OPTIMIZING EFFICIENCY OF PRIOR AUTHORIZATION PROCESSES FOR PAYERS AND PROVIDERS

Proposed Solutions to Improve Patient Access to Care

by the National Association of Healthcare Access Management

ABOUT NAHAM

The National Association of Healthcare Access Management (NAHAM) is the non-profit association for health-access professionals — individuals who work in, and oversee, hospital scheduling, admissions, registration, patient finance, benefits coordination and frontend revenue cycle-related services. NAHAM establishes best practices and subject-matter expertise; provides an array of networking, education, and certification opportunities; and enables its members to influence and promote high quality delivery of patient access services. Prior authorization falls within health-access professionals' responsibilities and directly affects NAHAM members. NAHAM members' experiences and perspectives provide insight into how prior authorization can be improved nationwide.

READ MORE

INTRODUCTION

The purpose of this whitepaper is to propose broad recommendations to help improve prior authorization processes, which set the stage for a roundtable discussion among payers, providers, and vendors. The goal of the roundtable is to collaboratively devise specific, actionable solutions that stem from these recommendations that will result in improved healthcare nationwide.

BACKGROUND

Prior authorization—sometimes called precertification or prior approval—is a cost-control process by which a provider must obtain advance approval from a health plan before a specific service is delivered so the patient can qualify for payment coverage. However, because no prior authorization standards exist in the United States, each payer uses a different process, which places a significant burden on providers[1] to navigate several different systems to obtain the appropriate coverage for their patients. Prior authorization, when measured in real time, has been found to cost approximately $2,100 to $3,400 (in 2010 dollars) per full-time equivalent physician annually.[2] Furthermore, because prior authorization is not optimally automated, payers also bear a higher cost than is necessary to staff inefficient prior authorization procedures. In its current form, prior authorization results in higher healthcare costs, delays in patient care, and potential harm to patients.

GOALS

In October 2021, NAHAM formed a Prior Authorization Task Force[3] to identify current challenges and feasible solutions to reduce administrative burden and costs for payers, providers, and patients that prior authorization can cause. The Task Force established the following goals upon its formation:

01 Partner with payers to make prior authorization more efficient for both providers and payers.

02 Ensure existing prior authorization requirements are based upon current evidence to ensure that cost savings for payers and providers outweigh the administrative burden for both parties.

03 Create criteria to enhance standardization and automation of the prior authorization process.

04 Create criteria whereby providers are deemed "gold members" and thereby exempt from prior authorization.

05 Develop a whitepaper that addresses potential solutions for the top challenges associated with prior authorization.

06 Host roundtables with stakeholders (including payers and vendors) to ensure potential solutions are a win for patients, providers, and payers.

SCOPE

The Task Force's scope includes prior authorization in outpatient settings, notice of admission, peer-to-peer reviews, and add-on/STAT procedures. The Task Force decided not to address prior authorization for inpatient procedures, prescriptions, and durable medical equipment at this time.

THEMES

This whitepaper is a result of the goals and scope outlined above as well as a survey of NAHAM members, Task Force discussion, and listening sessions with some of NAHAM's business partner members.[4] The business partners that participated in NAHAM's listening sessions included AccuReg, Change Healthcare, Experian, FinThrive (formerly Pelitas), and Voluware. NAHAM's business partners played a crucial role in contributing to NAHAM's understanding of the technological challenges and opportunities surrounding prior authorization.

During its many discussions and listening sessions, the Prior Authorization Task Force identified two overarching themes to improve prior authorization processes for all parties: standardization and automation. Standardization creates processes that vary as little as possible among payers and providers. Items and services requiring prior authorization, as well as the information required to prove their medical necessity, should be based upon current evidence, whereby the current evidence guides standardization efforts. Automation uses technology to improve efficiency in the process of seeking, receiving, and appealing prior authorization decisions.

STANDARDIZATION

The primary complaint with prior authorization that NAHAM members identified was a lack of standardization among payers. NAHAM members identified many other problems that can be traced back to a lack of standardization. These include, but are not limited to:

- excessive documentation required to obtain authorization;
- authorization denials lacking consistency;
- identifying the appropriate department/office to provide documentation proving medical necessity when multiple departments/offices are involved;
- varying and increasingly complicated peer review processes that are not convenient or accessible by providers caring for patients;
- delays in obtaining authorization;
- receiving conflicting information from various employees from the same payer regarding policies and procedures;
- and frequently changing policies and procedures.

NAHAM recommends establishing and implementing evidence-based prior authorization policies and procedures that use the most current data.

