

Prior authorizations: relieving the burden

Prior authorizations — also known as precertifications, utilization reviews, or utilization management — are necessary and unavoidable. They also cost your organization time and money and contribute to physician burnout. How did we get here? What are the options for managing prior authorizations — and the best practices for handling them? **Here is a clear look at the data.**



Prior authorizations are painful

They take time

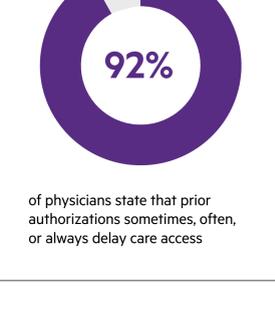
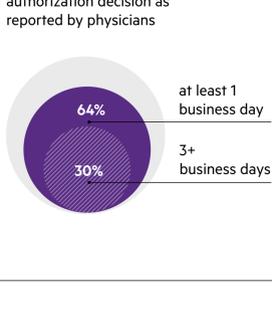
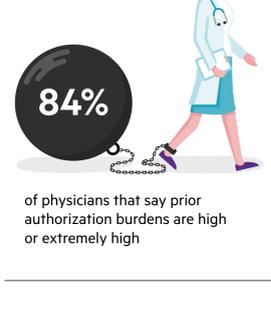


The collective staff average of time spent per physician for an organization is

14.6 on **29.1**
Hours prior authorizations per week¹

Some of that time is spent verifying whether a prior authorization is necessary. You might wait 45 minutes on hold with a payer, only to learn that a prior authorization is **NOT** required.

A McKesson study of 23 health plans found **1,300** procedure-specific authorization policies, with only **8%** commonality.²



They waste money

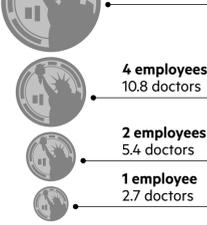
\$83K-85K equating to **\$23B-31B**
is spent per full-time physician each year on the prior authorization process across the U.S. healthcare system³



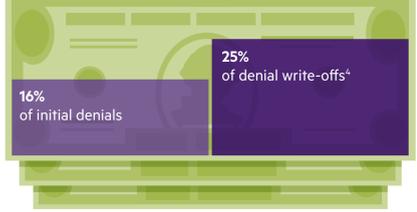
Study includes time spent by physicians, registered nurses, and clerical staff filing and processing prior authorizations.

34% of organizations report having a staff member exclusively dedicated to prior authorizations⁴

Assuming 15 hours per physician, that's **1 full time employee** for every **2.7 physicians**



Missing authorizations account for:



They aren't going away



of medical practice leaders polled in 2017 reported that prior authorization requirements were increasing — up 4% from the previous year's poll⁵

They contribute to the burden that drives burnout

54.4% of physicians report at least 1 symptom of burnout⁶



How did we get here?

The history

Employer-based health insurance starts at the turn of the century and is prevalent by the 1950s. Due to rising access to healthcare and other factors, hospital use goes up, and costs related to care increase.

To limit unnecessary stays and cut costs, hospital physicians begin peer-based “medical necessity” checks, but don’t have the tools or resources to standardize them. Insurers — highly invested in reining in costs — step in, and as insurance companies multiply, so do their custom review processes. By 2018, these have grown to encompass treatment, procedures, and medications, sparking controversy over who should decide what is “medically necessary” for patients — physicians or payers.⁷



1900

Rail, mining, and lumber companies enact workers' compensation insurance

1960s

Utilization review begins

1970s - present

Volume of payers and their dominance over prior authorizations increases

1920s

Employer-based health insurance begins (at Baylor University)

1950s

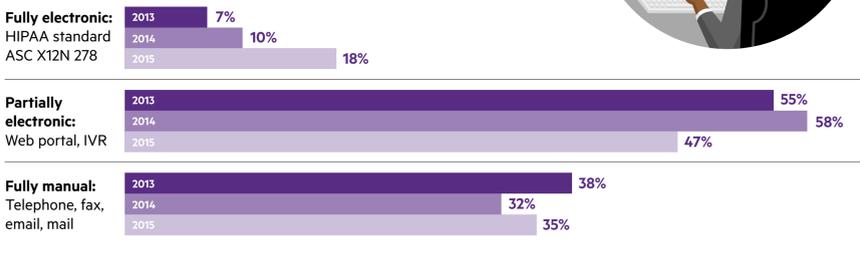
1. Employee access to health insurance — and affordable healthcare — expands
2. Technology and medical advancements make hospitals busier and more popular
3. Infant mortality rate decreases; people are living longer

