CAPLINE
HEALTHCARE MANAGEMENT

Effective Ways to Ease the Pain of Prior Authorizations

As might be expected, prior authorization is the most time-consuming and costly administrative transaction for providers. Physicians and practice staff work an average of 15 hours to get 31 prior authorizations per physician per week. This single task can cost nearly $11 per transaction when done manually, and it can be quite a waste of time when the individual realizes it is not required for the service being ordered.

The requirements for health plans can change considerably, and staying up to date with them is frequently difficult and expensive. Time spent on the phone with payers is time with patients who are traded for miserable paperwork. Considering the fact that prior authorizations can cost your practice a lot of time and money, it may be more beneficial to outsource this work.

Average staff time spent on authorizations

~ 15 hours per week on 31 authorizations

It's No Secret:

Prior Authorizations Are Slowing You Down

Which one activity, do you think, takes almost two days of your staff's time a week to serve an average physician? Healthcare practitioners and staff dedicate nearly 15 hours to obtain 31 prior authorizations per facility weekly.

01 Year in and year out, it can run up to $85000 for the full-time physician to support the needs that are required of him/her.

02 All too frequently, that time is lost—a nurse could be on hold with a payer for 45 minutes only to be informed that prior authorization is not required for the service that has been ordered.

The Costs of

Prior Authorizations

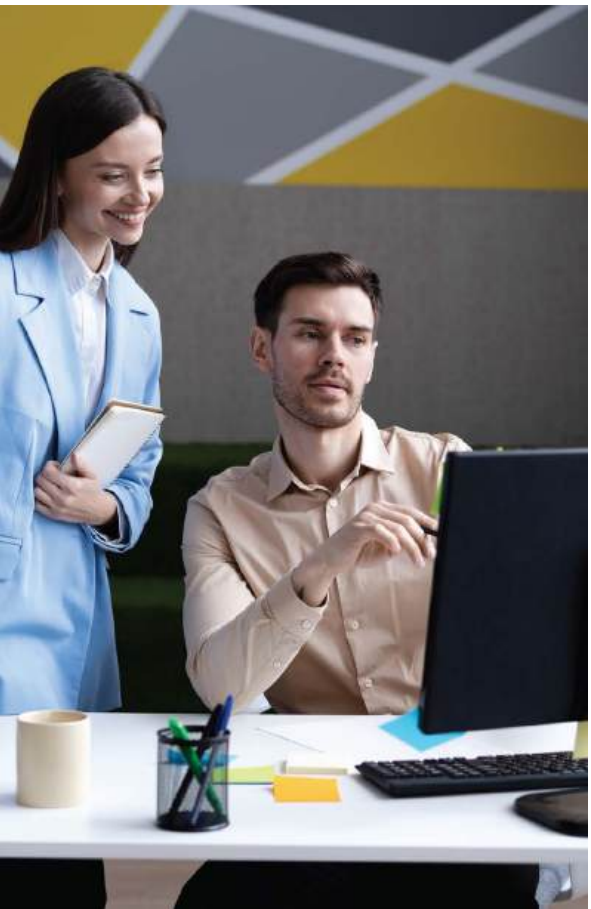
Many of these tasks involve the use of human knowledge – and, as such, are susceptible to human mistakes. First, a physician has to inform his or her nurse or medical assistant that an order has been made. Then, that nurse or medical assistant should be able to determine if the order in question warrants prior authorization.

This leaves lots of room for error because health plans can be quite different from one another. In fact, a study of 23 health plans conducted by McKesson counted 1300 specific authorizations for procedures, and only 8 out of the 1300 were similar.

Staying on top of requirements is far from straightforward – and expensive. Specifically, missing authorizations are responsible for 14% of claims denial at the initial submission and 19% of denial write-offs.

Besides the financial implications, the authorization process also has implications for the kind of care that patients receive. An online survey of 300 physicians revealed that 91% of them had experienced care delays because of the difficulties of obtaining prior authorizations. The impact of delayed care can be dangerous.

According to the survey, 75% of the respondents stated that delayed authorizations result in patients dropping treatment.



