

3 ways to take the pain out of prior authorizations

It's no secret: Prior authorizations are slowing you down

Can you guess which one task accounts for nearly two days of your staff's work each week to support the average physician? Physicians and practice staff spend nearly 15 hours securing 31 prior authorizations per physician each week.¹ Over the course of a year, that can add up to as much as \$85,000 spent to support the needs of a full-time physician.² Too often, that time is wasted — a nurse could spend 45 minutes on hold with a payer only to learn that a prior authorization is not needed for the service being ordered.



Much of this process relies on human knowledge – and therefore runs the risk of human error. First, a physician needs to let his or her nurse or medical assistant know that an order has been created. Then that nurse or medical assistant needs to discern whether the order requires a prior authorization. This leaves ample opportunity for mistakes, because health plans vary widely in their requirements. In fact, a study of 23 health plans conducted by McKesson counted 1,300 procedure-specific authorization policies, with only 8 percent of those policies shared in common.³ Keeping up with requirements is complicated – and costly. In fact, missing authorizations account for 14 percent of denials when claims are first submitted and ultimately 19 percent of denial write-offs.⁴

In addition to financial ramifications, the authorization process can also impact patient care. In a survey of physicians, 91 percent reported care delays due to the challenges of securing prior authorizations. And the impact of delayed care can be dangerous: 75 percent of those surveyed reported that delayed authorizations can lead patients to abandon treatment.⁵

Medical practices and groups use a range of models to manage this work. Most medical groups have centralized some of the functions of the authorization process, particularly in specialties that manage a high volume, such as orthopedics, while in smaller practices, the onus

falls on clinical staff who may already be overburdened by other work. Across organizations of varying sizes, 34 percent report having a staff member dedicated exclusively to managing prior authorizations.⁶ Assuming this work requires two business days per week per physician, organizations following this staffing model would need one full-time employee for every 2.5 physicians on staff — handling only prior authorizations.

86% of physicians describe the burden of prior authorizations as high or extremely high⁷



Here's how you can free up your practice today

Hours spent on the phone with payers are hours taken away from patients. Given the significant toll that prior authorizations can take on a practice, outsourcing this work may be a better alternative to handling it within your practice.

Vendors offering these services today can help you with different parts of the process, but few cover all the bases. Some can provide insight into payers' requirements regarding prior authorizations, and others will handle communication with the payer about your authorization. Some offer a technology platform, and some provide a service.

You'll need all of these things in order for a vendor to truly add value to your operation. The most effective way to lighten your practice's workload is to seek out an authorization management solution that can meet these three requirements.

3 things your authorization management service needs to do

1. Know that an order has been created.
2. Determine whether an authorization is needed.
3. Do the work of securing the authorization.

1. American Medical Association. 2018. "2018 AMA Prior Authorization Physician Survey." Accessed February 17, 2020. <https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf>

2. Morley, C.P., Badolato, D.J., Hickner, J., Epling, J.W. 2013. "The Impact of Prior Authorization Requirements on Primary Care Physicians' Offices: Report of Two Parallel Network Studies." *Journal of American Board of Family Medicine*, 26 (1): 93-105. doi: 10.3122/jabfm.2013.01120062.

3. Rogers, Jennifer. 2017. "Tackling Prior Auth: New Solutions to Address Provider-Payer Friction." Chilmark Research. Accessed April 23, 2018. https://www.chilmarkresearch.com/chilmark_report/tackling-prior-auth-new-solutions-to-address-provider-payer-friction/.

4. Advisory Board Webinar Presentation. 2020. "The 2020 Playbook for Revenue Cycle Leaders: Six requirements for revenue cycle excellence." Accessed February 17, 2020.

