or preadmission.

WQs for performing authorization functions could be assigned to one or more authorization specialist in a department or a central authorization unit.

On the Auth/Cert form in the Admission record, the Pre-Cert status indicates a pending status for case until authorization is secured, and authorization number is assigned and documented on the Auth/Cert form. Once authorization is secured and documented, Auth/Cert status is updated by accepting the completed action and removes the case from the WQ. Similarly, Referrals for outpatient services stay in the WQ until authorization is approved, denied, or cancelled, and status is accepted after completing all of the required fields.

The WQs used by authorization specialists include a list of active and pending or deferred cases requiring action to complete the authorization process. New cases are added each day, and completed cases are removed from the WQ when all required fields are filled and accepted. Authorization specialists may defer a case requiring additional action or awaiting result to clear it from active list, or keep the pending items on the active list, and only defer a case when it was a misrouted Referral and/or requires additional information. If there are changes to a completed Referral or Auth/Cert that had been removed from a WQ, such as when a new CPT is added, or a change in insurance payer, or assigned to a follow-up visit, the Referral will be added back to the active list with a pending status. There are also Referrals and Auth/Certs that have auto-approved status based on the insurance payer or procedure code, or visit type. In those cases, the Referral or Auth/Cert stays in active list for review by a specialist, and will drop out of the WQ once status is accepted.

The WQ displays various information, including age and number of days a case has been in the WQ, and volume of new, pending or authorized cases remaining in the active and deferred list. In order to evaluate controls in managing WQs, we reviewed a judgmental sample of WQs to analyze volume and the aging of cases. The WQs below were noted to have either large volume, or cases aged 6 months or greater.

Sample	WQ#	WQ Type	Owner	Total Active	Total Deferred	Oldest Day in WQ
1	2701	Patient WQ	Surgery	1605	23	744
2	1968	Patient WQ	FCC PA	920	0	
8	2848	Patient WQ	FCC PA	1259	18	
31	1325	Patient WQ	Orthopaedics	94	213	508
32	2945	Referral WQ	Surgery	394	36	361
35	1237	Patient WQ	Medical Grp	485	0	497
36	1238	Patient WQ	Medical Grp	821	0	831

Sample	WQ#	WQ Type	Owner	Total Active	Total Deferred	Oldest Day in WQ
37	1239	Patient WQ	Medical Grp	266	0	266
38	1339	Patient WQ	Medical Grp	745	0	745
39	3177	Referral WQ	Pulmonary	317	51	281
40	1408	Referral WQ	Pulmonary	2	0	808
43	1411	Referral WQ	Pulmonary	11	0	232
44	1656	Referral WQ	Pulmonary	260	0	506
45	1187	Referral WQ	Cardiology	969	192	182
46	1353	Referral WQ	Interventional Radiology	246	0	363

Except for two WQs, FCC Central Auth WQ's appear to be well managed in volume and age of referrals. One WQ had over 1200 active cases. However, this WQ could include accounts that were automatically "authorized" in the system based on the origin of the order (e.g. ER), nature of the procedure or visit (multiple follow-up visits), and/or insurance coverage (e.g. Medicare).

During interviews, units reported different strategies for managing volume in WQs. One unit in particular indicated that the volume of services and ability to manage the active WQs was challenging. There are about 135 patients seen per day on average at this location. Between all the functions that the clinical administrative staff performed, staff indicated it was nearly impossible to track whether prior authorizations for all services performed were obtained.

High volumes of accounts or cases remaining in the WQ for longer than intended contributes to unmanageable work load and difficulty in finding a specific account for status review or update, particularly when the WQ is assigned to more than one authorization specialist, which adds to the time it takes to work on accounts or cases assigned to specific authorization specialists.

B.	Documentation Standards
Documentation of notes and key information for each account on the Referral or Auth/Cert appeared inconsistent among Authorization units or assigned individuals.	
Risk Statement/Effect	
Inconsistent and incomplete documentation and completion of required fields could result in misrouting referrals and/or duplicate referral entries that affect authorization work flow and timeliness.	
Management Action Plan	
B.1	Revenue Cycle and FCC Management will incorporate standards for documentation in the initiative to develop standardized processes for all Referrals and Auth/Certs.