For example, if payer policy indicates that a certain medical procedure should only be covered under certain circumstances, those circumstances should be defined based on the strongest clinical evidence of the time, approved by the larger medical community, and shared by all payers. As best practice, NAHAM recommends that the information required to prove medical necessity for items and services requiring prior authorization–and who must provide such information– should not vary among payers.

NAHAM recommends standardizing the process of reviewing clinical data and updating requirements on a regular basis.

The unpredictability and variability of payer updates to their prior authorization requirements result in unnecessary treatment denials and delays in patient care. If clinical data for items requiring prior authorization were reviewed annually by a board of payers and clinicians, and policies and procedures were updated on a predictable schedule, providers and payers could adjust their practices more efficiently. This would also help keep payer personnel informed and updated, which would decrease payer inconsistencies in approvals and denials.

NAHAM recommends that all payers institute a standard prior authorization grace period.

This applies to the addition of procedure codes after a surgery, retrospective approvals when urgent treatment is needed, treatment for newborns, and appealing any prior authorization denials. Implementing a grace period for providers to complete the aforementioned tasks reduces the financial and administrative burden on patients when presented with unexpected medical bills for a denied claim.

AUTOMATION

Automation is critical to improving prior authorization processes. Some of the prior authorization challenges that healthcare access professionals regularly face that automation could improve include:

- excessive documentation required to obtain authorization;
- authorization denials lacking consistency;
- obtaining procedure codes;
- delays in obtaining authorization;
- phone calls with payers including long hold times, leaving voicemails and waiting for responses, and receiving conflicting information from various employees from the same payer regarding policies and procedures;
- staffing for both providers and payers to handle the high volume of work associated with prior authorization;
- notice of admission (NOA);
- and peer reviews.

NAHAM recommends using integrated technology with electronic health records (EHR) to support prior authorization.

Adherence to the existing electronic 278 standard transaction is the fastest, simplest way to take an enormous burden off of providers. Under the current system, payers depend upon personnel to handle faxes, emails, and phone calls to share clinical information related to prior authorization. By integrating EHR and the 278 standard transaction into prior authorization portals, payers could handle much of this process through automation, which would decrease the need for additional staff and reduce costs. Additionally, automation would decrease discrepancies in approvals/denials of care, saving time for payers and providers by reducing the need for appeals and policies and procedures clarifications.

NAHAM recommends that payers use diagnosis codes as the foundational information to support medical necessity in authorizing treatment.

This would not only simplify the documentation required for prior authorization requests, but would also ease standardization among payers and providers. Diagnosis codes would also expose less private health information, which should be a high priority among all payers and providers in the age of frequent cyber attacks. NAHAM supports a "trust but verify" approach in which a diagnosis code is sufficient in most cases, but payers retain the right to audit a prior authorization request by reviewing physical records retrospectively, if necessary in certain circumstances.

NAHAM recommends transparency in prior authorization policies and procedures.

For automation to be fully functional, providers and industry partners need visibility into payers' policies and procedures. Transparency into treatments that require prior authorization, as well as the procedural requirements for obtaining prior authorization, would allow industry partners to create integrated technological platforms that would quickly and accurately transmit prior authorization information.

WHY IT MATTERS

Although this information is not new, it bears repeating: improving the prior authorization process will help providers, payers, and patients. Prior authorization is a barrier to care that, if improved, could increase access to care, especially among the most marginalized who do not have the time, support, or financial means to advocate for their healthcare. Improving processes, while challenging and potentially costly in the initial phases of implementation, will ultimately improve efficiency. Improving efficiency could also reduce delays in patient care and decrease the potential for patient harm. Improving prior authorization would not just result in a better healthcare experience for patients, but would also result in reduced administrative costs and procedural burdens for payers and healthcare providers alike.

Improving processes

Improving efficiency

Improving prior authorization

Improved patient care

REFERENCES

1. “Providers” throughout this whitepaper refers to both healthcare facilities and clinicians/practitioners
2. Morley CP, Badolato DJ, Hickner J, Epling JW. The impact of prior authorization requirements on primary care physicians' offices: report of two parallel network studies. J Am Board Fam Med. 2013 Jan-Feb;26(1):93-5. doi: 10.3122/jabfm.2013.01.120062. PMID: 23288287.
3. The Task Force is comprised of NAHAM Immediate Past President Michelle Fox and President Stephanie Benintendi, along with eight other NAHAM members and three members of NAHAM staff.
4. Business partner members of NAHAM are businesses who service the healthcare industry with particular relevance to patient access services.