Models for

Managing Authorizations

This work is organized using different models that healthcare practices and groups apply. Many healthcare groups have outsourced some of the roles of the authorization process, especially in the specialities that handle a huge load, for instance, the orthopaedic specialities and in small practices, the task lies with the clinical staff who are already congested with other tasks.

By organizational size, 34% of organizations indicate that they have a staff solely responsible for prior authorization. Suppose this work takes two business days per week per physician. In that case, organizations using this staffing model would need one full-time employee for every 2.5 physicians on staff – for prior authorization alone.

86% Of Physicians Describe The Burden Of Prior Authorizations As High Or Extremely High

How to Free Up

Your Practice

Time spent on calls with payers is time spent with patients. Considering the amount of time and effort that prior authorizations consume in practice, outsourcing this work may be more beneficial than doing it in-house. Today, there are many vendors who can assist with different stages of the process, but there are few who can provide it all in one place.

Some can give information on what the payers need in terms of prior authorization, and others will be responsible for notifying the payer of your authorization. Some of them are actually a technology platform, while others are a service. All of these things would be required before a particular vendor could be of value to your business. The only way to reduce the practice's burden is to look for an authorization management solution that will address these three factors.

3 Things Your Authorization Management Service Needs to Do:

01 Know that an order has been created.

02 Determine whether an authorization is needed.

03 Do the work of securing the authorization

Taking the Pain Out of

Prior Authorizations

Here are three ways an authorization management service can alleviate the burden:

Provide Visibility Into the Care Being Ordered

The first problem that arises when prior authorizations are managed within a practice is the awareness that an order has been written, which may necessitate a precertification or a referral. When there is no specific authorization management solution in place or when the practice does not have a well-defined process, the job of reminding a medical assistant or a nurse that the physician has created an order that requires authorization falls to the physician.

The same applies, especially when you are dealing with a vendor that will not have direct access to your EHR.

For a vendor to provide the best support for your prior authorizations, they should have visibility from the EHR, where the order is initiated, to the revenue cycle management system, where the order is paid.

Cloud-based EHR and revenue cycle systems provide access to the required data, while traditional software applications perpetrate data warehousing in different systems.

Since your vendor has access to a cloud-based system, they can receive instant notification of an order as soon as it is created and monitor the prior authorization throughout the process of claim submission.

Curate and apply knowledge of payer requirements

Data reveal that authorization needs vary depending on the specialty, and up to 19% of orders require prior authorization – one in five. When a practice performs the authorization process internally, the staff is also liable for deciding when to obtain prior authorization, which entails being conversant with the ever-changing rules of different payers.

In the course of selecting an authorization management vendor, determine whether the vendor's system can interface with your EHR to determine if certain orders require precertification or, otherwise, referral.

Percent of orders requiring precertification, by specialty

- 8.6% Family practice
- 10.1% Multispecialty (primary and specialty care)
- 5.1% OB/GYN
- 18.7% Orthopedic surgery
- 14% Pediatrics

Check that the vendor's rules are updated more often and ask where they get their information from. Payer guidance may be ambiguous or even lacking at times, so the choice of vendor should be able to confirm the correctness of the rules that are being implemented.

In this case, a vendor can achieve this by monitoring authorizations throughout your revenue cycle while relating payer rules to claim results. If a claim is denied because of a lack of prior authorization, the vendor can take that information and change the rules for prior authorization to avoid future denials.

Example: A health system implemented an ePA platform integrated with its electronic health record (EHR) system. The automation led to a 40% reduction in the time it took to obtain prior authorizations and a 25% decrease in claim denials.

Take Work off Your Plate

While a vendor can assist with at least meeting the first two criteria on this list, the largest burden for most practices is the amount of work to report information to payers and to wait on authorization. Rather than spend several days or weeks gathering documents, filling out submission forms on payer portals, or on hold, look for one that will manage all that for you.

For the vendor to truly help to reduce your load, he or she should conduct a clinical review to ascertain the documents that will be required and then ensure that he or she chases the next necessary step in the authorization process and do this over and over if necessary. To better understand how much work the vendor will handle, consider asking these two questions:

What's the pricing model?

