ZOLL®

Take the Pain Out of Prior Authorization:

Four Ways to Streamline Workflows, Preserve Revenue, and Improve the Patient Experience

Contents

The prior authorization (PA) process is a textbook example of the law of unintended consequences.

Created for sound reasons — as a utilization management tool for healthcare insurance companies to control costs and protect patients from surprise bills — it has unintentionally paved the way for a corresponding surge in **administrative burdens, claim denials and rework, and barriers to care for patients**. The problems inherent in the PA process have taken a toll on healthcare providers' financial performance, not to mention the psyches of billing teams and patients.

The obvious solution to process delays, sub-optimal patient experiences, heavy administrative burden, and claim denials with ensuing write-offs is to address these problems at their root causes. But preventing them from occurring is not that easy, and the **increasing PA demands** only complicate matters.

If your organization is suffering from the pain of manually managing PA, read on to better understand the root causes of the problems and explore solutions that can provide relief.

You'll learn about the relative advantages of using technology to incrementally improve your current PA process, partially automating PA, and fully centralizing PA to **streamline workflows, preserve revenue, and provide a better experience for patients**.

Delays, Distractions, and Denials: The Problems Plaguing the PA Process

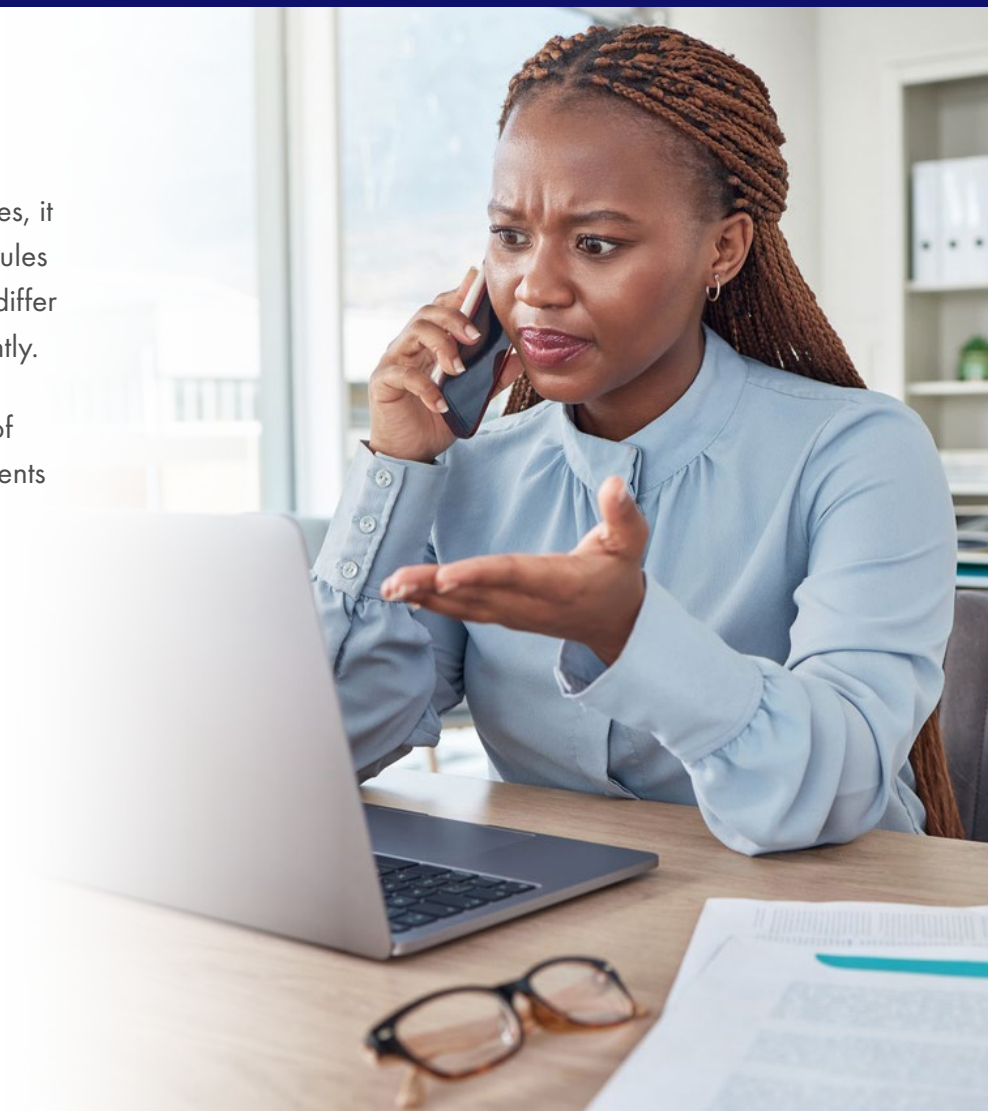
Payer rules are not standardized and differ from health plan to health plan, or even from plan to plan within a specific payer. The rules change frequently, placing a heavy burden on administrative staff to manually search paper documentation, PDFs, or payer web portals. Physicians must review the PA requests and medical charts, distracting them from their primary role of caring for patients.

