AASM Preauthorization Survey
Regional Data Report, West

In May, the American Academy of Sleep Medicine conducted its first survey of private payer preauthorization protocols. The survey asked members to answer questions about the administrative burden created by preauthorization protocols for sleep testing. The AASM received responses from 38 members and accredited member centers in the West region. The data are not scientific and results have not been validated by a statistician. The survey results demonstrate the varying experiences AASM membership face with the burdens of preauthorization.

Responses Received For Each Payer

Responses Received from Each Payer	
Payer	Frequency
Aetna	16
Anthem	15
Premera Blue Cross	11
Cigna	27
Humana	1
Moda Health	8
United	22

Authorization Requirements by Test Setting

Members were asked to report whether each payer requires preauthorization for in-center sleep testing, out of center sleep testing, or both types of sleep testing. Aetna, Anthem, Premera Blue Cross, Cigna, Humana, Moda health and United require preauthorization.

Authorization Required - Test Setting*		
Payer	In-Center	OCST
Aetna	Yes	Yes
Anthem	Yes	Yes
Premera Blue Cross	Yes	Yes
Cigna	Yes	Yes
Humana	Yes	No
Moda Health	Yes	Yes
United	Yes	No
**Information was collected through each payer's website and authorization requirements are subject to change.*		

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Patient Information Required
Members were asked to report on patient information required to complete preauthorization for each payer.

Members reported that Aetna requires: BMI (n=1); Clinical (n=7); CPT Codes (n=2); Demographics (n=2); Epworth (n=1); History & Physical (n=1); ICD-9 Codes (n=2); and Office Notes (n=4).

Members reported that Anthem requires: BMI (n=1); Clinical (n=8); CPT Codes (n=1); Demographics (n=3); Epworth (n=2); History & Physical (n=4); ICD-9 Codes (n=1); and Signs & Symptoms (n=1).

Members reported that Premera Blue Cross requires: BMI (n=1); Clinical (n=4); CPT Codes (n=2); Demographics (n=3); Epworth (n=1); History & Physical (n=2); ICD-9 Codes (n=2); and Office Notes (n=4).

Members reported that Cigna requires: BMI (n=2); Clinical (n=13); CPT Codes (n=3); Demographics (n=7); Epworth (n=2); History & Physical (n=4); ICD-9 Codes (n=3); and Office Notes (n=8).

Members reported that Humana requires: no responses.

Members reported that Moda Health requires: Clinical (n=2); CPT Codes (n=2); Demographics (n=3); History & Physical (n=1); ICD-9 (n=7); and Office Notes (n=3).

Members reported that United requires: Clinical (n=8); CPT Codes (n=5); Demographics (n=5); Epworth (n=0); History & Physical (n=1); ICD-9 Codes (n=7); and Office Notes (n=3).