B. Documentation Standards – Detailed Discussion

Clear, concise, and complete documentation is pertinent to billing and revenue cycle, as well as patient service. Consistency in documentation includes timeliness and frequency of documenting actions on cases or accounts worked, as well as the use of standard abbreviations or smart texts. Appropriate notes should only state facts regarding a communication such as when contacting the payer or patient, and must be placed in appropriate location, screen or field. As multiple departments and/or users access patient accounts and information, it is important to keep information and documentation up to date at all times.

Each Referral or Auth/Cert includes data fields and records that are used to move the flow to the next process or user, or communicate a status or next action required. For example, a scheduling status "Ready to Schedule" moves the Referral record to a Scheduling WQ, an "Approved" status requires authorization dates, or a Pending status requires a pend reason. In order to properly route a record or form, appropriate data fields should be completed in a timely manner. Incorrect data or fields used in documenting communication or status could route the Referral or Auth/Cert to the wrong WQ. Misrouted accounts or cases require additional time to research and make adjustments, or could result to creation of unnecessary duplicate records.

During our review, we noted that departments or specialists responsible for securing authorization and updating the Referral or Auth/Cert did not have an established guideline or standard documentation process. We reviewed 21 completed Referrals for the month of January 2016 and noted the following inconsistencies in documentation:

Criteria[9]	Observations	Number of Exceptions
A note is required whenever patient or payer is contacted	Missing Notes	14
Authorization number is required for all valid and authorized service coverage	Authorization Number field was not completed	10
Authorization Number field should not be used for authorization reason	Authorization number field included text "no-auth-required"	3
Authorization reason is required except if "no-auth-needed" or auto-closed at EOD	Reason for Authorization was not completed or selected	6
Cancel reason is required if account is closed due to patient cancelling or declining service	Reason for Cancel was not completed or selected	1

We also noted two accounts for which the "Referred by" department or specialty was not completed. While it matters less than "Referred to" department in routing the Referral to the right WQ, information about the referring department could facilitate obtaining required information that was not completed by the origin of the Referral or Auth/Cert.

During interviews, we also noted that responsible staff were not properly documenting information in Epic. Some staff held on to a paper document until authorization was secured, then the specialist

[9] Based on available training materials.

updated the case status in the system as “authorized." In some cases, such as when schedulers or clinic staff scheduled a visit, the required information such as insurance eligibility or procedure codes were not indicated or attached, or incorrect or expired insurance plan was entered.

While the training materials provided to staff include some documentation standards or choices, flexibility and options were available in the system. However, inconsistency in documentation could result to delays in processing an account or identifying required information necessary for securing a service authorization. The establishment of minimum documentation standards could improve standardization in the authorization process, consistent with the requirement from the *Patient Financial Policy*.

C.	**Inconsistent Use of Assigned Authorization WQs**
Authorization specialists in some departments may not be using assigned Authorization WQs when processing Referral accounts.	
Risk Statement/Effect	
Inconsistent use of appropriate WQs assigned to staff or units obtaining authorizations could result in unnecessary creation of duplicate accounts, and/or accounts aging in the same WQ when the Referral had not been attached/linked to a visit, reviewed or updated.	
Management Action Plans	
C.1	FCC management is in the process of developing standardized processes, optimizing Epic workflows, and creating efficient staffing models, for UCSDH authorization units.

C. Inconsistent Use of Assigned Authorization WQ – Detailed Discussion

During interviews, we noted inconsistencies in workflow impacted the processing of authorizations in the system which could result in missed authorizations. Some Authorization specialists did not utilize their assigned Referral Authorization WQ consistently to access and work on accounts for securing authorization. Instead, staff would work from a Referral Scheduling WQ (which shows appointments scheduled), or a paper log from a daily appointment schedule. However, this was problematic because these views may not show all scheduled cases that have a referral in the system to trigger requirement for authorization. Cases pending review by authorization staff but not yet scheduled may go unnoticed, and result in delays in coordinating patient care.