If PA is required, providers must track down specifics pertaining to each current procedural terminology (CPT) code applicable to the prescribed treatment. They also must obtain a number, assigned by the payer, that corresponds to the PA request and include it when the final claim is submitted. These things are usually accomplished through **a cascade of phone calls, faxes and emails between payer and provider.**

The complex, changeable nature of PA inevitably **causes delays and distracts providers from their core focus: patients.** Claim denials are not uncommon, due to missing, incomplete or incorrect data, patients with ineligible or terminated insurance coverage, and PA requests that call into question the medical necessity for a prescription or treatment.

The **responsibility falls on the provider** to continue to follow up with the insurance company until there is resolution of the prior authorization request — an approval, redirection, or denial.

1 Prior Authorization Can Be Slow and Painful



Prior authorization is complex. There are **few standards** governing how it operates, it is open to interpretation, and the policy rules used to render decisions on PA requests differ from payer to payer and change frequently.

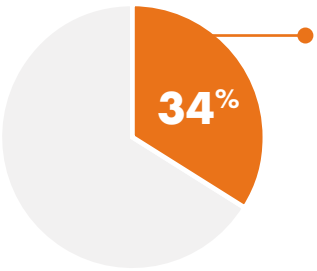
Depending on the complexity, the level of manual work involved, and the requirements stipulated by the payer, a **PA can take anywhere from one day to a month to process.**

The "2021 AMA prior authorization (PA) physician survey"[1] revealed that 93% of providers reported that PA "Always," "Often," or "Sometimes" causes delays.

