End-to-End Prior Authorizations

How AI, automation and business intelligence are changing the prior authorization game

Availity®

Executive Summary

Prior authorizations, a critical tool of utilization management, are necessary for establishing checks and balances in the healthcare system. Unfortunately, too many providers and health plans consider the prior authorization process, which relies heavily on manual interventions and analog technologies, burdensome and a potential impediment to timely patient care.

Market research indicates that adoption of electronic prior authorizations remains the lowest among all healthcare transactions but could save the industry approximately $450 million per year.

According to the *2022 CAQH Index Report*, prior authorizations are among the most cumbersome and time-consuming transactions in healthcare. Resource allocation on providers and payers to complete this end-to-end process is significant and costly.

...Time associated with conducting a prior authorization manually **(20 minutes)**, via a portal **(12 minutes)** and electronically **(nine minutes)** remained the highest among the transactions studied. Given the ongoing burden associated with conducting prior authorizations, public and private efforts continue to focus on best practices, standards, and technology to help **reduce burden** and **support use of the electronic standard.**

2022 CAQH Index Report

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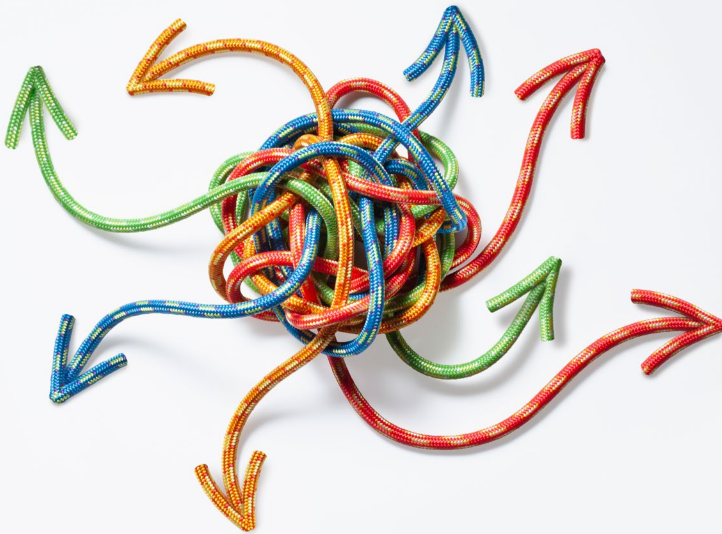

The complexities of prior authorizations make automation and the application of artificial intelligence difficult for several reasons, including:

- Every health plan has its own policies and processes for prior authorizations, which can vary by procedure, provider, and even patient.
- Healthcare's inconsistent data standards challenges provider integration and automation across multiple health plans.
- The clinical data from the longitudinal patient record required for medical necessity review are trapped in different information silos.
- Patient variability, based on such factors as age, disease states, treatment response, and comorbidities, creates complexity in determining whether an individual meets the medical necessity criteria and poses the most significant challenge to the prior authorization process.

This white paper will focus on bringing clarity to a process riddled with confusion and provide technology recommendations to solve the associated problems.

Authorizations: By the Numbers

94% Physicians who say that the authorizations process "sometimes" or "always" delays access to necessary patient care.[1]

35M Authorization requests submitted to Medicare Advantage insurers on behalf of Medicare Advantage enrollees in 2021.

80% Physicians who report that the authorizations process has sometimes lead to treatment abandonment by the patient. AMA. 2022 AMA prior authorization (PA) physician survey.[1]

75% Denied authorizations requests overturned on appeal by Medicare Advantage Organizations between 2014–2016.[2]

45 Average number of authorizations individual physicians complete per week. Physicians spend an average of two business days per week just on authorizations.[1]

35% Physicians who have full-time staff dedicated entirely to authorization management.[1]

1 Source: American Medical Association (AMA)
2 Source: HHS

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Why Prior Authorizations Lag Other Healthcare Transactions

Part of the reason prior authorizations are hard to automate is that they are both **administrative** and **clinical transactions**. In fact, to call an authorization a "transaction" is misleading. The nature of prior authorizations is much closer to a conversation.

The administrative side requires objective information—Who is the patient? Which service do they need? Where is it going to take place?