The reason that several staff indicated they obtained authorizations based on the schedule is that they felt that not all scheduled cases would appear in their assigned authorization WQ. This could occur if a clinic staff member scheduled a visit without creating a Referral for authorization. The patient would appear on the schedule, but the system would not create a referral shell, and the requirement to obtain an authorization would not be triggered. As a workaround, some Authorization specialists used a Scheduling WQ to work on securing authorization for already scheduled services that may or may not appear in the Authorization WQ to avoid delays in patient visit.

WQs may look similar on the front end, however, the various data points and data drivers on the back end, particularly when each case is accessed and/or updated may present a challenge in the WQ in setting up performance metrics, or reviewing data. During interviews, it appeared that users did not have a full understanding of the importance of the data or information entered in each field and creating or linking appropriate patient records. In the same way, users assigned to perform authorization updates were focused on upcoming or completed visits that require authorization, and didn't fully understand the need to update or document authorization in the appropriate WQ.

D.	Definition of Responsibility For Obtaining Authorizations
In some areas we noted gaps or overlap in ownership and responsibility for obtaining authorizations, due to lack of clarity of functional roles between the authorization team and other staff within the same departments/specialty services, or between the referring department and department that will provide the service.	
Risk Statement/Effect	
Lack of well-defined roles and responsibility in the authorization process could result in confusion, overlapping and duplicative actions, and lack of accountability. In addition, the ability to improve efficiency and timeliness in securing authorization is impacted. Downstream, this could also affect revenue flow and patient satisfaction.	
Management Action Plans	
D.1	FCC Patient Access Management is working on redesigning WQs and process work flows for specialty areas that are currently transitioning to the FCC Centralized Authorization. The redesign is aimed at providing clarity and definition in the assignment and monitoring of responsibilities.
D.2	FCC Patient Access management has assembled a workgroup that is currently in the process of prioritizing departments for evaluation of authorization work flows at the department level. The workgroup also assists in standardizing and optimizing work flow and WQ design that would generally meet the goal of securing and appropriately documenting authorization by the responsible department authorization specialists prior to scheduled service.

D. Definition of Responsibility For Obtaining Authorizations – Detailed Discussion

Generally, the ordering, or referring provider's department is responsible for collecting the authorization for patients sent to another specialty or service. However, in some cases we noted a lack of clarity for the responsibilities for obtaining authorizations, which can lead to confusion and missed or delayed authorizations. Examples we noted where the responsibility for obtaining authorizations was not clearly defined included:

- The CPO Authorization team processed and secured authorization for various clinic specialty services. In the past, Medicine specialty clinics were responsible for initial consults, and the

CPO Authorization team assisted by with securing authorization for follow-up consults. Over time, CPO support expanded to include some outpatient procedures, or laboratory services for other non-Medicine specialties in order to provide better customer service. This has led to even more expansion to the Referral scope, including follow-up visits from a number of other departments. Assigning a specific group separate from the department specialty to secure authorization presented even more complexities to the design of the CPO authorization work flow, to the extent that areas of responsibilities were no longer clearly defined. There was also no service level agreement for the service that would ensure clarity on responsibilities of either party in the process. One specific example we noted was the lack of clarity between Pulmonary and the CPO Authorization team. Issues with changes to the design of the Pulmonary WQs (which were initially based on clinic location, but have now been consolidated) contributed to this confusion.

- In Interventional Radiology (IR), Referrals or Auth/Certs that are the responsibility of IR as the clinic providing the service to obtain authorization, are routed back by IR authorization team to the referring clinics for securing authorization, apparently due to staffing constraints. This resulted in inaccurate and invalid authorizations due to misunderstanding of the requirements, and at times, misunderstanding on which area is responsible for securing authorization for the service. We also noted this was done for about 25% of all IR Referrals. IR Management indicated that this should be resolved when IR makes its transition to FCC Central Authorization as FCC has better staffing levels to accommodate this volume.

The lack of clear and defined ownership of responsibilities between the department and the authorization team results in overlapping work queues, which leads to delay in securing authorization, or updating a Referral or Auth/Cert documentation for timely communication with other functions, such as Scheduling, Admissions, or during the patient encounter.