[1] 2021 AMA prior authorization (PA) physician survey

2 Delays Hurt Patients

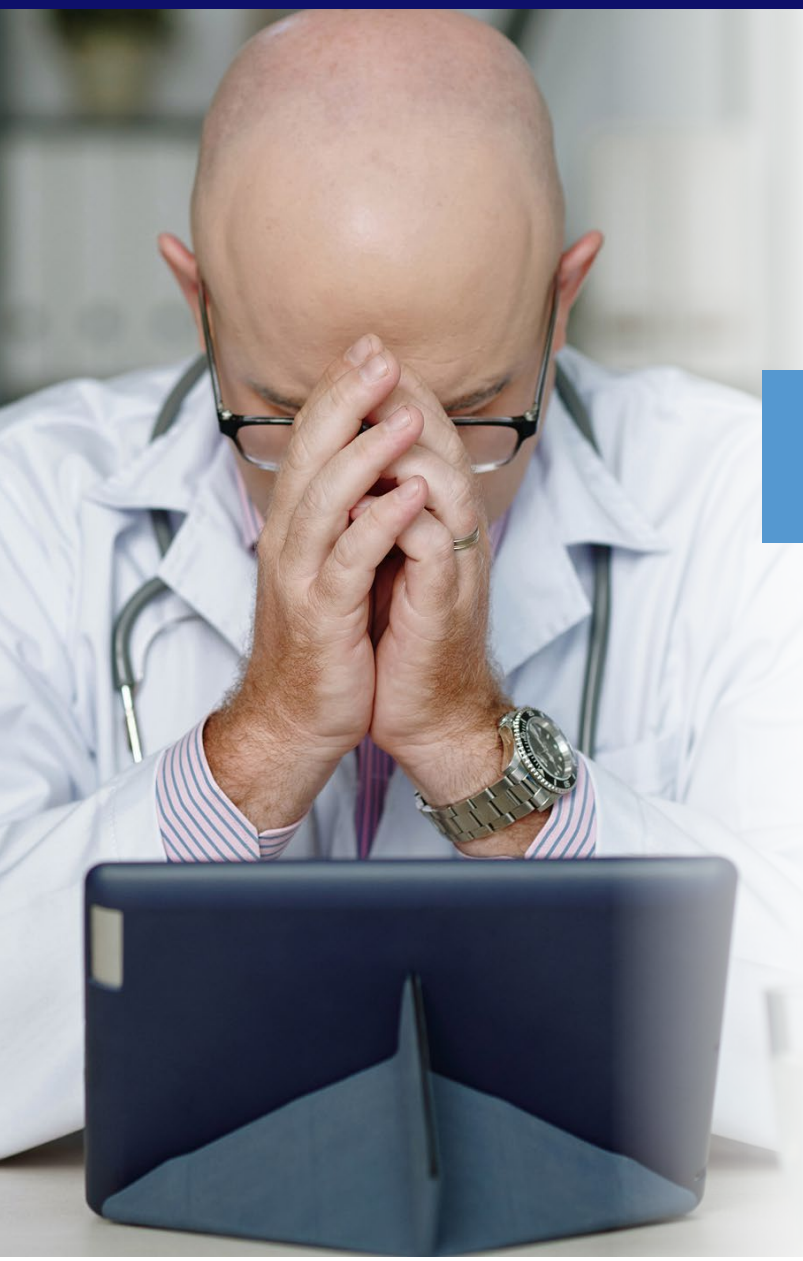
This speed bump in the patient journey can cause problems for both patients and for the healthcare professionals attending to them. When obstacles like postponement or additional steps to authorize care are introduced, **some patients may forego treatment** or fail to adhere to prescribed medication.



According to the same AMA survey, 34% of physicians reported that **prior authorization has led to a serious adverse event** for a patient in their care.

There also can be unintended side effects caused by the delay while a PA request is reviewed. Patients may seek interim treatment at an emergency department, a decision that can often result in a large, unexpected bill not covered by the patient's health plan.

3 Administrative Demands Distract Providers and Shrink Margins



The burdensome PA process robs clinicians — and the administrative team that supports them — of **time that would be better spent attending to patients** and contributes to the growing healthcare worker burnout epidemic.

The AMA has reported that physicians can spend 13 hours per week on authorizations.