5. AMA 2018.

6. Ibid.

7. Ibid.

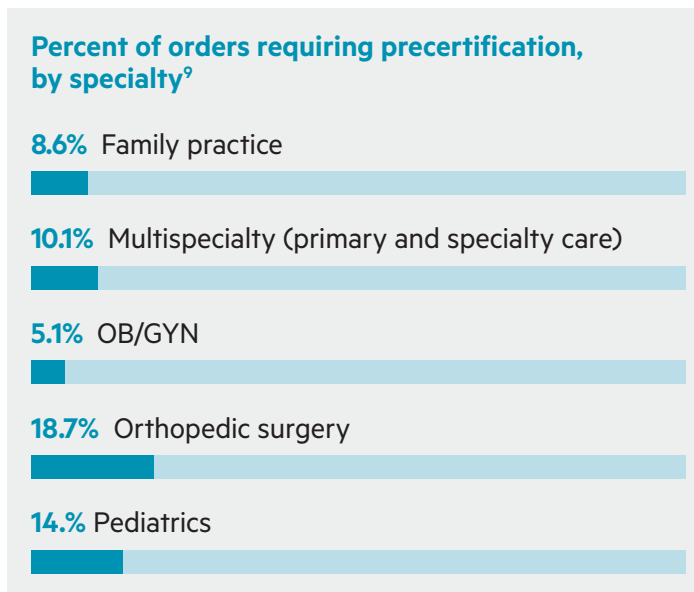
1 Provide visibility into the care being ordered

When prior authorizations are managed within a practice, the first challenge is knowing that an order has been created that may require a precertification or referral. In practices without a designated authorization management solution or a clear process, the burden often falls to the physician to alert a medical assistant or nurse that he or she has created an order that requires follow-up. The same holds true when working with a vendor that may not have direct access to your EHR.

To fully support your prior authorizations, a vendor should have end-to-end visibility from the EHR, where the order is created, to the revenue cycle management system, where it is paid. Cloud-based EHR and revenue cycle systems allow access to the necessary data, while legacy software silos that data in multiple systems. With access to a cloud-based system, your vendor can get immediate notice of an order as soon as it's created and track the prior authorization all the way through to a successful claim submission.

2 Curate and apply knowledge of payer requirements

Based on the athenahealth data, authorization requirements vary across specialties, but in certain specialties, nearly 20% of orders may require a prior authorization.⁸ That's almost 1 in 5. When a practice handles the authorization process on its own, it's up to the practice staff to know whether or not to pursue a prior authorization – which requires keeping track of many, ever-changing payer rules. When looking for an authorization management vendor, consider whether it has rules that can be integrated into your EHR workflows to identify those orders that may require a precertification or referral.



Make sure rules are updated regularly, and ask about the source of the vendor's knowledge. Sometimes payers issue guidance that is confusing or incomplete, so you'll want a vendor that can validate the accuracy of the rules it follows. The ability to track authorizations through your revenue cycle is one way a vendor can cross-reference a payer's stated rules with claim outcomes. If a claim is denied because of a missing authorization, the vendor can use that knowledge to update its prior authorization rules and prevent future denials from occurring.

Less time on hold, more time with patients

Wilson Stream Family Practice • Farmington, Maine

2 providers

3 medical assistants (1 part-time)

3 staff

up to 1 day of work per week saved per medical assistant

Wilson Stream Family Practice prides itself on providing personal attention to patients in its rural Maine community. But as with many small practices, keeping up with increasing administrative work has been a challenge — especially authorizations. Medical assistants at the practice estimated that they were each spending half a day to an entire day each week on the phone with payers, tracking down prior authorizations for their patients' imaging needs or referrals for consultations. "It was never a quick process," says medical assistant Susan Beauchesne. "We'd have to wait till we had time, usually at lunch time...It made our day frustrating."

After the practice began using athenahealth's authorization management service, clinical staff were able to hand over that work and focus on more impactful things — like talking to patients about their treatment or answering relatives' questions about how to care for a loved one. "We can spend more time talking to patients and not feel so hurried," says Brenda Belanger, who works in the front office. And with fewer frustrations to handle, she says, "It puts us all in a better mood."

