Unlocking The Future of Prior Authorization Management

A Comprehensive Guide to Reducing Cost & Increasing Revenue with Automation

Prior authorization and referral management is the largest source of revenue cycle cost, complexity, and frustration for most healthcare organizations. Worse, prior authorization and referral processes also pose the largest administrative risk to patient satisfaction, clinical outcomes, and revenue.

Medical Group Management Association's (MGMA) most recent Annual Regulatory Burden Report highlights that 89% of surveyed physicians state prior authorization is "very or extremely burdensome" on their practices. Similar findings have been published by the American Medical Association (AMA), revealing the costly administrative burden of today's prior authorization process pulls resources from direct patient care. These surveyed physicians indicate that prior authorizations consume 14 hours, or almost two full business days of physician and staff time per week.

There must be a better way. After all, most of the revenue cycle has been streamlined by now. Automated patient engagement, access, claims, and billing have reduced administrative time, labor costs, and avoidable revenue write-offs. So why not prior authorization and referral management? The key reason until now has been the lack of technology to automate prior authorization and referral management workflow in the same way it's been automated throughout the rest of the revenue cycle. However, there's a growing interest in the industry around leveraging technology to revolutionize healthcare finance, with a recent report from the Healthcare Financial Management Association (HFMA) highlighting an exponential growth in the value HFMA members place in preparing for the future impact of technology compared to last year.

This comprehensive guide illuminates the cost and complexities of prior authorizations for most healthcare organizations- and possibly yours. It then provides a detailed solution roadmap for healthcare providers to address prior authorization-related challenges and enhance the overall delivery and speed of care. **With these practical solutions, physicians and other healthcare providers can embrace a touchless future and alleviate administrative burdens in a sustainable, scalable way.**

Whether you're ready to adopt automation for the first time or make a switch from your current automation provider, here's where to start.

Step 1: Identify Your Core Challenges

As the saying goes, "You may know your destination, but to get there, you need to know where to begin." Before adopting prior authorization and referral management automation, you need to understand your organization's most significant challenges and prioritize them. If your organization relies on a manual workflow for these processes, there are likely financial, operational, and emotional costs and complexities to evaluate.

Financially, the toll of manual prior authorizations is evident in both unnecessary labor costs and avoidable denials resulting from errors and omissions. Operationally, manual prior authorizations are resource-intensive, with labor costs devoted to repetitive, less impactful, time-consuming work and training and retaining providers and staff. Manual processes also leave the door open for avoidable, human-made errors. Emotionally, burnout and attrition rates escalate due to manual prior authorization procedures' inherent complexity and repetitiveness. The administrative burden places a major toll on healthcare providers and their staff.

At the same time, processing prior authorizations manually can create costly and, in some cases, life-threatening treatment denials and delays. The impact of delays can be felt across patient satisfaction, reputation, clinical outcomes, reimbursement rates, revenue, repeat visits, and health system cash flow. Clinical outcomes are compromised as delayed care leads to postponed wellness and heightened risks of adverse events. Financially, the consequences include less revenue due to abandoned care and delayed revenue impacting cash flow.

You may know your destination, but to get there, you need to know where to begin.

Step 2: Understand Your Automation Options

Once you have a clear picture of your organization's prior authorization challenges, it's time to understand your options for addressing them.

Determination Automation: First-Generation Solutions

Automation can speed and simplify prior authorization and referral management, but not all automation is created equal. For instance, some artificial intelligence has proven to be more artificial than intelligent in automating parts of prior authorization management. The AI landscape is already littered with companies that gained traction with the promise of replacing manual processes and crashed with the disappointment of their automation shortcomings.

Like many flashy automobiles that spend more time in the shop than on the road, many bots spend a lot of time in the shop. Many bots require constant and costly programming and reprogramming to adapt to continuous payer portal changes, only to determine whether a prior authorization is necessary. Most importantly, provider organizations need to know that bots are delivering accurate information; otherwise, their users face denied claims from payers and consequential appeals and write-offs.

Most bots also pose risks and challenges to payer websites – this is if they can even access them through multi-factor authentication. Multi-factor authentication exists to thwart the continuous and indiscriminate traffic many bots generate. Bots can add to payer infrastructure costs, create a risk of crashing websites, and slow down responsiveness for discriminant traffic. Payer website forms and rules are dynamic, often requiring bots to be taken offline and reprogrammed to adapt. By the time many are reprogrammed and brought back online, they're often rendered obsolete. Additionally, bots are often limited to specific payers, plans, and specialties. Payers have nuanced processes, and various medical specialties and service types have their own unique nuances.

All this cost is incurred before the most expensive part of prior authorization management even begins- manual workflow to gain prior authorization for procedures, medicines, equipment, and more. Most solutions fail to automate the comprehensive manual workflow, including submission, status checking, verification, reporting, and bi-directional data sharing for all payers, specialties, care settings, and service types.