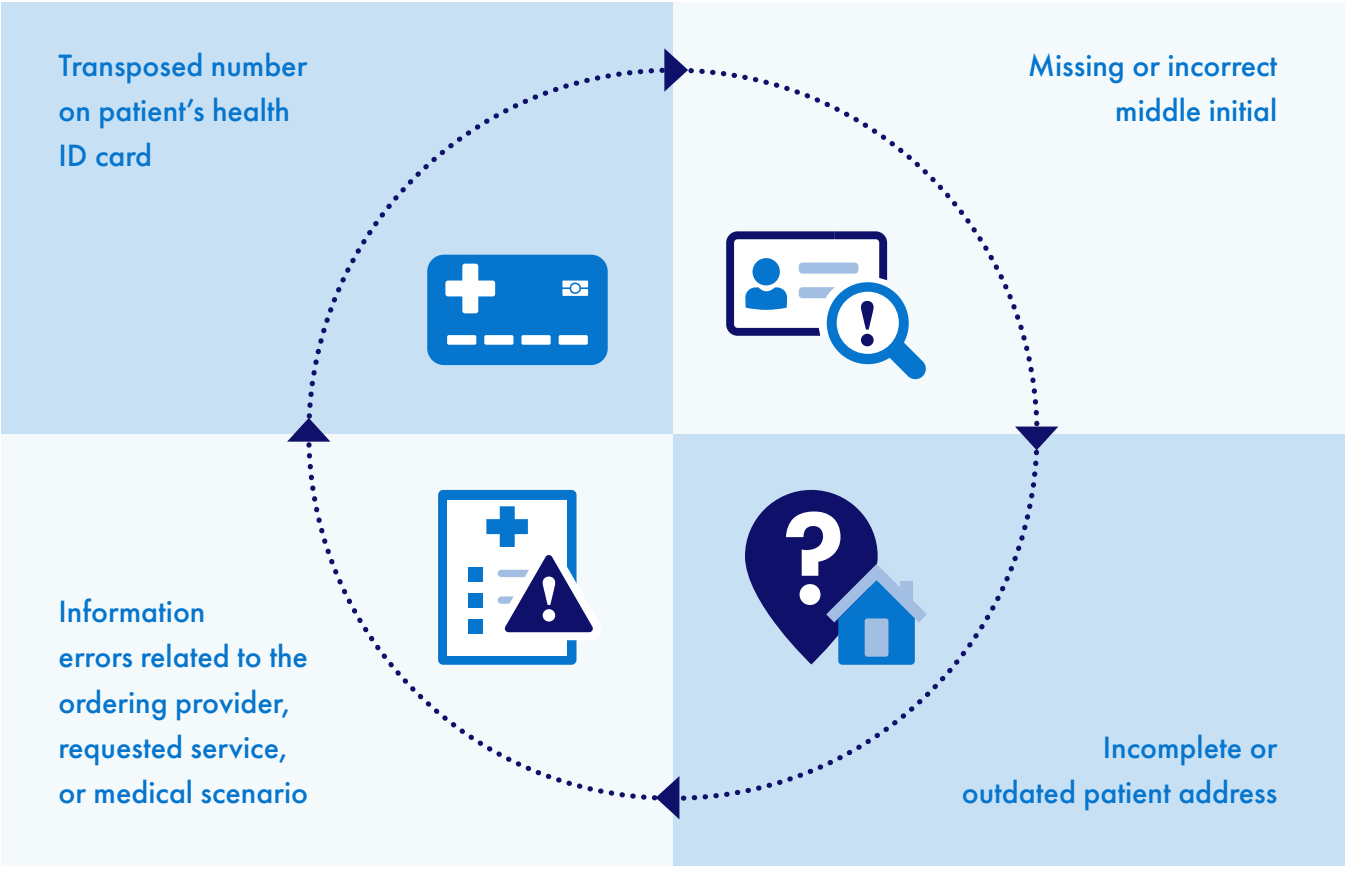
The unstructured and unpredictable nature of PAs can wreak havoc on the normal administrative workflow of a practice. In fact, the 2021 AMA survey found that 40% of physicians have staff who work exclusively on PA, devoting almost two business days per week to the effort. These inefficiencies and the extra overhead required to address them can overextend administrative staff and put additional pressure on dwindling profit margins.

Sometimes PA requirements are not determined until after treatment is complete. As a result, payers withhold some or all of the expected reimbursement. In such cases, **providers often must try to collect payment directly from patients, a process that often results in writing off uncollectible revenue** as bad debt.

PROBLEMS WITH THE PROCESS

4 Data Errors Trigger Denials and More Delays

A primary reason that PA requests take so long to resolve is poor quality information. **Inaccurate or incomplete data submitted to the health plan triggers a denial, followed by a lot of manual re-work on the provider side.** Whether egregious or seemingly innocuous, common information errors can flag a submission for denial.



The PA process typically involves manual processes and multiple stakeholders, which can make it ripe for mistakes that precipitate a denial. Once a denial has been rendered, it is difficult to reverse and creates uncertainty for both providers and patients.

How to Streamline the PA Process, Protect Margins, and Improve the Patient Experience

Healthcare providers often bristle at the idea of having to justify a prescribed treatment with insurance companies. Adding **the "paper chase"** triggered by a PA request only intensifies frustration, **compounds the administrative burden on the billing team, and worsens the friction** between providers and payers. **There are ways, however, to change this scenario** and give doctors back those hours to spend on patient care. Providers can take actions ranging from introducing electronic PA to automating labor-intensive tasks and fully centralizing their PA process.

DOING SO CAN:

Electronic Prior Authorization

Electronic prior authorizations (ePAs) refer to those instances where some or all of a PA verification is processed electronically.

What constitutes an ePA is open to interpretation. Manual keystroke entries to a payer portal or an eFax might technically count as ePA, as would more sophisticated computer-to-computer information exchange using electronic data interchange (EDI) or clearinghouse transmissions.