The clinical side of prior authorization is much more subjective and falls under payers' bespoke medical policies and the holistic care of patients—What are the various clinical aspects of this patient? What treatment have they been under previously? What comorbidities do they have? What are specific carve-outs for their plan that caused this to be more complex?

Ultimately, the payer is burdened with determining if the request is medically necessary (consistent with evidence-based literature) across a myriad of clinical conditions while managing the overall spend. Furthermore, the payer is required to offer benefits to a diverse set of stakeholders and create policies the support the benefit structure uniquely. While standardizing those policies may add to improved automation, it might also prevent the level of variability payers need to be competitive.

Digitizing and automating authorizations also surfaces the challenge of data standardization. There is not one set of standards that are adopted across the industry in terms of when prior authorizations are required. The requirements for a prior authorization can vary all the way down to the plan or even product type, and employer group level. In addition, there are variations on how payers interpret literature for the clinical condition or how stringent to apply this literature to their approach to managing utilization.

To help marry workflows, technology vendors are necessary to help facilitate the exchange of clinical data and administrative data into a more seamless process.

Due to the complexity of the authorization rules, providers submit prior authorizations that are not necessary, adding additional work for payers and providers. Checking prior authorization status and exchanging required claims and clinical information often requires multiple rounds of phone calls, faxes, and emails, often leading to long wait times and delayed patient care.

Health plans face their own set of challenges when it comes to prior authorizations. This includes reviewing thousands of prior authorization requests every day and expending significant capital operating call centers to handle incoming calls and managing faxes from providers.

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There are several focus areas that will help the industry achieve wider electronic adoption:

1 Standardize the administrative components of prior authorizations

One of the key obstacles with prior authorizations is that they are not purely administrative or clinical, but more of a conversation that addresses both. On the administrative side there are key tactical details, including what patient, what procedure or test was ordered, where it will be performed, etc. On the clinical side, there are more subjective aspects that ensure a holistic approach to care, such as prior treatments, comorbidities, specific plan coverage, and more.

2 Encourage interoperability

The current environment is fraught with variability in policy and process, highlighting the need to normalize requirements and data for better interoperability among the systems that house data, including EHRs, radiology, billing, and member management systems. While HIPAA 278 and HL7® FHIR® (Fast Healthcare Interoperability Resources) standards exist to standardize healthcare data exchange, they have not yet gained high adoption and it is unclear how effective adoption will be given variation in provider and payer systems and data storage locations.

More work needs to be done among stakeholders to acknowledge the complexity inherent to prior authorization transactions and create a robust framework that ties administrative and clinical information together, making wider adoption of electronic transactions possible and effective.

To that end, recent proposed rules from the Centers for Medicare & Medicaid Services (CMS) may require payers to build and maintain a FHIR Prior Authorization Requirements, Documentation and Decision (PARDD) API that would automate the process for providers to determine whether a prior authorization is required, identify prior authorization information and documentation requirements, as well as facilitate the exchange of prior authorization requests and decisions from their EHRs or practice management system.

