5 Best-Practice Steps to Automate Prior Authorization

Preventing no-authorization denials and getting patients timely, quality care is no easy feat. As payers increase prior authorization requirements, providers struggle to hurdle escalating barriers to scheduling care, incurring millions of dollars in administrative costs and lost revenue.

Worse, patients are caught in the crossfire. While payers say the intent of prior authorization is to control healthcare costs, nearly one in four physicians surveyed said prior authorization requirements led to a serious adverse patient event. And when no-auth denials come knockin', guess who foots the bill? The *surprise* bill, that is. You guessed it. Patients.

Why Providers Need Intelligent, Automated Prior Auth

Despite the 278 transaction standard readily available for years, and the tremendous cost savings adopting electric transactions would bring, insurers continue to maintain arcane, convoluted prior authorization processes. Hospital groups are calling for government oversight to enforce the use of electronic transactions and to regulate payer response times, but in a time where hospitals are drowning in staffing shortages and managing constricted budgets, they can't afford to wait for a lifeline.

Instead, providers have looked to technology companies to build automation tools using robotic process automation (RPA) and intelligent rules engines to navigate the ever-changing labyrinth of payer portals, rules and requirements. Many EHRs provide work queues for staff to manually complete prior authorization processes, which still rely heavily on human intervention—putting a strain on already short staff. Others solve for parts of the problem, one for determination, one for submission, another for retrieval. None deliver a comprehensive solution.

It doesn't have to be that way. Using intelligent automation, technology can solve for determination, submission and retrieval. Providers need real solutions, not more empty promises or misconstrued artificial intelligence.

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Step 1: Demographic Audit

It's critical to have automated quality assurance measures in place to audit patient data before prior authorization submissions. If not, you're susceptible to rework, denials and lost revenue.

An integrated first step of the prior authorization process, quality assurance:

- Automatically audits 100 percent of patient registrations to identify and prevent financial and administrative errors
- Alerts staff in work queues with errors and payment risks along with instructions for resolving issues
- Automatically re-audits registrations after any changes
- Uses pattern recognition analysis to continuously update automated rules engine to prevent recurring errors and related rework

Step 2: Eligibility Verification

Eligibility verification consists of two levels of automation: eligibility verification, plus benefit mapping. Our intelligent rules engine analyzes remit data and isolates likely denial-causing payment risks before they occur.

Using AccuReg for eligibility verification provides:

- Benefits verification on 100 percent of accounts
- General and targeted service verification
- Automated batch and manual real-time submission
- Self-pay verification
- Found coverage and coverage change detection
- Benefit threshold alerting
- Coordination of benefits alerting
- RTE, 270/271, HL7 transactions
- Benefit post-back to EMR

Step 3: Determination

Arguably the most critical and time-consuming step in prior authorization, hospitals dedicate a significant number of resources to determine when an account requires authorization. AccuReg reduces time spent on the phone, at the fax machine and searching payer websites to get patients authorized for the services they need—faster and with fewer denials.

Using AccuReg for automated determination:

- Automatically determines if authorization is needed using rules that are payer- and employer-specific to ensure rules are as current as possible to predict and prevent denials
- Offers flexible options for grouping and sorting work to meet the unique needs of each customer (e.g., by payer, patient alphamix)
- Notifies staff within their work queues when authorization is needed
- Enables staff to easily look up when auth is needed by payer to reduce manual processes

Step 4: Submission

Using AccuReg for automated submission:

- Standardizes manual and fax-based authorizations through a single web portal
- Automates the generation and submission of web forms for easy staff upload
- Guides staff through payer rules and requirements, providing necessary forms and questionnaires, while pre-populating data as available
- Provides staff insight into the status of submissions within their work queues (i.e., appended/additional documentation needed)
- Customizes rules that alert to specific payer and employer plan needs
- Provides in-depth, real-time reporting on key authorization metrics, including payer turn-around time, coverage determinations and authorization requirements

Step 5: Retrieval

AccuReg eliminates the need to manually check status on payer portals. Our intelligent automation does the work for you, monitoring response status and retrieving the authorization or denial number, along with additional documentation requests.

Using AccuReg for automated retrieval:

- Eliminates manually checking status on portals
- Delivers automated responses into staff work queues, including auth status, denial number or instruction if further documentation is required
- Enables clinical staff to proceed to service more quickly with less staff resources
- Eliminates time on hold, waiting for returned phone calls and manual updates to spreadsheets
- Allows staff to reallocate time to managing submissions to improve accuracy and likelihood of approval

Intelligent, End-to-End Automated Prior Authorization is Here

Authorization Manager, part of the AccuReg EngageCare® integrated patient access, intake and engagement platform, integrates with your EHR and simplifies disjointed phone, fax and web-based processes to reduce frustration and increase productivity.

Read the eBook to learn how to automate determination, submission and retrieval for all payers and service lines so your hospital can prevent prior auth denials before they happen, streamline staff processes and generate more revenue.

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