8. Based on data from clients using the athenahealth Authorization Management service between October 2017 and April 2018. Data represents the number of orders submitted by clients that required a precertification, but does not include referrals.

9. Ibid.

3 Take work off your plate

While there is opportunity for a vendor to lighten your workload by meeting the first two criteria in this list, the biggest pain point for practices is the work required to actually submit information to a payer and secure the authorization. Instead of spending time gathering up documentation, filling out submission forms on payer portals, or waiting on hold on the phone, find a vendor who will handle all that work for you. To truly lighten your workload, the vendor should be able to perform a clinical review to determine which documents are required and doggedly follow up to ensure the authorization is processed in a timely fashion – and repeat, if needed.

Press further to find out how much work the vendor will handle by asking these two questions:

- What's the pricing model? If you pay a flat rate or percentage of collections, rather than paying per authorization, then your vendor can be conservative in pursuing any order that might need a prior authorization.
- When will you be consulted? You can free up more time by pursuing an arrangement in which you are consulted only when you need to be – such as when a peer-to-peer conversation between a physician and the payer is necessary.

To prepare for the future, look for more automation

As with medical records and claims, there was a time when everything was done on paper. Today, of course, electronic health records and billing systems are the norm. When it comes to prior authorizations, however, payers have been slow to embrace electronic methods.

Adoption of electronic prior authorization lags other administrative transactions

Medical Plan adoption of fully electronic administrative transactions in 2019:¹⁰

- 13% prior authorization
- 84% eligibility & benefit verification
- 86% coordination of benefits
- 70% claim inquiry status

A higher rate of adoption of existing standards governing authorizations could help automate certain aspects of the prior authorization process. The HIPAA-compliant Health Services Review (HSR) 278 electronic data interchange (EDI) transaction already allows someone to initiate a new prior authorization or referral and to submit an electronic inquiry about its status to a payer's system. But there is great opportunity to

expand the adoption of this standard, as very few providers submitting precertifications and referrals make use of it, compared with other submission methods.

In the future, other aspects of the authorization process could also become automated. For example, what if your EHR could recognize the right information to submit to a payer? With natural language processing, your EHR technology could perform the clinical chart review by analyzing encounter summaries and other notes to submit the information needed to meet the payer's submission criteria. By taking on this part of the process, straightforward precertifications and referrals (those that don't require follow-up) could be submitted and approved without any extra work on the provider's side.

As you're assessing your practice's needs, look for a vendor that you can stay with well into future — a partner that's already testing the limits of machine learning, natural language processing, and similar technologies. Set your sights beyond quick-fix solutions that take on your staff's busywork (important though that may be), and look for an approach that can seamlessly integrate into your ongoing operations, from charting to revenue cycle management. New technologies loom on the horizon, but the right strategic decision can have an immediate impact on your practice today.

athenahealth authorization management service

athenahealth offers an integrated authorization management service to clients who use our cloud-based EHR and practice management services. As soon as an order is created in our EHR, rules fire to determine whether it requires a precertification or referral, based on research conducted by our in-house teams and lessons learned from managing the claims of our network of more than 130,000 providers. If it looks like an authorization may be needed, our staff review the patient chart and submit the required documentation electronically, whenever possible, using HSR-278 EDI standards – a transaction that is made easier by the connections to over 2,000 payers already built into our national network and available to every client.

We follow up with the payer to continually check on the status of the authorization, through a combination of electronic and human methods, and our clients have full visibility into our progress and each interaction with payers via an integrated dashboard. We manage any requests for additional documentation, only surfacing a task to our client when it's absolutely necessary or when a peer-to-peer conversation is needed. Any time we learn about changes to payer rules, we update them across our entire network so no client has to experience a denial.

To learn more, visit athenahealth.com

10. 2019 CAQH Index. 2019. "Conducting Electronic Business Transaction: Why Greater Harmonization Across the Industry is Needed". Accessed February 17, 2020. <https://www.caqh.org/sites/default/files/explorations/index/report/2019-caqh-index.pdf?token=SP6YxT4u>