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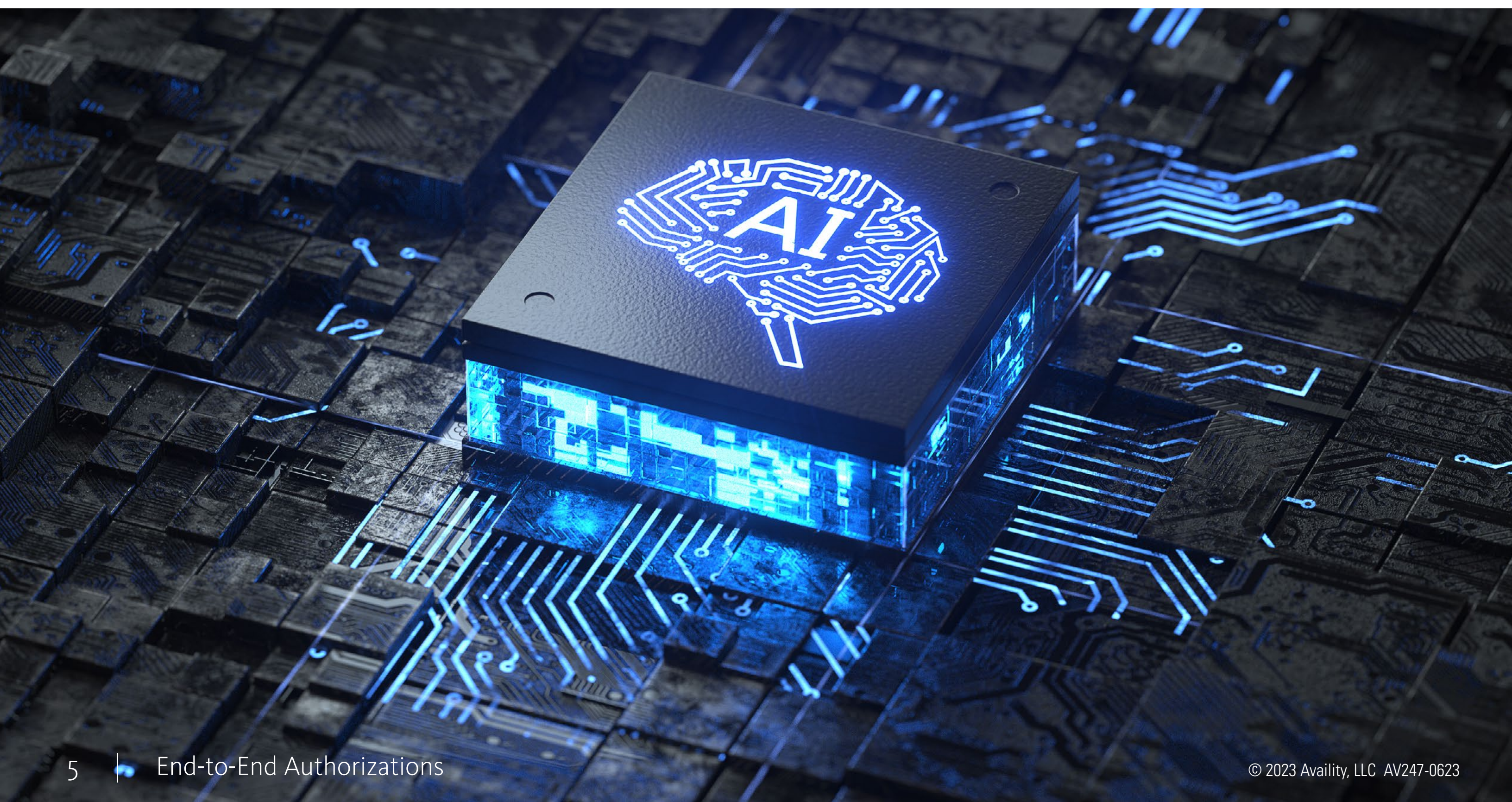
3 Integrate AI into the end-to-end process

True integration among provider and payer systems **is possible** with standardization and interoperability. With access to required data, prior authorization workflows can be automated, **reducing** the administrative burden on staff.

Artificial intelligence (AI) capabilities are rapidly evolving and demonstrating they can take on some of the more complex processes in healthcare. For example, providers are using AI tools to determine if authorization is required and then automate and streamline key steps in the submission process.

True integration among provider and payer systems is possible with standardization and interoperability. With access to required data, prior authorization workflows can be automated, reducing the administrative burden on staff. For example, when a provider orders a shoulder MRI for a patient, AI can gather documentation for the prior authorization from the patient's record that confirms recommended imaging, pain management, and physical therapy protocols have been completed. When additional information is required, the user can be prompted to take further action.

The key will be applying automation to protocols already well-aligned across payers. This automation will enable faster processing for patients within a standard protocol, such as meeting the criteria to proceed with a joint MRI, while complex cases, such as transplants, follow the traditional process.



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Prior Authorization Abrasion Points

According to the American Medical Association's **2022** provider survey, **93%** of respondents reported care delays, **82%** said that patients abandoned a course of treatment, and more than a third reported adverse clinical outcomes due to prior authorizations.

