Steps to smarter prior authorization

Health care organizations are burning time and money on prior authorization.
With automation and skilled partners, providers can save resources and improve patient care.

Read the e-book

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Doctors, nurses and patient access staff have struggled with prior authorization for years, but the burdens have been compounded by the COVID-19 pandemic.

In the early stages of the pandemic, some insurers relaxed requirements, but within a short time, doctors were again encountering hurdles in getting approval for services, according to the American Medical Association. More than half of all doctors (52%) said payers never relaxed prior authorization requirements in the pandemic, according to an AMA survey in April 2021. Another 34% of those surveyed said insurers temporarily eased requirements but then reverted back to normal.

“Delayed and disrupted treatment due to an archaic prior authorization process can have life or death consequences for patients, especially during a public health emergency,” said Dr. Susan Bailey in April 2021, as then-AMA president.

“This hard learned lesson from the current crisis must guide a reexamination of administrative burdens imposed by health insurers, often without any justification.”

In the process of prior authorization, providers spend hours working with insurers to get approval for a test or service for patients. If a payer requires more information or denies the request, clinical staff provide more answers or appeal the denial for the treatment. Because different payers have different policies, health care professionals must try to figure out the varying requirements across their patient populations.

Payers view the prior authorization process as a crucial tool for weeding out low-value care and controlling costs as part of their utilization management programs. For providers, prior authorization can feel like an obstacle course they have to navigate.

The average physician practice spends 13 hours per week on securing authorization, according to the AMA, which can result in each pre-authorization request costing between $35 to $100 per hour. With practices handling hundreds or even thousands of requests each week, the costs add up. In fact, UW Health estimated the total costs in a recent Healthcare Finance Management Association publication, which, including lost revenue due to appointment cancellation and rescheduling, was $18.2 million annually.[1]

In addition to the financial costs, the prior authorization system takes a toll on patient care. According to an AMA survey released in February 2022, 93% of doctors said that prior authorization delays care, and 91% said it resulted in negative outcomes. About one-third (34%) of doctors said prior authorization delays contributed to adverse events for patients, as well as being a contributing factor to physician burnout.[2]

In addition to the financial costs, the prior authorization system takes a toll on patient care.

When some patients are initially denied approval for a certain treatment, they assume it's a lost cause. Roughly 4 out of 5 (82%) doctors surveyed said some patients grew so frustrated with the prior authorization process they gave up on treatment.

Medical groups say prior authorization requests are rising. The Medical Group Management Association surveyed its members in May 2021 and found 81% said prior authorization requests increased over the previous year, while 17% said they stayed the same. Only 2% of those surveyed said the requirements decreased.[3]

It's difficult to get a precise figure on how many medical services require prior authorization, but a study published in the *Journal of the American Medical Association* in May 2021 sheds some light on the prevalence of the practice.

The study examined how beneficiaries of Medicare Part B, which is not subject to prior authorization, would have been affected if they faced the requirements of a typical insurer.

Among Medicare Part B's 6.5 million beneficiaries, 41% received at least one service that would have been subject to prior authorization, the study found. Some specialties had high rates of services that would have required prior authorization, including radiation oncologists (97%), cardiologists (93%) and radiologists (91%). The lowest rates of authorization were among pathologists (2%) and psychiatrists (4%).

The excessive manpower spent on the prior authorization process is particularly glaring with the "Great Resignation" triggered by the COVID-19 pandemic.

Hospitals and health care providers are dealing with serious staffing shortages, which have taxed their ability to serve COVID-19 patients and the rising number of patients seeking treatment for other reasons, including those who have delayed care during the pandemic.

An October 2021 study by Morning Consult found that 18% of health care workers have left their jobs during the pandemic.[4]

Health care providers may have to brace for even more labor problems. One in 5 doctors and 40% of nurses surveyed said they plan to leave practice in the next 2 years due to the fatigue they've experienced during the pandemic, according to a study published in *Mayo Clinic Proceedings* in December 2021.[5]

Health care technology leaders have urged providers to use automated systems for the prior authorization process. With health care providers facing unprecedented staffing challenges, it's now become imperative.

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Why automation makes sense

Most of the prior authorization process is still done manually, according to the Council for Affordable Quality Healthcare (CAQH), a non-profit alliance of health organizations. Only 1 in 4 prior authorization requests (26%) are handled fully electronically, according to the 2021 CAQH Index.[6]

Staff spend hours in front of computer screens and on the phone when they could be caring for patients. Many requests are still sent via fax.

More than 1 in 3 prior authorizations (35%) are fully manual (phone, fax or email), a number that hasn't substantially changed in recent years, CAQH reported.

The costs to the health care industry are staggering. CAQH projected the industry would save $437 million annually by handling all prior authorization requests electronically. But that only represents the tip of the iceberg by estimating only the submission of the authorization.

Efforts to bring more automation into the authorization process need to cover each back-and-forth communication between payer and provider. These efforts have been hampered by a lack of standards for clinical documentation and a limited number of products that support electronic prior authorization.

As technology leaders have noted, the health care industry has managed to make several other transactions almost fully electronic, such as the submission of claims and verification of benefits. More health care organizations are examining ways to bring automation to the authorization process.

Federal law is pushing the health care industry to move toward interoperability, the capability of information systems to exchange information seamlessly.

The federal Interoperability and Patient Access final rule represents a sweeping change for the health care industry. In July 2021, the government began requiring providers to give patients access to their health records. The law compels providers and payers to remove barriers to sharing health care information.

To meet the demands of federal regulators, health care providers and payers are developing application programming interfaces (APIs) to exchange information between systems, enabling patients and providers to easily see their records. With greater interoperability, a provider will be able to quickly connect with an insurer's system to determine if a service or procedure is covered.

