UW HEALTH JOB DESCRIPTION

Authorization Representative

Job Code: 440031	**FLSA Status: Non-Exempt**	**Mgt. Approval: R Klein**	**Date: Nov. 2023**
Department: Rev Cycle – Financial Clearance		**HR Approval: B. Haak**	**Date: Nov. 2023**

JOB SUMMARY

The Authorization Representative supports patient access to procedures by obtaining prior authorization from payers for inpatient and outpatient services provided by UW Health. The Authorization Representative role is key to proactively securing reimbursement, minimizing organizational write offs, educating patients on UW Health Payment Collection Policy, identifying efficiency opportunities related to the prior authorization workflows, documenting of activities on all applicable software platforms including the electronic health record, and providing an accurate clinical patient review. The incumbent will assist in training prior authorization functions and serve as a resource to other departments with questions regarding prior authorizations. When an authorization cannot be obtained, the incumbent must be able to educate staff, providers, and/or patients on the options and complete the necessary steps to resolve the barriers to obtaining the prior authorization and/or to bring closure to the case.

The Authorization Representative must consistently demonstrate the use of critical thinking skills, skilled communication and troubleshooting techniques as well as have excellent customer service skills. This position will have the ability to anticipate and respond to a wide variety of issues/concerns, and the ability to execute tasks efficiently and effectively. The position requires the ability to independently plan, schedule and organize numerous tasks as this position directly impacts patient care, hospital, and physician reimbursement. A substantial portion of the normal duties of the incumbent requires proper judgment, sensitivity, and strict adherence to UW Health policy on confidentiality.

MAJOR RESPONSIBILITIES

Core Responsibilities:

- Confirms the need for an authorization and takes the appropriate actions to ensure the authorization is obtained.
- Submits clinical information to third party payers to secure coverage for all high-end services provided, including, but not limited to, surgical cases, imaging, in clinic procedures, diagnostic testing, rehab, orthotics and prosthetics.
- Tracks status of prior authorization requests from initial submission through final insurance determination.
- Verifies the basic patient/service information is available - the minimum data set for securing a prior authorization. If not present, initiates appropriate activity to obtain the required data set, such as missing coverage information, procedure, and diagnosis codes.
- Ensures coverage eligibility, deems if care is a covered service, determines if there are site of service or out of network restrictions, etc.
- Prioritizes the urgency of the authorization by anticipating the approximate time it may take to obtain the authorization from the insurance company, the complexity of the procedure and the scheduled date of service; follows up with insurance company to accelerate responses and expedite urgent/emergent authorizations.
- Evaluates or assists with the status of cases when the insurance company has denied payment to determine next steps; this may include building a case for appeal.
- Interacts with medical and professional staff to obtain appropriate clinical documentation for review; this may include referring stakeholders to a member of the clinical authorization team. Takes the appropriate actions when the authorization will not be provided in a timely manner; including escalation to leadership, the patients care team or the clinical authorization team.
- Determines if medical policy exists, and if possible, will ensure that a case meets payer requirements. When unable to discern if a case meets the medical policy, will escalate the case appropriately to the clinical authorization specialists or the patients care team.
- Understands the critical delineations of patient status (outpatient, inpatient and observation) based on payor regulations and participates in the appropriate decision making with the clinical team members such as care management, coding, or billing.
- Advises and coordinates with providers regarding problematic (i.e., high risk) admissions or any episode of service requiring additional attention.
- Communicates with patients when an authorization is not able to be secured, provides options, and de-escalates concerns when they arise relating to denials and/or cancellation of cases/procedures.
- Educates patients on payment expectation, collects pre-payments and verbal financial responsibility agreements, when necessary, for a patient to proceed with their care.
  Supports the single case agreement process by using critical thinking skills, and an ability to discern when these are needed, and then escalating appropriately, including ensuring follow up is completed.

UW HEALTH JOB DESCRIPTION

Customer Service Standards:

- Supports co-workers and engages in positive interactions.
- Communicates professionally and timely with internal and external customers.
- Provides helpful assistance in anticipating and responding to the needs of our customers.
- Collaborates with customers in planning and decision making to result in optimal solutions.
- Ability to stay calm under pressure and deal effectively with difficult situations.

