**Insurance Prior Authorization Approval Does Not Substantially Lengthen the Emergency Department Length of Stay for Patients with Psychiatric Conditions**

A recently published prospective study of emergency department (ED) data from over 1000 patients with psychiatric illnesses found that psychiatric patients stayed in emergency rooms an average of 11.5 hours, and those who were transferred to another hospital averaged 15 hours.1

We recently undertook a small pilot sample of convenience cases over a 3 month period of psychiatric patients deemed in need of inpatient admission and tabulated length of stay in the Cambridge Health Alliance psychiatric ED and the amount of time spent obtaining authorization from the insurer, to see if the prior authorization requirement adds to the overall length of time psychiatric patients wait.

Data were recorded on a total of 53 patients. The patients were mostly Caucasian (n=36) and ranged in age from 7 to 68 years old. Diagnoses spanned the entire psychiatric spectrum. The chief complaint was overwhelmingly suicidal ideation. The insurance companies involved included all of the major public and private insurers in Massachusetts with the exception of Medicare (which does not require prior authorization for psychiatric admissions), and in all but one case the request for authorization was granted.

Residents averaged 38 minutes from time of first contact with the insurance company until authorization was either granted or denied. Although half of the authorization requests took under 20 minutes to be approved, for about 10% of patients authorization requests took an hour or more to approve, with the longest request taking 5 hours to be approved. Median total time in the ED was 8.5 hours, with the shortest stay lasting 3 hours and the longest lasting 20 hours. We did not differentiate whether our patients were placed within our own institution or another one, but anecdotally patients admitted to our own institution left the ED more quickly than those placed elsewhere, something that was in fact true in the recently published study cited above.1

Our actual average length of stay is undoubtedly higher than we calculated, though, because our data do not include 5-7 patients who boarded in the ED over the weekend while waiting for an inpatient bed to become available for them. Because these individuals were shuffled between residents over several shifts, their data were not recorded. In addition, we did not record data for uninsured patients—since these individuals obviously did not require any prior authorization--whose placement at any institution other than our own was essentially impossible.

Our findings indicate that the need to obtain prior authorization does not add much time to the total time psychiatric patients spend in EDs. Furthermore, if the pre-authorization process does help contain costs, it does so largely through a deterrent effect—we call it “rationing by hassle factor”--given that in all but one case physician requests for authorization were granted.

Because reimbursements for psychiatric services are lower than for other types of care, health care organizations that do offer psychiatric services frequently place obstacles in the way of accessing outpatient psychiatric care and limit the number of inpatient psychiatric beds they maintain. As a result, demand for psychiatric services frequently outstrips supply,2 and the result is that our nation’s EDs are *de facto* psychiatric wards, with 79% of emergency physicians reporting that their hospitals board psychiatric patients for whom appropriate treatment resources could not be found, sometimes for days.3 The situation is so dire that EDs now being designed and configured to house psychiatric patients awaiting placement.4

Given our small sample size, our results probably cannot be generalized. However, given that Massachusetts was the model for national health care reform and the greater Boston area has more psychiatric offerings than many other locales, the difficulty of accessing psychiatric services in most other parts of the US is likely worse than what we found in our study. Emergency personnel and psychiatric patients deserve better.

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