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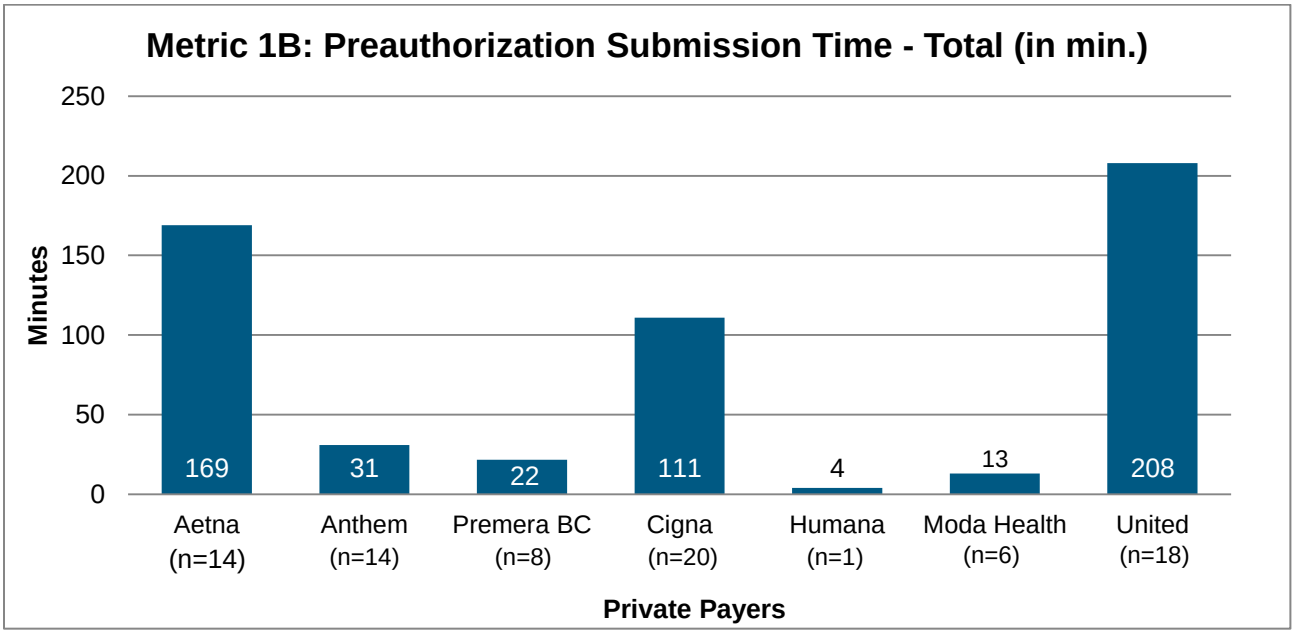
Preauthorization Submission Time
Members were asked to report on the amount of time it takes to complete each step of the preauthorization submission process for each payer.

Metric 1A: Preauthorization Submission Time
Description: How many minutes does it take to complete preauthorization tasks for the payer including: information collection, form completion and form submission?

Metric 1A: Preauthorization Submission Time (in min.)				
Payer	Collect Info	Complete Form	Submit Form	Total Time
Aetna (n=14)	147	15	7	169
Anthem (n=14)	12	14	5	31
Premera BC (n=8)	11	7	4	22
Cigna (n=20)	93	13	5	111
Humana (n=1)	2	1	1	4
Moda Health (n=6)	7	4	2	13
United (n=18)	191	11	6	208

Metric 1B: Preauthorization Submission Time – Total
Description: How much time does it take to complete all tasks related to submitting a preauthorization request to the payer?



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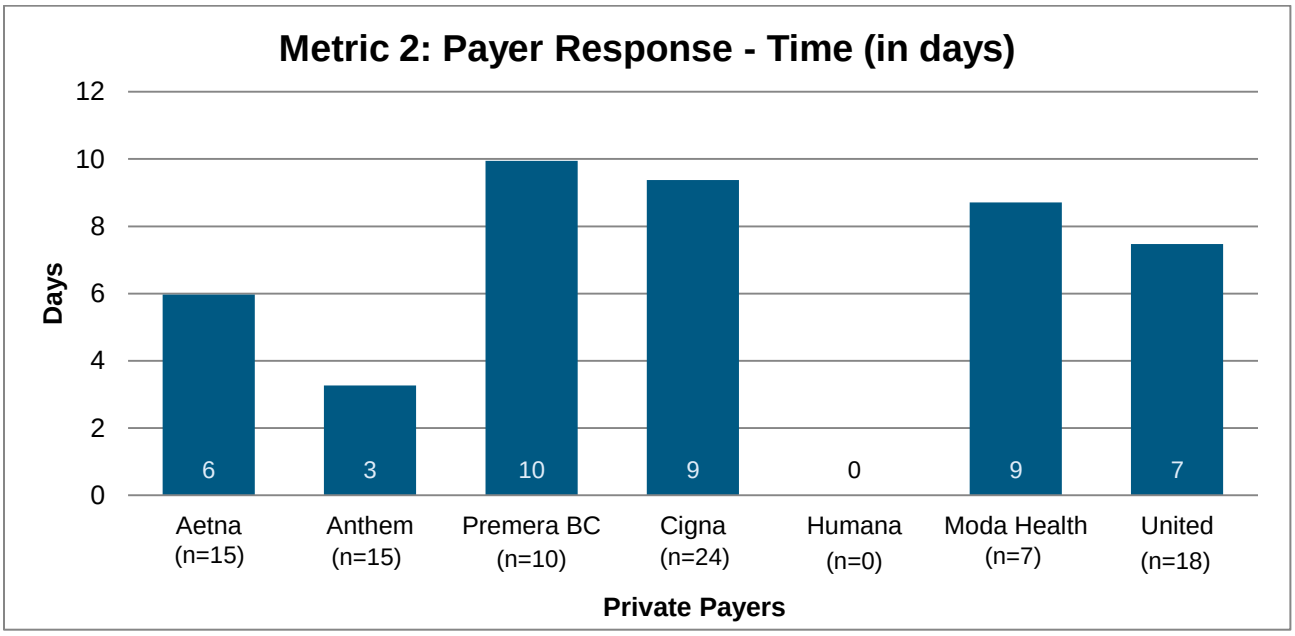
Payer Response

