KLAS RESEARCH | K2 Collaborative

Points of Light 2023 Case Study 24

Simplifying the Prior Authorization Process through Automation

April 2023

KLAS 2023 K2 Collaborative A Payer/Provider Initiative POINTS OF LIGHT RECOGNITION

Case Study 24

Simplifying the Prior Authorization Process through Automation

Executive Summary

Manual prior authorization workflows are time consuming and costly for payer and provider organizations and can delay patient access to care. To increase provider visibility into which services require prior authorization and to bring automation to the submission and decision processes, the collaborators in this case study worked together to develop a more automated, self-service solution that allows providers to determine whether a given service requires prior authorization, submit a request, and receive a determination, all within their EMR workflow. The technology has improved efficiency, reduced denials, and increased revenue.

Applicable to Other Organizations and Partnerships

The Collaborators

Healthcare Organization 24

Anonymous
Location: MN
Sizing: 1,400 beds

BlueCross BlueShield Minnesota

Location: MN
Sizing: 2.5 million members

Availity

Headquarters: FL
Segment: Claims management and clearinghouse

ITILITI HEALTH

Headquarters: MN
Segment: Utilization management

Points of Friction—Challenges to Be Solved

- **Time-consuming manual workflows associated with determining when prior authorization is required for patient care:** Providers don't always know which care services require prior authorization, resulting in staff from the provider organization and the payer organization spending significant time in manual workflows trying to determine coverage. Nearly 40% of the calls Blue Cross and Blue Shield of Minnesota's call center received from provider organizations were for questions related to prior authorization. Blue Cross and Blue Shield of Minnesota estimated that this cost $5–$7 per call and $13–$15 to process requests that came via fax. Additionally, provider staff had to input considerable data to determine whether an authorization was required, which was inefficient and took an average of 15 minutes per request. Policies differ from payer to payer and are constantly changing, adding to the provider organization's burden.
- **Delayed or disputed authorizations delay patient access to care and affect reimbursements:** Requests for prior authorization sometimes get lost in the manual shuffle, delaying patient access to needed care. Provider staff often spend time manually tracking requests to make sure they get approved before a patient's visit or procedure. Additionally, authorizations given over the phone may not be tracked, resulting in denied claims down the line. To prevent this, provider personnel have to manually record the details of such calls in case documentation is required later.
- **Lack of single source of truth for payer resources:** Blue Cross and Blue Shield of Minnesota did not have a single source of truth for authorizations, which made responding to provider queries challenging. When providers queried whether prior authorization was required, payer staff had to consult multiple resources, including medical policies, Medicare rules, Medicaid rules, local coverage determinations (LCDs), national coverage determinations (NCDs), and various provider manuals.

Action Plan—How the Collaborators Worked Together to Reduce Friction

- **Developed a more automated, self-service solution for providers to quickly determine whether a given service required prior authorization:** The partners in this case study collaboratively developed a database and an app (accessed through the Availity Essentials portal) to help providers determine when an authorization is required. The information is stored in one place, so Blue Cross and Blue Shield of Minnesota's staff can easily access it when responding to provider queries. Availity's platform connects to an app from Itiliti Health that allows Healthcare Organization 24's providers to submit a 278 transaction directly from their Epic EMR to check whether authorization is required. The 278 transaction and response are integrated into the provider workflow and require minimal patient data from the provider. Service codes are checked against the payer database, and responses are sent in real time directly into the EMR workflow, indicating whether an authorization is required or embedding additional instructions. If authorizations require review, providers can request the authorization through the Availity Essentials portal and electronically attach the required medical record. A dashboard in the Availity Essentials portal provides the status of all

authorizations the provider has requested. The Availity Essentials portal connects to the appropriate payer app and can advise providers on which medical policies and rules apply to a particular patient on the specific date the patient is going to receive the service. The automation is accurate, reducing errors in authorization queries. Further, the technology has a tracking mechanism that allows providers to return to a query if there is a claims dispute

Points of Light—Outcomes Achieved through Collaboration

Authorization requests dropped from 200 per month to 50 per month: The number of authorization requests decreased significantly as providers now have better visibility into which services require prior authorization.

Reduced denials for Healthcare Organization 24, resulting in a considerable revenue increase

Improved efficiency: Providers report reduced interpretation errors and increased efficiency in the prior authorization process due to receiving real-time feedback. Additionally, the automation of what were previously manual tasks has saved provider staff time and allowed them to reallocate their time to tasks of higher priority.

More streamlined process for Blue Cross and Blue Shield of Minnesota: Improved efficiencies in the authorization review process have reduced the administrative workload for the payer's staff as well and decreased the number of queries that have to be reviewed. The provider support center has seen a reduced call volume, there are fewer appeals, and fewer requests come in for services that don't actually require prior authorization.

Positive provider feedback on the ease of use of the Availity portal and associated app

Lessons Learned—What Best Practices Can Other Organizations Replicate?

- **Make sure all stakeholders understand the provider workflow:** Payers and technology vendors need to partner with the healthcare organization to make sure they fully understand the provider workflow and what the providers hope to achieve by redesigning them. This prevents wasted time and effort guessing what providers need. In this case study, it was important to the providers that they would not have to enter a lot of information into the portal to get an accurate response back.
- **Begin with a pilot and validate new processes via regular data checks:** To ensure payer and provider expectations are being met, collaborators should start with a pilot that uses a subset of the data and have a clearly defined and attainable goal that can be realized within the pilot time frame. These clearly delineated goals and use of data will improve the potential for success and build trust and willingness to partner on future collaborations.
- **Have regular meetings with all stakeholders to discuss details of the collaboration:** These meetings should include representatives from IT teams, business teams, provider EMR experts, and any other relevant groups who will be using the technology. Open communication in meetings builds trust. Meetings should address details of the project, including goals, workflow redesigns, testing phases, implementation timelines, and so forth. Trust and mutual collaboration are built when all stakeholders are transparent, understand the processes, and are willing to iterate and pivot as needed.
- **The sky is the limit:** There are many opportunities to improve processes and efficiency between payer and provider organizations. Choose an area that is a high priority and work to improve that administrative aspect of healthcare.

What's Next?—Vision for the Future

- **Expand the pilot to include additional clinical information:** Availity and Itiliti Health plan to expand the pilot to include the electronic exchange of additional clinical information and further automate and speed up the prior authorization process.
- **Add links to detailed explanations of the payer decision:** Availity and Itiliti Health plan to add hyperlinks in the provider correspondence that will offer providers a detailed explanation of the payer decision. This information will improve knowledge of medical policies, thereby making the authorization process more efficient.