Managing prior authorizations

Transaction methods

Health plan web portals are the prevailing method for submitting prior authorizations, though fully electronic use is increasing⁸

Adoption of electronic prior authorizations for commercial health plans and providers



Prior authorization process time is affected by the transaction method. Electronic transactions, especially when automated, are the fastest method. Manual transactions, which require additional staff work to process, are the slowest. Peak efficiency occurs when both provider and payer transact electronically.

Faster transactions save payers and providers both money and time, while improving care quality and patient satisfaction.

Options for sharing responsibilities

While some prior authorization tasks require input from physicians, there are multiple options for handling those that don't:



In-house staffing:

Share responsibilities across all staff. Everyone pitches in, including physicians, taking time away from patients.

Hire dedicated full-time employees. Expect to hire 1 FTE for every 2.7 physicians.



Partnerships:

Outsource all work that's not directly related to patient care. This will free up internal staff to focus on higher-value work and spend more time with patients.

Best practices for handling prior authorizations

Taking on prior authorizations internally?

Here are some tips for handling the extra administrative work:

- 01. Keep lists and references handy.** Payer criteria, state law, and common “trigger” medication information should be kept on hand and updated often, so physicians and staff know what to include in requests. Focus especially on payers that insure the majority of your patient base.
- 02. Assign one (or two) payers per staff member.** Have each staff member become familiar with their assigned payer's processes, including preferred methods of communication (fax, phone, or electronic), and serve as a “go-to” for questions about that payer.
- 03. Encourage nurses and staff to keep physicians informed.** When prior authorization issues arise, physicians won't be blindsided with extra administrative work and can prepare secondary plans for care if needed.
- 04. Put a system in place to follow prior authorization requests to completion.** Don't lose sight of prior authorizations in the hustle of practice activity. Track what types of care are frequently denied and why — apply those learnings.

Looking to partner with a vendor?

The ideal prior authorization process is as automated, integrated, and complete as possible — eliminating large amounts of work from your organization. Since EHRs are already connected to your data, EHR vendors tend to be the most full-service partnering options, but they're not all alike. Here's what to look for:

- 01. A cloud-based rules engine:** Prior authorization criteria change regularly and vary among payers and states — including local payers and contracts. The best EHRs are constantly learning from their network and automatically applying that knowledge to similar cases in real time.
- 02. Full transparency:** An EHR that integrates with your revenue cycle solution can give you end-to-end visibility from order creation through payment, with status alerts and updates at every stage — including when an approval is filed in a patient's record, or when a follow-up for clinical input is needed.
- 03. Full-service support:** Some EHR vendors provide real prior authorization specialists to assist physicians, clinical staff, and administrative staff, cutting your work even further. Look for a vendor that offers clinically trained experts who can submit documentation to payers, help you understand why a denial occurs, and work with the payer to approve your request.

1. American Medical Association. 2018. “2017 AMA Prior Authorization Physician Survey.”
 2. Rogers, Jennifer. 2017. “Tackling Prior Auth: New Solutions to Address Provider-Payer Friction.” Chilmark Research.
 3. 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.
 4. Advisory Board Financial Leadership Council. 2014. “Benchmarking Revenue Cycle Performance: Results from the 2013 National Survey of Hospital Revenue Cycle Operations.”
 5. Medical Group Management Association. 2017. “Medical practice leaders say prior authorization requirements continue to rise.”
 6. Mayo Clinic. 2014. “Changes in Burnout and Satisfaction with Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014.”
 7. CoverMyMeds.com. 2017. “A Brief History of How We Got to Electronic Prior Authorization.”
 8. Council for Affordable Quality Healthcare (CAQH) Index. 2016. “A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings.”