Members were asked to report on the number of days it takes to receive a response from payers regarding preauthorization as well as the frequency with which each payer denies in-center sleep testing and all types of sleep testing.

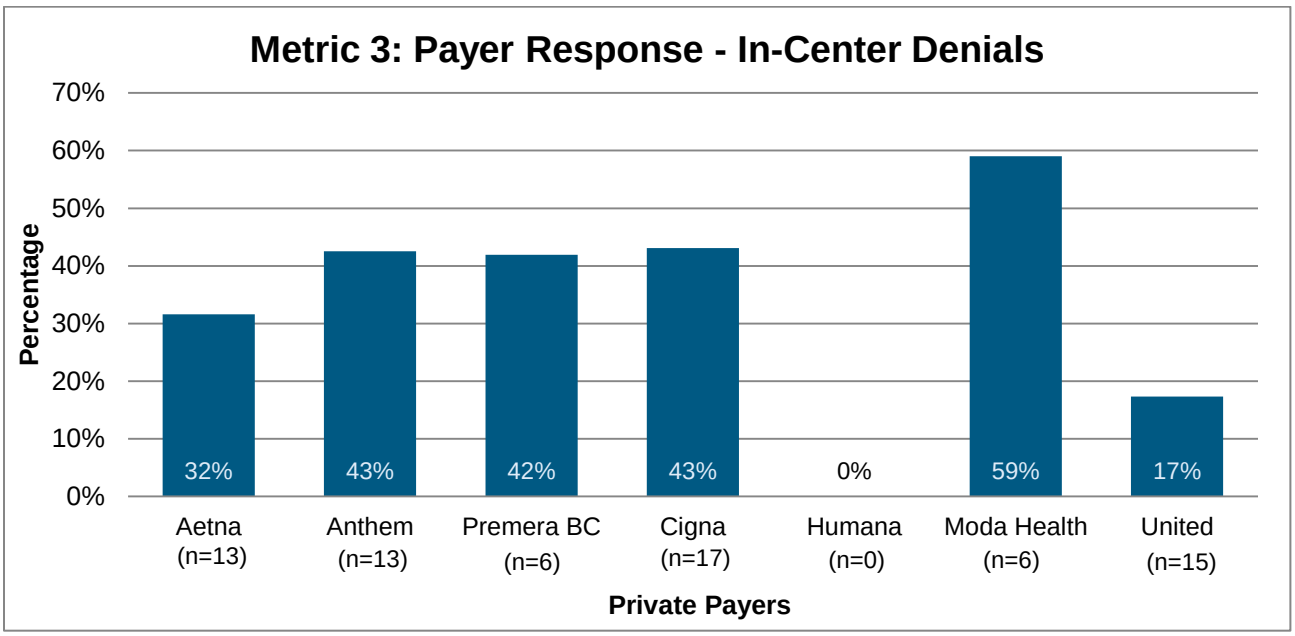
Metric 2: Payer Response – Time

Description: How much time does it take to receive a response from the payer to a preauthorization request?



