The prior authorization process: What makes it painful and how to improve it

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Healthcare workers are highly respected across the globe for delivering effective treatment and ensuring care is provided in the most efficient manner. Patients and their families trust their clinicians and nurses to deliver appropriate, high-quality care that achieves the best possible outcomes.

However, challenges arise that impede effective care delivery—one being prior authorization. Issues presented by prior authorization have further exacerbated the physical and emotional toll providers experienced during the COVID-19 pandemic, and is a contributing factor to clinician burnout. Despite the pain points of prior authorization, it's a necessary process in healthcare. Together, we can improve it.

The need for prior authorization

Prior authorization is a utilization management technique in which payers require providers to obtain pre-approval to administer a service or a medication. Prior authorizations are essential to supporting patient access to clinically appropriate, medically necessary, evidence-based care. They help provide high-value, low-cost treatment, thereby reducing overall healthcare costs. Prior authorization ultimately benefits patients by ensuring they're provided the appropriate level of care. However, the prior authorization process is cumbersome, not just for providers but also for patients and payers.

The cross-industry impacts of prior authorization processes

Providers

Though the prior authorization decision-making process lies in the hands of payers, providers experience frustration from the inefficiencies—time, energy, and cost—required to receive prior authorizations. Prior authorizations for prescriptions and tests remain a sore point in care delivery. Due to lengthy approval timelines, scheduling patients' treatments or procedures can be delayed, which often frustrates patients and may result in adverse events. Frequent prior authorization denials result in significant administrative burden, increased operating costs, and care delays as various resources and modes of communication—escalation channels, appeals, and phone calls—are utilized to complete the approval process. Many institutional providers

must often deal with multiple health plans, all with different authorization guidelines, which adds to provider burnout and frustration.

Payers
Within the payer prior authorization workflow, highly skilled resources—including clinicians and nurses—are utilized. Review processes aren't straightforward as they require the thorough review of each case along with submitted documentation. Additional due diligence is also needed to identify less expensive but medically appropriate alternative treatment options, if any. Moreover, certain US states mandate timeliness in prior authorization approvals; hence, they must maintain the appropriate staffing levels to complete approvals on deadline. Lastly, additional provider follow-ups and appeals result in increasing pressure and higher operating costs.

Patients
Ultimately, the patient suffers the most from the prior authorization process. Delays in treatment are upsetting, frustrating, and may complicate existing illnesses. These administrative barriers to care are discouraging and may result in a patient abandoning his or her treatment, contributing to poor health outcomes.

The complexities of prior authorization

The prior authorization challenges providers, payers, and patients face are caused by the various complications involved in the process, beginning at identification and concluding with the approval, if and when an approval is received.

Manually intensive process
Physician staff must complete a series of steps in receiving prior authorization approval before care is delivered, the majority of which take place outside of the core electronic health record (EHR) workflow. These tasks include the determination of prior authorization needs for a particular treatment, understanding the payer's prior authorization requirements, and filling out the necessary paperwork for payer approval.

Similarly, as most requests require documentation—such as clinical notes or patient history—there's limited automation for payer approvals. Several systems are also referred before a decision is made, as multiple levels of approval may be sought for high-cost treatments.

Rule inconsistency
Prior authorization rules are generally available on payer websites. However, they vary from payer to payer, and frequent rule updates result in increased staff confusion. What may be a covered, pre-approved service for one payer may be a prior authorization-requested service for

another. In fact, prior authorization rules often vary by US state and among health plans. In some cases, providers proceed with treatment only to realize post-claim submission that the service required prior authorization approval. These oversights cause further delays in recouping payments from payers and patients.

Varying submission requirements
Each payer offers multiple channels for prior authorization submission, including phone, fax, provider web portal, or HIPAA Healthcare Service Review X12-278 transactions, among others. Submission channels aren't uniform across payers, and providers must therefore determine which channel should be used for each payer, as well as the documentation that must be submitted.

Prone to errors and delays
Due to the manually intensive process involved in prior authorization submissions, each step in the workflow is error prone. Unfortunately, these errors aren't immediately identified during early submission stages because of limited audit capabilities within the process.

Limited electronic adoption
Prior authorization holds the lowest electronic adoption rate—approximately 26% according to a report from the Council for Affordable Quality Healthcare (CAQH). This low adoption and a continued dependence on archaic healthcare transaction methods, backlogs the entire healthcare system.

Outdated appeals process
Prior authorization is predominantly a paper-based appeals process. Even when leveraged, the digital channels in this space—for example, web portals—are insufficient. The appeals process involves review of the originally submitted prior authorization request, the claim submitted in case of claim denial, and any further documents the provider submitted. Matching the documents to the appeals, as well as the original submission, is often a laborious process.

Making prior authorization a better experience

Publish application programming interfaces (APIs) for prior authorization rules
Develop APIs that allow providers to directly access payer prior authorization rules, as well as the required documentation. The Centers for Medicaid & Medicare Services' (CMS) Interoperability and Prior Authorization proposed rule, effective January 1, 2023, is the path forward to making these APIs publicly available.

Reduce prior authorization-eligible services
Trim the number of services and drugs that require prior authorizations, which will help decrease administrative burden for all stakeholders.

Accelerate industry adoption of electronic transactions
Encourage use of electronic prior authorizations (ePAs) across provider and payer organizations. Significant time and cost savings can be achieved with this adoption (as seen in the below table).

Develop automation at the core
Provider systems can be further enhanced by leveraging advanced machine learning (ML) techniques to suggest alternative treatments, therapies, and drugs for patients. Similarly, payer systems will benefit from incorporating natural language processing (NLP) and optical character recognition (OCR) techniques to make automated decisions on prior authorization submissions. More automation equates to lower operating and administrative costs, and enabling real-time approvals for less invasive, high-value treatments will help decrease inventory levels.

Leverage interoperability resources
Allow access to clinical documentation directly from within payer workflow using interoperability and fast healthcare interoperability resources (FHIR) standards. This will prevent additional back and forth between the two parties.

Increased transparency
Patients and providers should always have access to prior authorization status, as well as expected approval timelines. Up-to-date information should be made available on patient portals and within EHR systems, and should include notifications and alerts when decisions are made or have been delayed.

Imagine providers spending 15 hours or more every week to complete prior authorization requirements. They can instead spend their time in a far more productive, beneficial way: delivering care to patients. Time saved in prior authorization workflows helps maximize facetime with patients and reduces the administrative burden associated with the prior authorization submission process. There's immense opportunity for providers and payers to collaborate and create a frictionless experience that benefits everyone across the ecosystem, but most of all, patients.

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Nahush Patel has 20 years of experience in the healthcare domain. Prior to joining Oracle, Nahush worked as one of the senior directors for Elevance Health's Commercial Claim platform.

He managed the team and provided solution guidance for Elevance Health's platform modernization initiatives, along with a focus on improving claims automation and reducing operational overheads. Nahush has worked with multiple large US healthcare payers with expertise in claims and accumulator management, inventory management, and correspondence handling. His understanding of the payer space has helped solve multiple complex problems through simplified workflows and IT solutions.