ALL DUTIES AND REQUIREMENTS MUST BE PERFORMED CONSISTENT WITH THE UW HEALTH PERFORMANCE STANDARDS.

JOB REQUIREMENTS

Education	Minimum	High School Diploma or equivalent
	Preferred	Associate degree in business, Finance, Health Information Management, or a related field
Work Experience	Minimum	One (1) year of experience in healthcare, business, finance, or insurance related field
	Preferred	• One (1) year of experience in Healthcare Revenue Cycle that includes prior authorization. • Knowledge of CPT and ICD coding highly desired • Knowledge of Medicare and third-party payer regulations and guidelines highly desired • Knowledge of Epic Software, use of Rfax, and Calabrio Call System • Experience with payment collections
Licenses & Certifications	Minimum	
	Preferred	
Required Skills, Knowledge, and Abilities		• Maintains current knowledge of medical modalities as well as new protocols established for patient populations. • Solid understanding and knowledge of payer contractual requirements, registration workflows, and prior authorization requirements to ensure staff follow established procedures to maximize reimbursement and minimize write offs. • Excellent written and oral communication skills. • Maintains effective and cooperative working relationships with co-workers, leaders, clinical staff, and the public. • Must be detail oriented and accurate. • Ability to multi-task and prioritize tasks. • Displays an aptitude and willingness to learn new responsibilities. • Willingly accepts feedback. • Flexible and innovative. • Ability to problem-solve and work independently. • Displays a professional appearance. • Dependable and reliable in achieving goals. • Experience with use of personal computers in a home workspace. • Familiarity with medical terminology and abbreviations.

AGE SPECIFIC COMPETENCY (Clinical jobs only)

Identify age-specific competencies for direct and indirect patient care providers who regularly assess, manage and treat patients.

Instructions: Indicate the age groups of patients served either by direct or indirect patient care by checking the appropriate boxes below. Next,

	Infants (Birth – 11 months)		Adolescent (13 – 19 years)
	Toddlers (1 – 3 years)		Young Adult (20 – 40 years)
	Preschool (4 – 5 years)		Middle Adult (41 – 65 years)
	School Age (6 – 12 years)		Older Adult (Over 65 years)

JOB FUNCTIONS

UW HEALTH JOB DESCRIPTION

Review the employee's job description and identify each essential function that is performed differently based on the age group of the patient.

PHYSICAL REQUIREMENTS

Indicate the appropriate physical requirements of this job in the course of a shift. *Note: reasonable accommodations may be made available for individuals with disabilities to perform the essential functions of this position.*

	Physical Demand Level	**Occasional** Up to 33% of the time	**Frequent** 34%-66% of the time	**Constant** 67%-100% of the time
X	**Sedentary:** Ability to lift up to 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers and small tools. Although a sedentary job is defined as one, which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.	**Up to 10#**	**Negligible**	**Negligible**
	Light: Ability to lift up to 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may only be a negligible amount, a job is in this category when it requires walking or standing to a significant degree.	**Up to 20#**	**Up to 10#** or requires significant walking or standing, or requires pushing/pulling of arm/leg controls	**Negligible** or constant push/pull of items of negligible weight
	Medium: Ability to lift up to 50 pounds maximum with frequent lifting/and or carrying objects weighing up to 25 pounds.	**20-50#**	**10-25#**	**Negligible-10#**
	Heavy: Ability to lift up to 100 pounds maximum with frequent lifting and/or carrying objects weighing up to 50 pounds.	**50-100#**	**25-50#**	**10-20#**
	Very Heavy: Ability to lift over 100 pounds with frequent lifting and/or carrying objects weighing over 50 pounds.	**Over 100#**	**Over 50#**	**Over 20#**
Other - list any other physical requirements or bona fide occupational qualifications not indicated above:				

Note: The purpose of this document is to describe the general nature and level of work performed by personnel so classified; it is not intended to serve as an inclusive list of all responsibilities associated with this position.