Optimizing the Prior Authorization Process

Speed turnaround, reduce administrative burden, improve patient experience

AMA Prior Authorization (PA) Physician Survey Results:

- 93% report prior authorizations cause delays in access to necessary care
- 93% report prior authorization causes care delays
- 82% report that prior authorization sometimes lead to treatment abandonment
- 34% of physicians report that prior authorization has led to a serious adverse event for a patient in their care
- Physicians and their staff spend an average of nearly 2 business days each week completing prior authorizations
- "While 98% of health plans report they used peer-reviewed evidence-based studies when designing their prior authorization programs, **30% of physicians report that prior authorization criteria are rarely or never evidence-based."**

In a world where roughly 90 percent of authorization requests are ultimately approved, dedicating payer and provider resources to administering prior authorization processes is expensive. What's more, lag time in approvals can have serious consequences for patients, leading to delays in access to care that can affect outcomes and sometimes cause patients to abandon treatment. With the spotlight on the human costs of the prior authorization process, it is critical to improve authorization accuracy and speed to positively impact outcomes and experience and to lower costs.

Prior Authorization Process Creates Significant Burden

For many organizations, the authorization process is a manual but complex process—a mix of phone calls, faxes, portals, and even snail mail that requires multiple steps and touchpoints, each vulnerable to errors and delays. During all the back and forth required to ensure information is accurate and complete, the clock keeps ticking and critical care can be delayed or denied altogether, creating stress for patients and providers and decreasing satisfaction for all involved. And, of course, these manual processes tie up clinical resources better spent on patient care.

The challenges of the preauthorization process were recently highlighted in a Department of Health and Human Services Office of Inspector General (OIG) report that showed that Medicare Advantage (MA) plans not only delayed and denied patient access to medically necessary treatment, but also denied payments for services that met both coverage and billing rules.

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In addition to suggesting new guidance and updated audit protocols, OIG recommended that CMS direct MA plans to address vulnerabilities that can lead to review and system errors.

CMS Prior Authorization Reforms Improving Access to Healthcare

As part of CMS' goal to ensure that Medicare Advantage (MA) beneficiaries receive consistent access to medically necessary care, CMS has proposed a rule that changes the prior authorization process to improve patient and provider access to health information and streamline prior authorization processes through electronic prior authorization. The proposed rule would require the implementation of Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) standard Application Programming Interface (API) to facilitate data exchange and shortening prior authorization response times for certain payers. The rule also would establish policies to make the prior authorization process more efficient and transparent, and to implement standards enabling data exchange between payers to support patient transitions.

While these proposed reforms will stage in over time, taking steps toward speeding prior authorizations will help reduce the administrative burden today while ensuring swift, evidence-based care that improves the value, experience, and satisfaction for those you serve.

Technology Solves Prior Authorization Headaches

The right technology can automate manual processes, reducing these points of friction and replacing repetitive, manual tasks to speed decision-making so that your organization can meet mandated turnaround times. InfoMC's Incedo care management platform offers a highly configurable and automated approach to managing care across interdisciplinary teams supporting medical, behavioral, and social determinants. By automating authorizations through the standard process flow of intake, clinical review, medical director review, and decision notification, Incedo prevents delays and ensures the right care is delivered to members no matter what their condition or risk factor.

Department of Health and Human Services Office of Inspector General (OIG) results:

- 13% of prior authorization requests denied by Medicare Advantage plans met clinical coverage rules of traditional Medicare
- 18% of denied payment requests met Medicare coverage and MA plan billing rules

Automation helps remove the administrative roadblocks that delay care, freeing up clinical resources and eliminating miscommunication and errors through streamlined workflows and accurate, timely authorization feedback. Near real- time determinations reduce provider/member abrasion and worry about even the most stringent turnaround time requirements. This increased responsiveness not only improves the quality of the experience

for both patients and providers, but reduces costs and leakage, ultimately preventing lost revenue. Incedo also includes a dedicated provider portal with automated workflows which speed authorization processing, enable auto-approvals, and improve communication and provider self-management.

Personalize and evolve processes to support innovation and compliance

Incedo's authorization process is highly flexible and can be personalized for the individual needs of each program and provider, with configurable rules and workflows that improve efficiency, reduce cost, and help you adapt to changing regulatory and business requirements. Authorization workflows can be configured for automatic approval or routed for review based on authorization type, process stage, type of service, and priority—and even tailored to "gold-card" providers based on performance or other criteria.

Incedo processes and workflows align with regulatory guidelines—including CMS NCQA, URAC, and state-required elements and processes—so that you can proactively monitor and manage performance and ensure compliance. Configurable reporting enables you to track key metrics, including turnaround time, to support compliance with standard and expedited UM decisions and notification timelines.

Integrated care guidelines improve and automate decision-making

Incedo is integrated with MCG Care Guidelines for Behavioral Health and InterQual clinical decision support for medical and behavioral health to support a more efficient clinical review process, standardizing the process for determining appropriate levels of care for individuals with complex needs. Guidelines can be seamlessly accessed from within a decision support workflow and searched by category, keyword, or indication. The platform automatically identifies the relevant guideline for a service request and whether the request meets the necessary criteria, then populates the fields accordingly.

Technology Innovation Boosts Productivity

InfoMC is actively innovating to improve Incedo's prior authorization functionality. Recent innovations include logic-based rule configuration improvements to reduce the human costs of authorizations, UI improvements to enhance usability and productivity, submission process enhancements to ensure information accuracy and prevent errors, concurrent service requests for claims continuity, integration of CMS 1500 form with auto-population into our provider portal to ensure accuracy, and provider payment holds management functionality. Stay tuned for additional functionality that will help you address CMS requirements.

Ready to learn more?

InfoMC's team of experts can help you navigate the challenges of integrated healthcare to improve outcomes, efficiency, and satisfaction. Contact us today to find out how we can partner with you to achieve your value-based care goals.

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