Metric 3: Payer Response – In-Center Denials

Description: How frequently does the payer deny a request for in-center sleep testing?



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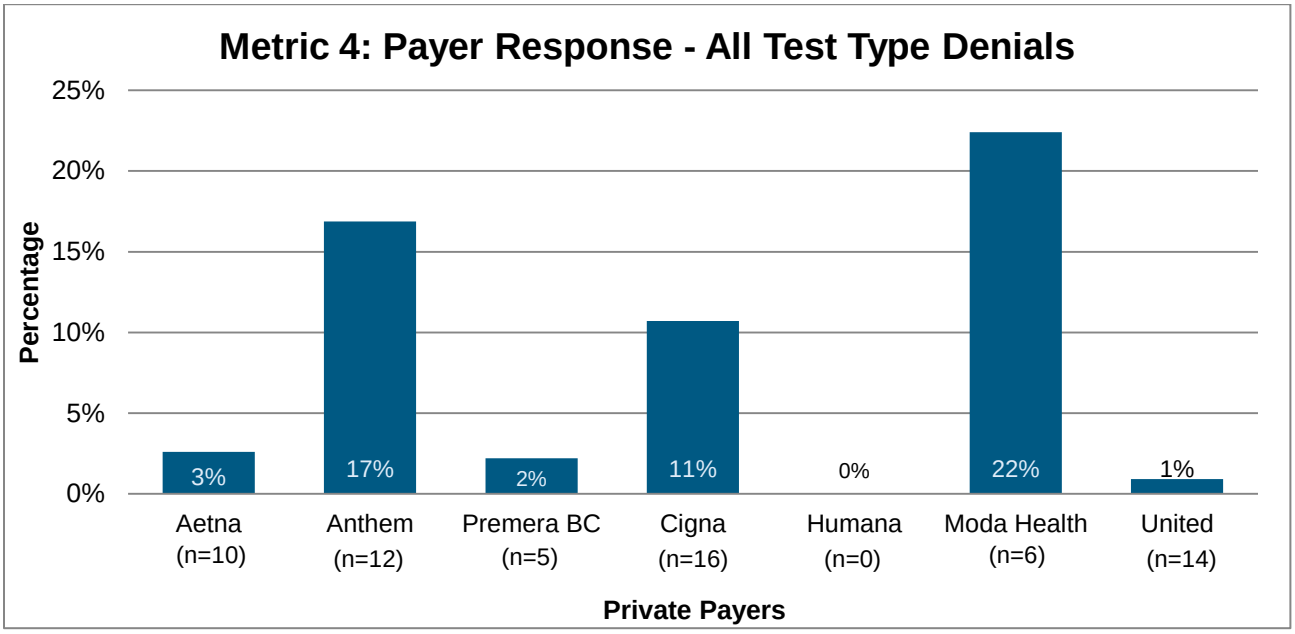
Metric 4: Payer Response – All Test Types Denials

Description: How frequently are all types of testing denied by the payer?