To more legitimately be considered an ePA, a solution typically requires specific capabilities:

EDI capabilities, particularly the capability to send a 278 transaction (standard protocol to electronically transmit patient data pertaining to authorizations and referrals between providers and payers)

Direct connections with health plans

Rule sets that automate the submission and tracking of PA requests

Use of multiple, web-based prior authorization applications for payers or pharmacy benefit managers (PBMs), each with their own username and password requirements

Automating Prior Authorization

One of the best methods for preempting prior authorization problems is to semi-automate and centralize the PA process to eliminate the need for **faxes, phone tag, and emailing** so that providers are less likely to be consumed by the process.

As the volume of treatments requiring PA has spiraled, so too has healthcare industry enthusiasm for enacting standards and automating the process for providers and payers. With **the number of PAs predicted to climb higher,** there is urgency to find a way to remove a lot of tedious, time-consuming, manual tasks through automation.

There are three approaches to electronic PA, from partial digitization to centralizing and enhancing the entire process using artificial intelligence (AI).

Centralizing and using AI to dynamically enhance the end-to-end prior authorization process as early in the revenue cycle as possible reduces the likelihood for errors, lessens the amount of manual work wasted on tedious tasks, and accelerates patient care.

1 Partially Digitize the Current Prior Authorization Process

For those healthcare providers looking to at least partially **free themselves from faxes, phone calls, and endless email loops,** digitizing claims management can be a small step forward in automating PA and reducing the number of claim denials.

Digitization might involve something as simple as a web portal that allows providers to create, validate, and submit healthcare claims electronically. **This option solves some problems,** but the medical billing team still is required to pull data in from multiple sources and is ultimately still doing most of the work manually.

2 Automate Eligibility and Verification Processes

Providers will often start by automating eligibility checks and benefits verification. By doing so, they can reap some efficiencies at the front end of the encounter and determine quickly whether a patient is eligible for a procedure or medication. They have the opportunity to engage the patient and **rectify potential conflicts at the point of care,** averting a denied claim.

Some providers may automatically **calculate patient financial responsibility** up front and collect payment (if appropriate) in order to comply with price transparency rules.

3 Centralize and Partially Automate Electronic Prior Authorization

Providers can build upon automated eligibility by centralizing and enhancing the entire prior authorization process with assistance from artificial intelligence (AI). Doing so adds functionality, such as the ability to automatically **identify whether PA is required and to determine the optimal submission route.**

A centralized, AI-enhanced approach includes:

- **A master patient index (MPI)** that can identify each unique patient
- **An extensive library of payer rules** that synchronizes eligibility and PA rules
- **Ability to integrate with automated revenue optimization tools**, such as demographic verification, insurance discovery and verification, self-pay analysis, and deductible monitoring
- **Direct, real-time connections** to most payers
- **A self-learning system** that uses AI to dynamically update automated workflow and rules engines based on the actual responses and results from submitted PAs

A **fully centralized, AI-enhanced, end-to-end PA** solution enables providers to validate a PA request against payer guidelines, automatically locate and populate the correct payer PA form from claim and account information, and enable the provider to review the form prior to submission. After submission, PA status is displayed in a centralized location where all PA statuses can be viewed. It **slashes the administrative burden** on billing departments and physicians. Furthermore, it improves access to care for patients, enabling better outcomes and cost avoidance through reduction or prevention of hospitalizations and emergency room utilizations.

Prior Authorization Can Be Painless

Although PA is complex, using an **AI-enhanced, real-time solution to automate the process lifts the administrative burden** from the shoulders of billing staff and puts the focus back where it belongs: on the patient.

By streamlining the PA workflow, **patients can access care faster**, with the added benefit of understanding and planning for their out-of-pocket financial responsibility. Patient satisfaction increases as a result of better outcomes and a better overall experience.

And automated PA makes good business sense, too. It delivers **game-changing efficiency and certainty** for healthcare systems and providers where manual processes and claim denials once bogged down workflows and contributed to suboptimal financial performance.

If you're ready to learn more, please call us at 800-231-8573 or visit our website at www.zolldata.com/automated-PA.

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