Workflow Automation: Best-In-Class Solutions

A new generation of solution providers has learned from the disappointments of first-generation "determination automation" and workflow automation solutions that don't address every payer, specialty, care setting, and service type.

An innovative type of best-in-class prior authorization automation has emerged, focused on the most expensive part of prior authorization management – the workflow of submitting, verifying, and proving prior authorizations for all payers. These solutions address the costly, complex, and error-prone aspects of prior authorization and referral processes by automating human processes. More practicality and less wizardry. They enable a simple, standard workflow utilizing a single platform and portal, replacing the need to submit and verify prior authorizations through dozens of disparate payer portals with their unique web and fax submission forms.

Additionally, these solutions enable a single workflow and platform for all care settings. This provides health systems with a consolidated view of staff productivity and payer performance across teams, specialties, and care settings. A single workflow, platform, and portal also requires less training for most organizations to adapt to multiple manual processes and technologies. This consolidated view is crucial for measuring productivity on an apples-to-apples basis, allowing health systems to optimize operations seamlessly.

The best of these solutions are also payer-friendly platforms. Rather than flooding websites indiscriminately, they replicate discriminant user workflows. This ensures smoother interactions with payer websites and reduces the risk of overloading and crashing the systems.

By all standards, a workflow automation solution is going to give you the best results for your investment.

Step 3: Prioritize the Features Your Organization Needs for Success

The features embedded in today's best-in-class workflow automation solutions reflect a commitment to comprehensive, efficient, prior authorization and referral processes with fewer errors. As you research your potential prior authorization automation options, these features will offer the biggest impact:

- One unified platform and portal that encompasses all payers, care settings, service types, and specialties. This consolidation minimizes the complexity of navigating diverse processes across payers, specialties, service lines, and care settings, providing a normalized experience for healthcare providers and their staff.
- Bi-directional data integration is another cornerstone feature. These solutions seamlessly integrate with Electronic Health Record (EHR) and Revenue Cycle Management (RCM) solutions, ensuring a cohesive flow of information across the healthcare ecosystem. No more wasted time and costly errors from key stroking or copying and pasting.
- Automated submission capabilities streamline the process of submitting data, documentation, attachments, and notes, eliminating manual redundancies and reducing the likelihood of errors.
- Continuous status-checking and verification/adjudication through one portal for all payers eliminates the time-consuming, tedious need to check and recheck status updates and verification through dozens of payer websites.
- Robust reporting functionalities offer insights into staff productivity and payer performance, enabling data-driven decision-making, continuous staff productivity improvements, and negotiating leverage with payers based on factual performance.
- Continuous, near-time payer rule updates to ensure that the system is always aligned with the latest payer requirements for successful prior authorization submission. No need for bots here.
- A strong service and support framework provides accessibility to a dedicated team through in-application channels and email, offering prompt assistance whenever needed.

Once you prioritize which features your organization needs to streamline and simplify your prior authorization process, you can turn your attention to evaluating specific solutions in the marketplace.

Step 4: Evaluate Solutions Based on Your Specific Needs

The number of solutions available to automate healthcare revenue cycle challenges is massive – one estimate indicates more than 250. It can feel overwhelming to navigate the space and narrow down the best automation partner for your organization. When you're ready to evaluate the suitability of a best-in-class automation solution, a comprehensive checklist ensures that you're equipped to make the most informed decision aligning with our specific needs and pain points.