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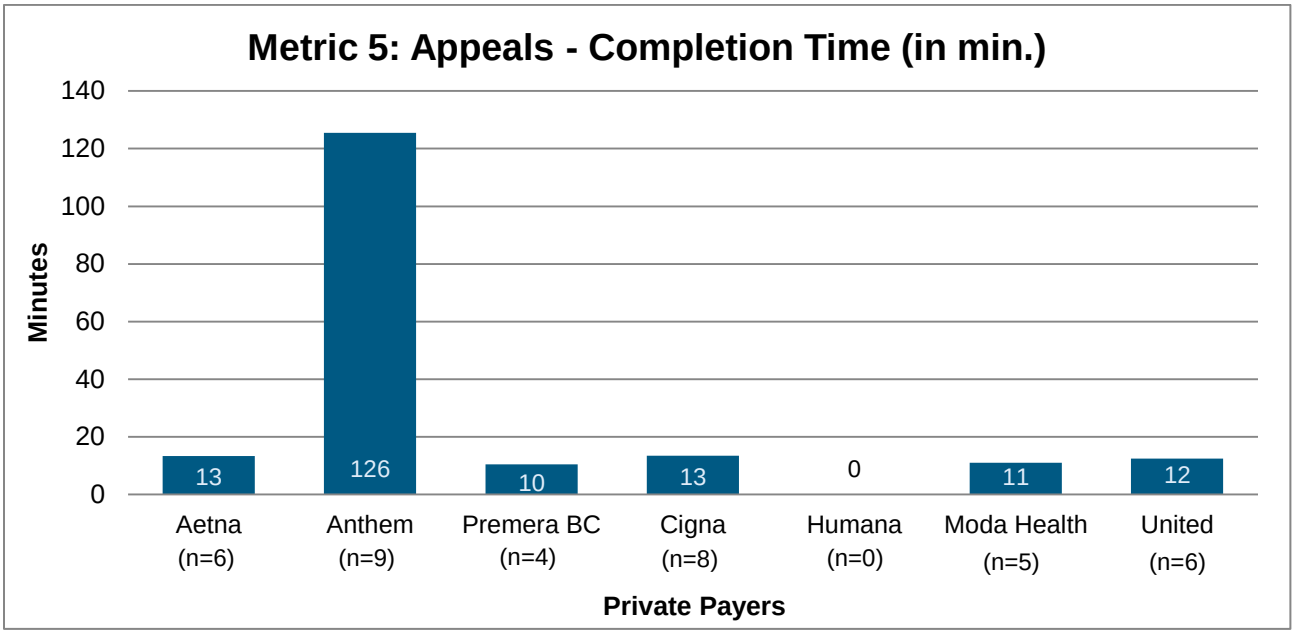
Appeals

Members were asked to report on the time it takes to complete an appeal for each payer as well as the time it takes to receive a response from each payer regarding an appeal. Finally, the percentage of appeals that are denied and approved was collected.