A closer look, however, reveals that the cause of provider frustration is not the prior authorization itself but the underlying, mostly manual processes that support it:

- **Many medical services don't require prior authorization, but provider staff still spend time on hold or wait for a call back from the payer to receive confirmation. With so many payers—each with different types of plans—providers lack a fast, easy way to determine if a prior authorization is even necessary.**
- **Many providers lack clarity whether a prior authorization request should be submitted directly to the health plan or to a utilization management vendor.**
- **In many cases, the individual submitting the request for prior authorization does not have access to the clinical information requested by the payer.**
- **Another factor complicating prior authorizations is the requirement to include medical documentation for clinical review. Reliance on fax and mail to exchange records increases the chance that information will be lost, resulting in a delayed response from the payer.**

Front desk personnel must carefully track prior authorizations against patient rosters to ensure they receive an answer before the patient's visit. Not surprisingly, it's easy for requests to get lost in the shuffle, potentially delaying a patient's access to treatment. While a HIPAA-mandated ANSI transaction—X12 278—exists for prior authorizations, it remains poorly adopted and only solves part of a complex equation. Prior authorizations require a careful conversation between the payer and providers to ensure the right data is shared in the right way with little guessing.

Federal regulators have proposed several rules mandating the use of automated or electronic prior authorization processes, but many payers and providers lack clarity into an automated solution.

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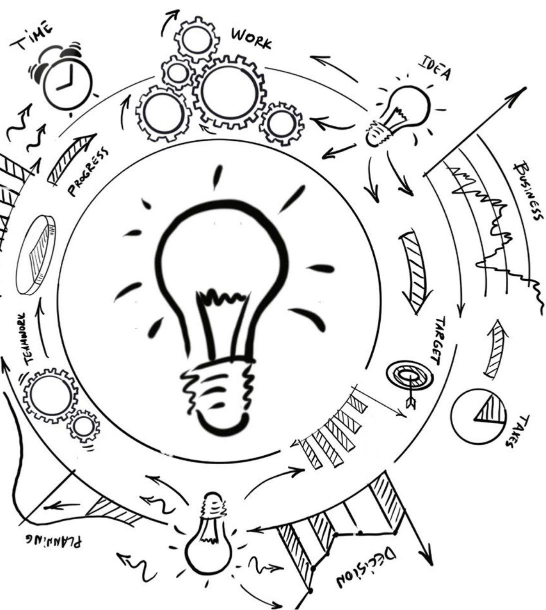


Availity Solutions

As the nation's largest real-time health information network, Availity processes more than **13 billion** electronic transactions a year across **thousands of payers** and **millions of providers**. Additionally, Availity has served as an active collaborator with industry organizations, including Health Level Seven International (HL7) DaVinci Project, the Workgroup for Electronic Data Interchange (WEDI), ASC X12, and the Cooperative Exchange to advance standards in data usability and exchange.

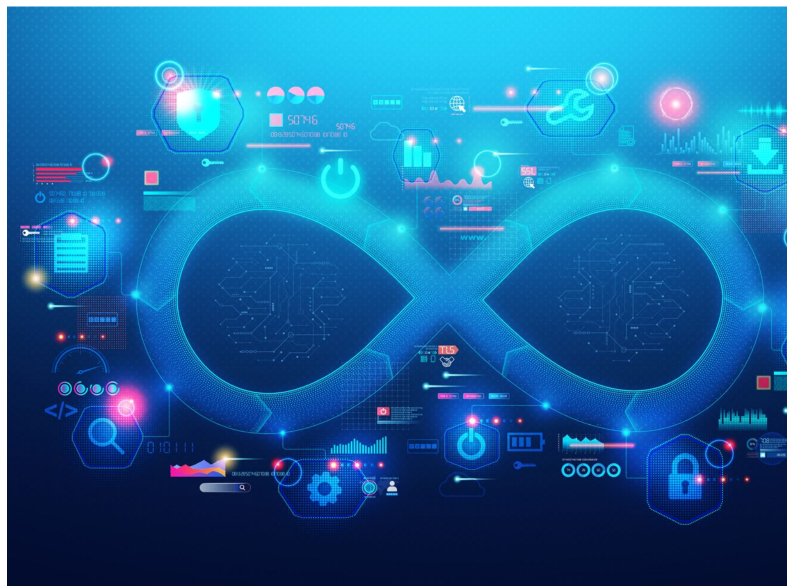
Availity's Intelligent Gateway is home to Availity's core authorizations functionality, offering 278 and API tools for electronically submitting prior authorizations. The Intelligent Gateway uses bi-directional EHR integration to ensure that providers capture the information payers need for an authorization request. Availity applies X12 edits, validations, and payer edits to the request and ensures that the data is formatted correctly to allow payers to consume the request within their utilization management systems.