The Centers for Medicare & Medicaid Services says that when health information is shared more freely, it will eventually reduce the burdens of prior authorization and a host of other administrative procedures.

To meet the demands of federal regulators, health care providers and payers are developing application programming interfaces (APIs) to exchange information between systems, enabling patients and providers to easily see their records.

Electronic prior authorization technologies can help organizations move toward interoperability. These technologies can also save providers time and money, while sparing patients stress and delays in treatment. By utilizing artificial intelligence and electronic data interchanges, technology companies can drastically reduce the time and effort invested in prior authorization.

An automated process can determine if prior authorization is even required for a service or procedure, or if a request has already been submitted. Health care providers can use automation to submit requests to insurers, or process requests for more information from payers. Providers can also use automated processes to check the status of an authorization request.

Providers who have moved to electronic prior authorization have seen greater efficiencies. Providers who shifted from manual to fully electronic prior authorizations saved, on average, 16 minutes per transaction, according to the 2021 CAQH Index. An electronic prior authorization is typically done in 7 minutes, while a manual authorization takes an average of 23 minutes, the CAQH Index reported. Some manual prior authorizations can take up to an hour, CAQH said.

Health care providers who are only beginning to explore the possibilities of automation in prior authorization should do due diligence. Providers must find partners who understand the rapidly changing field.

Electronic prior authorization technologies can help organizations move toward interoperability.

Finding the right solution

To find the right strategic partnership for automating authorization processes, providers must consider several factors.

Look for experience

When looking for a strategic partner, providers must choose a partner with experience in automation, said Patrick Drewry, vice president of product management at Optum.

“I think the first thing that you look for is a partner that is well known in the industry and has shown the ability to work with both providers and payers in improving automation,” Drewry said.

Providers should ask technology companies what types of electronic health records they are integrating with, what technologies they are using to work with payers, and which payers they are working with.

Ask the right questions

When weighing prior authorization choices, health care organizations should ask prospective partners about how they plan to integrate their service into the provider's health information system. Providers should ask how data will be pulled from electronic health records and how it will be returned. "It's not enough to remove data out of your EHR and shove it back in a nonstandard way," Drewry said. "Does your partner work with your EHR vendor to optimize the integration?"

There are real risks, Drewry added, if a company is not following standard industry processes.

Providers need to be sure they're choosing partners that have the capability of gathering electronic records and can submit the authorization requests to payers.

Health organizations should also ask prospective technology partners if they know when authorization is required and when it isn't. One of the major causes of wasted time and effort is seeking prior authorization when it isn't required.

This is critical for health care providers. Despite calls for more transparency in prior authorization requirements, 58% of doctors said it is difficult to determine if a service requires prior authorization, according to the AMA.

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– **Patrick Drewry**, Vice President of Product Management, Optum

Seek versatility

Prior authorization involves many technologies and processes. Providers need to find a company adept at handling different systems, said Drewry.

"You need a partner that's going to give you broad payer coverage and can do so based on the myriad of technologies necessary to do that," Drewry said.

Providers should also look for technology partners who have experience integrating with individual payers and the benefits managers contracted by payers for medical management. Find a technology company with experience with different payers.

Providers should look for firms well versed in providing automation services across a variety of health care services. "You need a partner that is going to be able to help you with prior authorizations across diverse clinical services, not just a single service line, such as radiology," Drewry said.

Look for the human element

Artificial intelligence and algorithms can't do everything people can do, at least not yet. For now, it's not realistic to expect to automate all prior authorization processes.

Providers need to find technology partners who can meet their needs now while also moving toward a future with more interoperability.

Look for companies that understand the market today, and where the market is going in the future.

"You need to partner with a vendor that's going to guide you through that transition versus telling you that one solution is going to solve all of your problems," said Drewry.

Look for a company that can offer technology solutions and experienced authorization professionals who can intervene when some processes cannot be automated.

Health care organizations should be searching for a partner to improve the authorization process, not just a technology vendor.

Look for a company that can offer technology solutions and experienced authorization professionals to intervene when some processes cannot be automated.

Why Optum is the right choice

With cutting-edge technology and exceptional staff, Optum offers health care providers a better way to manage the prior authorization process and can help health care providers save money, improve efficiency and take better care of their patients.

“Our solutions are really focused on using different tools and different mechanisms to deliver what we call intelligent automation or smarter prior authorization,” said Patrick Drewry. “We are committed to making authorizations an exception-based process for providers and payers, whether for an inpatient admission or outpatient service.”

Optum can help providers who are grappling with labor shortages stemming from the COVID-19 pandemic.

Why Optum is the right choice

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1. **Expansive reach**
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3. **Substantial ROI**
4. **Work with experts**
5. **Reduce burnout**
6. **Better outcomes, better returns**

Automation technology is important, but so is the ability to communicate with information systems used by hundreds of payers. Optum offers extensive connections across the health care system.

Learn more about streamlining your prior authorization process

1. Kaplan AS, Abongwa A. Front-line stories: How today's prior authorization processes create a burden of waste for providers. HFMA. Feb. 19, 2021.
2. AMA press release. Physicians report prior authorization hurts workforce productivity. Feb. 10, 2022.
3. Ernst C. Prior authorization burdens for healthcare providers still growing during COVID-19 pandemic. Journal of the Medical Group Management Association. May 19, 2021.
4. Galvin G. Nearly 1 in 5 health care workers have quit their jobs during the pandemic. Morning Consult Pro. Oct. 4, 2021.
5. Sinsky CA, Brown RL, Stillman MJ, Linzer M. COVID-related stress and work intentions in a sample of us health care workers. Mayo Clinic Proceedings. Dec. 2021.
6. 2021 CAQH Index.

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