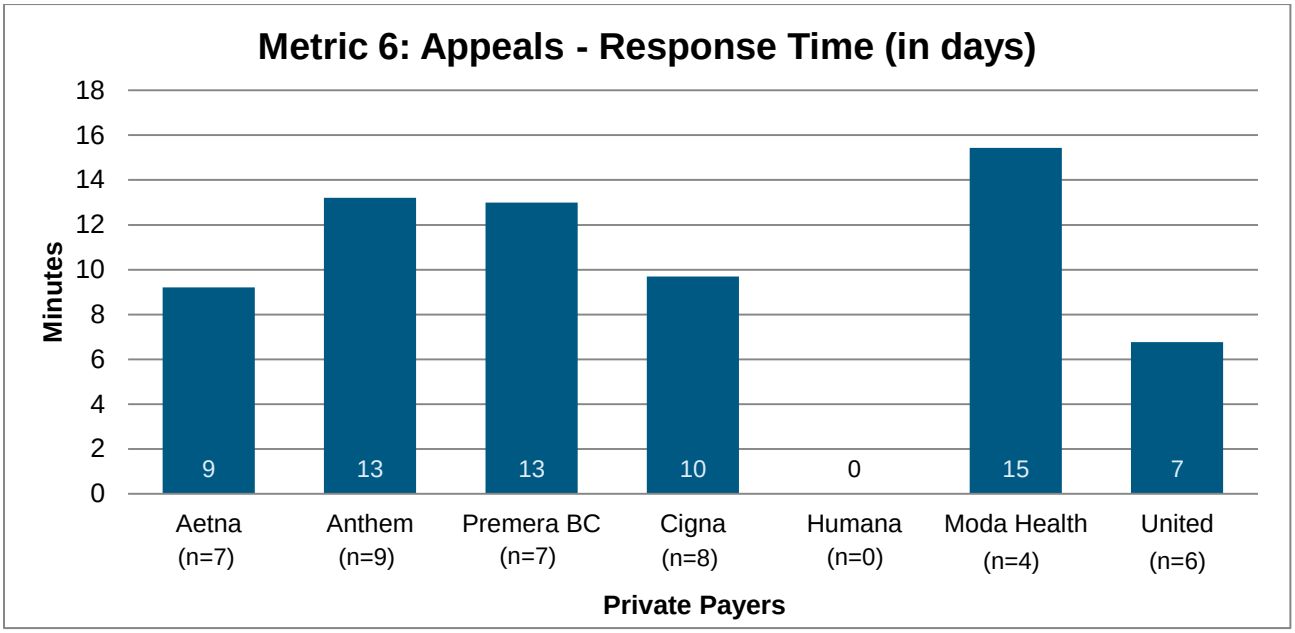
Metric 5: Appeals – Completion Time

Description: How long does it take to submit an appeal to the payer?



Metric 6: Appeals – Response Time

Description: How long does it take to receive a response from the payer regarding an appeal?



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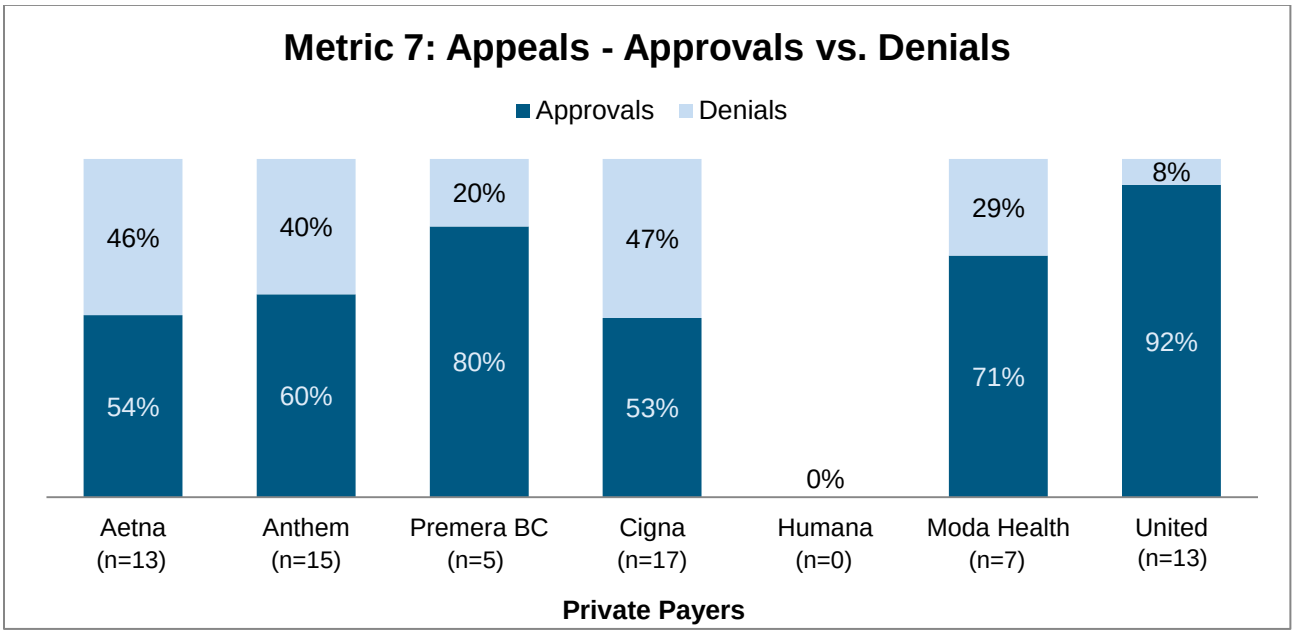
Metric 7: Appeals – Approvals vs. Denials
Description: How frequently does the payer approve and deny appeals?



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