Availity also exchanging medical attachments through the X12 275 transaction. This connection saves providers additional time by fulfilling these requests from the health plan. This ensures that both the authorization request and any necessary medical documentation that needs to be submitted are supported.

Automation through the EHR platform and standard-based transactions through the Availity Intelligent Gateway have simplified and streamlined complex transactions between payer and provider by eliminating manual work, centering transactions completely through the providers' EHR, and leveraging standard-based transactions.

Additionally, Availity has implemented the Da Vinci PAS guide, which includes translation between FHIR and the X12 278 for prior authorization. Recognizing the industry's investment in, and continued use of, many X12 transactions, Availity will actively participate in the evolution and adoption of FHIR APIs to facilitate interoperable, standards-based data sharing between patients, providers, and payers.

Availity also offers integration into payer utilization management tools. Availity helps payers optimize the provider experience and timeliness by supporting a unified multi-payer integration for authorizations to manage the key functions of the process, including verifying patient coverage, determining if authorization is required, authorization submission, and status inquiry, as well as generation of the 278 authorization request through the EHR, which helps bridge information gaps between providers and health plans within a single entry point.



Availity also infuses workflows with actionable content to make authorization requirements more visible and manageable, including:

Displaying the payer medical guidelines in the submission workflow and allowing providers to upload clinical documentation to improve efficiency and reduce incomplete submission.

Providing transparency and clarity into authorization processes, including peer comparisons, root-cause analysis, and insights and trends for continuous improvement.

Eliminating—or significantly diminishing—the most visible abrasion points in the authorization process, including high call-center volume, uncertainty around authorization status, multiple workflows inside and outside the EHR, and unnecessary care delays.

Automation through the EHR platform and standard-based transactions through the Availity Intelligent Gateway have **simplified** and **streamlined** complex transactions between payer and provider.

Availity and Prior Authorizations

Availity's goal is to deliver a comprehensive and collaborative prior authorization platform that supports all provider channels, helping drive better patient outcomes. Our approach rests on three strategic pillars:

- **Optimizing provider experience and timeliness by supporting a unified multi-payer integration for prior authorizations regardless of the channel**
- **Infusing workflows with clinical data to make prior auth requirements more visible and manageable, and leverage clinical automation to drive efficiency**
- **Provide transparency and clarity into prior auth processes, including peer comparisons, root-cause analysis, and insights and trends for continuous improvement.**

Prior Authorization Requirements

One of the earliest abrasion points between payers and providers occurs at the **beginning** of the prior authorization process—determining if a prior authorization is **needed** for a given care service.

Health plans can cut down on many prior authorization-related calls by ensuring providers have key information early in the process and providing a central location for submission and management, including determining if a prior authorization or medical attachment is required and whether the prior authorization is managed by a delegated vendor.

In one Availity case study, which was recognized with the 2023 KLAS Points of Light Award, nearly 40% of providers' calls into a Midwestern health plan's call center related to prior authorization determination. The health plan estimated that the cost for each call was between $5 and $7, and up to $13 to $15 for fax requests.

To create a more automated, self-service solution for providers , the health plan utilized Availity's prior authorization determination app—Is Auth Required—available through the Availity Essentials multi-payer provider portal. The app linked to a database of the health plan's prior authorizations rules.

Together, these apps allowed the health plan's provider network to check if a prior authorization was required before initiating a request. Providers receive real-time approval messages within their existing workflow. If a prior authorization is required and pends for review, a provider can electronically attach the required medical record.

"This collaboration made it easy and intuitive for our providers and the health plan's service team to use a self-service tool to get the information they need quickly," said the health plan's Senior Business Implementation Lead. "We have seen significant provider utilization of the tool, a reduction in calls, appeals, and instances where authorizations were requested but not needed."

KLAS Points of Light Winner — Is Prior Auth Required?