If you pay a flat rate or a percentage of collections instead of per authorization, the vendor can take a more cautious approach when pursuing orders that may require prior authorization.

When will you be consulted?

You can save more time by establishing an arrangement where you are consulted only when necessary, such as during a peer-to-peer discussion between a physician and the payer.

To prepare for the future, seek out more automation. Just as medical records and claims were once managed on paper, they have now transitioned to electronic systems as the standard. However, when it comes to prior authorizations, payers have been slower to adopt digital solutions.

The adoption of electronic prior authorization lags behind other administrative transactions.
In 2019, medical plans adopted fully electronic administrative processes at the following rates:

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

Increased adoption of existing standards for authorizations could help automate parts of the prior authorization process. The HIPAA-compliant Health Services Review (HSR) 278 electronic data interchange (EDI) transaction already enables users to initiate a new prior authorization or referral and submit electronic inquiries regarding its status to a payer's system.

However, there is significant potential to expand the use of this standard, as relatively few providers use it for pre-certifications and referrals compared to other submission methods. In the future, increased automation may streamline various aspects of the authorization process.

Consider the Following Potential Advancements:

Automated EHR Integration

- **EHR Submission Automation:** Imagine if your electronic health record (EHR) system could automatically identify and submit the required information to payers.
- **Natural Language Processing (NLP):** With NLP technology, EHRs could conduct clinical chart reviews by analyzing encounter summaries and notes and then submitting the necessary data to meet payer requirements.
- **Simplified Precertification and Referrals:** By automating this part of the process, straightforward pre-certifications and referrals that don't require follow-up could be submitted and approved without extra effort from the provider.

Vendor Selection for Long-Term Success

- **Future-Proof Partnerships:** When assessing your practice's needs, choose a vendor that can grow with you—one that is actively exploring machine learning, NLP, and other advanced technologies.
- **Beyond Quick Fixes:** While quick-fix solutions that reduce staff busywork are valuable, aim for an approach that integrates smoothly with your overall operations, including charting and revenue cycle management.

Strategic Focus

- **Immediate Impact:** Although new technologies are emerging, selecting the right strategic partner now can directly and immediately impact your practice's efficiency and success.

Prior authorizations are a major source of administrative burden in healthcare, but outsourcing and automation offer effective solutions. By working with the right vendor, your practice can reduce time spent on administrative tasks, improve patient care, and prepare for future advancements in authorization management.

Capline Healthcare Management:

Leading the Way in Pre-Authorization Services

At Capline Healthcare Management, we pride ourselves on being industry leaders who navigate the complexities of prior authorizations. Our expertise lies in streamlining the pre-authorization process for healthcare practices of all sizes, enabling them to overcome administrative challenges with ease.

Why

Choose Us?

Comprehensive Support

We are fully responsible for the authorization process from the beginning till the end. We recognize when authorizations are required, assess the patients' records, as per the requirement, and liaise with the payers to expedite authorizations.

Advanced Technology Integration

Our solutions can be easily implemented into your current EHR and revenue cycle management software. This gives real-time approval status, which eliminates manual tracking and increases efficiency by shortening the time taken and increasing accuracy.

Tailored Solutions

We have special service packages to suit all practices, no matter how big or small. To meet your needs without putting a financial burden on you, our service is configured to offer the best pre-authorization services possible.

Expertise in Payer Requirements

This keeps our team informed of the continuously emerging payer policies. We use this expertise to reduce denial and write-offs, guaranteeing that your submissions meet current guidelines.

Faster Turnaround Times

We have made it our goal to ensure that authorizations are approved as soon as possible; thus, the long waiting time for patients is a thing of the past. Our efficiency not only improves the perception that patients have about the healthcare facilities, but it also improves the general health of patients.

A Trusted Partner

When you partner with us at Capline Healthcare Management, you're not just outsourcing a task; you're gaining a dedicated ally focused on improving your practice's efficiency and patient care. With our assistance, you can concentrate more on what truly matters—providing quality care to your patients.

We invite you to discover how we can transform your practice.

Visit our website at **www.caplinehealthcaremanagement.com** to learn more about our services and how we can tailor our solutions to your specific needs.

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Nov 05, 2024