- ❑ **Customization:** Can your provider tailor your solution just to your needs? Payer mix, healthcare settings, service types, and specialties all vary. A customizable solution ensures that your workflow aligns precisely with organizational needs.
- ❑ **ROI Expectations:** What ROI can you expect, and how will you generate it? Lower costs and increased revenue are key metrics. Lower costs may manifest through a reduced headcount managing prior authorizations and referrals, as well as less time spent appealing denied claims. Increased revenue may result from fewer denied claims due to prior authorization and referral errors, reduced cancellations/ abandonments, and improved reimbursement rates attributed to higher patient satisfaction.
- ❑ **Payer Connectivity:** Can your solution consolidate all payers into one portal irrespective of specialties, plans, and service types? Payer connectivity is integral to achieving operational efficiency.
- ❑ **Payer Changes:** Can your partner update without software releases to reflect current payer rules on a near-term basis? Near-time updates ensure that the platform is always aligned with the latest payer requirements.
- ❑ **Holistic Coverage:** Does your platform accommodate all care settings, service types, and specialties? The ability to provide a standardized workflow across diverse healthcare domains enhances efficiency.
- ❑ **Automation:** Does your solution take your information and clinical documents and automate the entire prior authorization and referral submission cycle? A comprehensive automation solution should cover submission, status checking, verification, reporting, and bi-directional data sharing.
- ❑ **Status Inquiry/Verification:** Can your solution verify and enable you to retain proof of previous prior authorizations and referrals? The solution's capability to prove verified authorizations is crucial for ensuring accuracy and minimizing errors in the authorization and referralprocess.
- ❑ **Real-time Reporting Tools:** Does your solution provide real-time reporting tools? These arm healthcare providers with actionable insights into their operations and relationships with payers based on their authorization turnaround times (TAT), rates of approvals, and the like. Data-driven decision-making becomes more accessible with comprehensive reporting functionalities.
- ❑ **Service/Support Quality:** A large, well-known technology provider may give you comfort in their brand, but who can you reach when you have an issue, and how do you reach them? Will bots provide you pre-programmed, diluted answers or will you receive personal attention? Accessibility, personal attention, and the importance placed on the partnership by the service and support team are critical considerations. Providers need assurance that they can reach a responsive team when assistance is required, fostering a collaborative and supportive relationship.
- ❑ **Pricing Transparency:** Is your proposal tailored just for you so that you're paying only for what you need? Clear and transparent pricing is essential. Tailored proposals that align with the specific needs of the provider ensure that they pay for the functionalities they require, avoiding unnecessary costs.
- ❑ **Onboarding:** What can you expect from your onboarding experience? How long will it take, and what is your role vs. your partner? The onboarding experience is a pivotal phase in implementing any automation solution. Clear expectations, defined timeframes, and understanding the roles and responsibilities of both the provider and the partner ensure a smooth transition.
- ❑ **Client Testimonials:** What do your prospective partner's clients say? Insights from existing partners provide valuable perspectives on the solution's performance, reliability, and the overall experience. Understanding the satisfaction levels of current users adds a layer of assurance for prospective adopters.
- ❑ **Authorization Submission:** Does your solution automatically submit to payers? This is a key differentiator among the vendor options in the space. Very few can truly automate this step and provide automated status checking throughout the prior authorization workflow.

Step 5: Select a Trusted Industry Partner

With the help of the checklist and the rest of this comprehensive guide, you can begin to identify your prior authorization automation needs and best options to address them. From there, it's time to make your decision. Engaging with a prospective partner involves a structured process aimed at understanding the unique needs of each organization and tailoring a solution that aligns with those needs. Healthcare organizations and providers that partner with Valer can expect to receive that level of care from the onset of the working relationship. We take a seven-step approach with our new clients, adapting our solution to your existing workflow and doing what we do best: speeding and simplifying your prior authorization workflows so you have more time for patients.

1. **Understanding Needs:** The initial step in working with Valer involves an in-depth consultation for us to comprehend your specific requirements. Understanding the intricacies of your healthcare setting ensures that our proposed solution is tailored to address your pain points.
2. **Tailored Solution Explanation:** Following a thorough evaluation of your organization's needs, the Valer team explains a solution that is tailored to your unique requirements. This phase involves a detailed presentation of how the proposed solution aligns with your pre-existing prior authorization and referral management workflow.
3. **Product Demonstration:** Next, we'll demonstrate the proposed solution in action, offering a view of its capabilities. This step lets you witness firsthand how the solution streamlines workflows and addresses your specific challenges.
4. **Developing Business Case and Expected ROI:** Collaboratively, a business case is developed outlining the expected return on investment. This collaborative approach ensures that we have a shared understanding of our solution's anticipated benefits and outcomes.
5. **IT Evaluation:** Integration and Information Security: An evaluation of your existing IT infrastructure and the potential integration points with the Valer solution is conducted. Information security considerations are also addressed to ensure the seamless and secure integration of the new system.
6. **Contracting:** Formalizing the partnership involves the development and signing of contractual agreements. This step ensures that both parties are aligned on the terms and conditions of the partnership.
7. **Onboarding and Training:** The onboarding phase marks the beginning of the implementation journey. We provide a structured onboarding process and comprehensive training sessions to ensure a smooth transition to the new system. In this phase, we define the roles and responsibilities of both our team and yours, setting the foundation for a collaborative and successful partnership.

Better Patient Outcomes Powered by Automation

The journey to efficient prior authorization and referral processes in healthcare requires a comprehensive understanding of the challenges, the limitations of existing solutions, and the potential benefits of best-in-class automation. As healthcare providers navigate this landscape, a thoughtful evaluation of solutions, adherence to a checklist, and engagement with reputable partners like Valer pave the way for transformative changes. The goal is not merely automation but a seamless integration that enhances overall healthcare delivery, improves patient outcomes, and ensures the financial sustainability of healthcare practices in an increasingly complex and dynamic healthcare ecosystem.

If you're ready to adopt better automation for your prior authorization process, Valer can help. Request a free demo today, or learn more online.

45% less staff time for submission

11% more staff productivity

13 days extended from 5 days in authorized days out

80% reduction in manual authorization processing time

Valer