- **$3.9 million in estimated savings over three years across the health plan's entire provider network.**
- **Increased portal use to 70% and eliminating the faxing option for local providers.**
- **Call volume for prior authorization requests dropped to 50 a month from 200 a month after tool was implemented.**
- **The Availity app is utilized about 100,000 times a month across the health plan's provider network.**
- **In a recent provider survey, 77% of respondents indicated they found the look-up tool very or extremely helpful.**

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Digital Correspondence

Another opportunity to streamline the prior authorization process is through **digital correspondence**. Rather than relying on fax machines, phone calls, and other analog solutions, health plans and providers can **leverage an intuitive, API-connected interface** to exchange digital correspondence, including prior authorization determination, clinical documentation requests, and other prior authorization-related tasks. Benefits include:

- **Reduced administrative expenses. Printing and mailing letters related to each prior authorization request represent a significant administrative expense for health plans. Electronic delivery of these letters can reduce costs.**
- **Improved delivery success and reduced phone calls. It can take time for prior authorization letters sent through the U.S. Postal Service to get routed to the appropriate recipient, especially in large organizations. If providers can't find a letter they expected to receive, they must call the plan to follow up, driving up inbound calls. Electronic delivery ensures the letter is received within the workflow of the user who created the prior authorization.**
- **Streamlined prior authorization process. Because electronic delivery is faster than the post office or hospital mailroom, providers receive the prior authorization information quickly, allowing them take the next required action on the prior authorization. Faster communication means faster resolution, improving provider and member satisfaction.**

Prior Authorization Letters is a new capability offered through Availity Essentials that allows health plans to electronically deliver prior authorization letters.

When providers visit the Auth/Referral Dashboard (see Figure 1 on page 11), they are notified that a document—such as a determination letter or a request for additional clinical information—is available for download, eliminating the need for health plans to mail or fax it. Prior Authorization Letters is managed through an API connection between Availity and the health plan. Once the connection is established, it's easy for health plans to route determination letters and other prior authorization-related correspondence to the provider.

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Figure 1

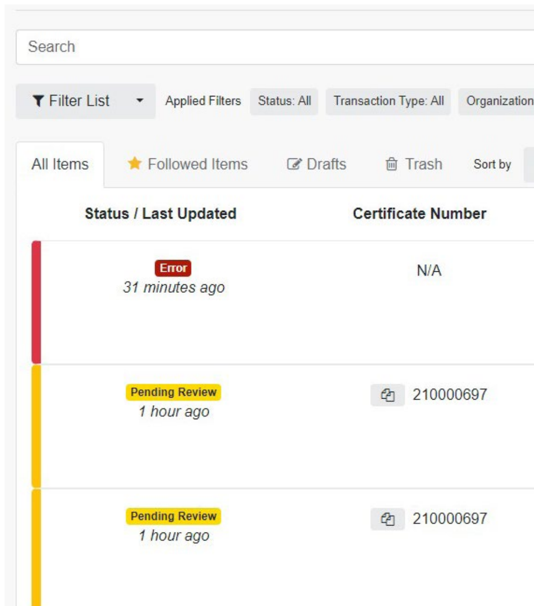
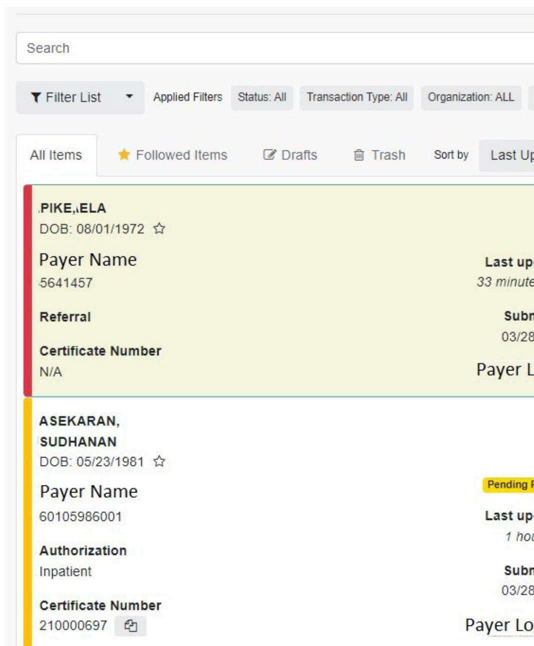


Figure 2



Availity's Reimagined Prior Authorizations Dashboard & Templates

Availity recently introduced our reimagined Prior Authorizations Dashboard. Designed with the provider workflow in mind, our new-look Dashboard boasts intuitive new features and an enhanced user experience, helping to make auth management faster and more intuitive than ever.

Redesigned View Experience. Our new dashboard updates our pop-up style view with a card view within the Dashboard screen. This allows users to view auth details more readily and easily scroll to and locate different prior authorization requests without the need to toggle between screens.

Time-Saving Templates. In addition to enhanced Dashboard features, Availity also has incorporated the ability to build customizable templates that pre-populate data elements ready to be validated. Moreover, you can save specific aspects of any prior authorization, including payer, transaction type, and even member-specific prior authorizations. Never created a template? No problem! With our Click-to-Copy feature, you can save completed prior authorizations as templates for future use and reference.

Little Changes, Big Difference. Availity has also incorporated several user-experience changes to help you save even more time, including:

- **A Click-to-Copy option that copies prior authorization data into new requests for quick validation and submission.**
- **The 'advance page' function has been built into the top and bottom of the Dashboard for easy navigation.**
- **Enhanced filtering capabilities to sort and find prior authorizations (Figure 2).**
- **An improved user view of your prior authorizations and easy access to all value-added capabilities.**

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Artificial Intelligence

Artificial intelligence (AI) technologies have evolved at a record pace over the last three years with language and image recognition generally better than humans. Unfortunately, its integration into the healthcare ecosystem **lags far behind other industries** (even where data privacy and compliance requirements are as stringent.) Identifying key use cases that can both radically improve the current experience or process but also maintain consideration for the human to human need to deliver **effective** care will be critical for effective adoption of this technology. Additionally, it will be important to establish both **transparency** of the algorithms being used as well as **auditability** of the determinations to establish and maintain trust of its use and **accelerate adoption**.

Prior authorization is an ideal use case for AI to tackle. Specifically, answering the question of medical necessity based on the merits of the request, the unique clinical scenario, and specific medical policy. AI can be trained to understand the health plan's medical policies and evaluate each unique case on the merits of the clinical information submitted. This approach is a radical departure from other approaches to automate approval decisions using regression models which inherently introduce bias into the system and offer no transparency or auditability of the decision.

The potential impact of an automated medical necessity decision is significant. For example, in about 85% of cases today, authorizations are approved. If that 85% can be automated, human intelligence can focus on the 15% of cases that need a more thorough review.

The Availity Auth AI solution reduces turnaround time from days to seconds at industry scale and delivers real-time business intelligence, creating a foundation for building a clinical intelligence platform that enables healthcare organizations to make decisions based on clinical data and drive deeper insights from the data.

The Availity Auth AI provides unparalleled speed and accuracy for reviews of incoming prior authorization requests—recommending prior authorization approvals in seconds, significantly reducing time and resources spent on the process for both payers and providers.

The system also integrates with electronic health record (EHR) systems and payer platforms by offering API integration, allowing for seamless data exchange and real-time updates. This enables providers and payers to collaborate more effectively and improve the quality of care while reducing administrative burdens and costs.

A payer recently implemented Availity's solution to support three programs that account for 80% of the organization's authorizations. The system handles 4,000 cases a day and 78% are resolved without human touch. The remaining 22% are handled by a human. From submission to authorization, the median response and resolution time is 27 seconds.

The average turnaround time used to be 2.5 days; now it's a matter of hours, including those cases that are handled manually. The 4,000 authorizations a day are handled by a fraction of what was required previously.

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Conclusion

Availity's suite of solutions creates a comprehensive, end-to-end prior authorization platform that streamlines the critical functions of the prior authorization process and, thanks to API protocols, empowers providers to manage prior authorizations and respond to prompts in their work queues. Moreover, Availity seeks to eliminate the bottlenecks that make the prior authorization process an untenable burden—swamped call centers, uncertainty around prior auth status, multiple workflows inside and outside the EHR, unnecessary care delays—through real-time status updates, auth administration within the Availity Essentials and Essentials Pro workflows, and facilitating automation and touchless experiences.

For more information about Availity's prior Authorization Solution visit: Availity.com/authorizationcapabilities

About Availity

Availity is the place where healthcare finds the answers needed to shift focus back to patient care. We work to solve communication challenges in healthcare by creating a richer, more transparent exchange of information among health plans, providers, and technology partners. As one of the nation's largest health information networks, Availity facilitates billions of clinical, administrative, and financial transactions annually. Our suite of dynamic products, built on a powerful, intelligent platform, enables real-time collaboration for success in a competitive, value-based care environment.

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