AKASA™

Stop Wasting Time on Prior Authorization

Prior authorizations are increasingly burdensome, growing in volume, and taking more time away from valuable, higher-priority healthcare revenue cycle tasks. **That ends now.**

Prior authorization is an all-too-common pain point for healthcare providers. They're costly and time-consuming, often requiring multiple touchpoints and delaying or preventing patient care.

Without prior auth, patients can't get timely treatments or procedures, coverage is often denied, and providers can end up eating the cost. And, worst of all, patient care is delayed or denied entirely when an authorization falls through the cracks.

Prior authorization eats up a significant chunk of effort in the revenue cycle.

With prior authorization requests increasing and consistently taking up **12 minutes per auth request submission and status check**, valuable time is being thrown out. That's 12 minutes your team could spend hunting down documentation for more difficult authorization requests. 12 minutes your team could spend on combating denials. 12 minutes your team could spend on **anything else.**

As leaders, our goal needs to be elevating our people in order to create capacity and allocate resources where they matter most. Current prior authorization processes are a major hurdle standing in the way of this goal.

We know payers have dictated that the prior auth process is necessary in order to receive reimbursement. We know it's a costly, time-consuming burden. We know it adds a lot to your plate. Every revenue cycle leader knows the sooner you can submit a request, the better. This is all true.

But I'm here to tell you to **stop wasting time on prior authorization.**

Why?

There's a better, more efficient way. Manually checking to see which procedure needs auth? Filling out request after request, day in and day out? Repeatedly checking to see if an auth is approved? That's time your people could shift to other financial clearance or patient-facing activities.

Every second counts in the revenue cycle, and prior auth is consuming too much time as it is. It's time to fix this problem and make prior authorization workflows more efficient. And AI-powered automation is the answer.

AMY RAYMOND
VP of Revenue Cycle Operations at AKASA

The Growing Cost of Prior Authorization

$528 MILLION
COST OF PRIOR AUTHORIZATION ADMINISTRATIVE TASKS IN 2019
Source: HFMA

84%
PHYSICIANS WHO SAY PRIOR AUTH REQUESTS HAVE INCREASED IN THE PAST FIVE YEARS
Source: AMA

~ $11
AVERAGE SPEND FOR EACH MANUAL PRIOR AUTH TRANSACTION
Source: CAQH

12m, 07s
AVERAGE TIME IT TAKES TO SUBMIT AN AUTHORIZATION REQUEST AND CHECK ON THE STATUS
Source: AKASA

Does Your Department Have Time To Spare?

It's unlikely your team is fully staffed. Even if it is, it's unlikely they have time to spare. This is true for several reasons.

Staffing challenges

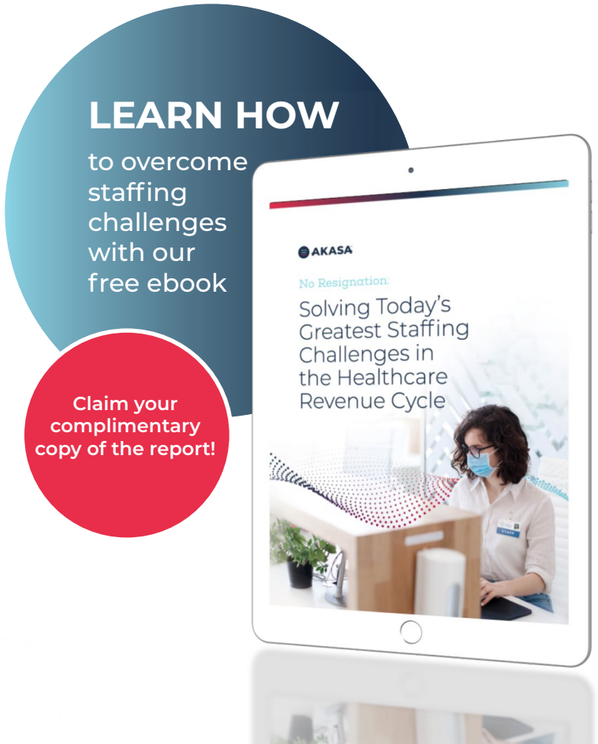
Most healthcare revenue cycle departments are facing staffing shortages stemming from the pandemic, retailers and fast food offering better pay, or the rise of remote opportunities. From the front desk to the back office, employees are in short supply. Providers in rural locations are hit especially hard, as their talent pool is smaller. If any of this sounds familiar, you're not alone.

AKASA surveyed more than 400 healthcare finance leaders and found:

have 100+ open roles

need to hire 20+ revenue cycle staff

An understaffed department, coupled with rising prior authorization requests, is a recipe for added employee stress, burnout, and unmanageable queues.

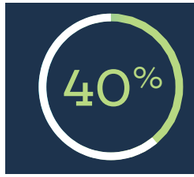


Payer rules are constantly changing

Payer rules and requirements are frequently changing, making the task of staying on top of prior auth even more difficult. Rules can adjust several times per year, increasing the odds of denials or underpayments. Between the frequency at which they change and the weight they carry in the reimbursement process, payer rules eat up a significant amount of time for RCM staff throughout the year.

Some staff solely focus on prior authorization

To fully drive home what a time-sink this stage of the revenue cycle is and how resource-heavy it is, consider this:



OF PROVIDERS
HAVE STAFF DEDICATED TO WORKING ONLY ON PRIOR AUTHORIZATION
Source: AMA

Do you have people who focus exclusively on prior authorization? If so, this repetitive, mundane, and frustrating work is likely to burn them out, which is also costly — replacing a senior revenue cycle employee can cost nearly $6,000 in recruitment spend alone.

Burnout aside, having someone dedicated to prior authorization in a climate rife with workforce challenges means having another person who can no longer work on other revenue-generating tasks or improving the patient experience.

> Payer changes around preauthorization requirements and increased demand to schedule diagnostic procedures as soon as possible is driving significant volumes for financial clearance. Hiring to handle these volumes can be challenging and isn't always the most strategic solution.
>
> **CYNDE MCCALL**
>
> Director of Patient Access and Health Information at Methodist Health System

Retro authorizations eat up time and drive denials

The best we can do is get prior auth for a patient's test or procedure, as we never know the outcome of that patient's test. It's not uncommon for codes to be added after a test — codes that weren't part of the initial auth submission.

This leaves your team scrambling to communicate with the physician, get the codes as quickly as possible, and then promptly submit additional auth requests for those codes. Plus, it's rare for the codes to be added immediately, meaning there's likely a delay.

These retro auth scenarios can take up even more precious time and, if not caught early enough, result in denials and the ensuing appeals process — wasting even more time.

Increased focus on patient experience

The patient experience and overall engagement is an increasingly important focus for providers. Patients represent a growing revenue source for healthcare providers, and with the consumerization of healthcare, they're demanding a better experience.

OF PATIENTS
WANT MORE COMMUNICATION AND ENGAGEMENT FROM THEIR PROVIDERS
Source: Actium Health

> Appointments are always approaching. That's the clock you're constantly trying to beat in patient access. This is difficult when you have rising prior auths, codes getting added after surgeries or tests, and talented team members wasting time on tasks like auth status checks. When you automate these menial tasks, suddenly you find yourself able to work farther out and get the rarest thing of all in healthcare RCM — breathing room."
>
> **AMY RAYMOND**
> VP of Revenue Cycle Operations at AKASA

When you're spending an increasing amount of time on prior auth, you're left with less time to spend on improving the patient financial experience. This can disappoint patients amid the growing expectation that providers should be more involved, and it can cost you financially.

On the other hand, automating prior auth means your front-end team has more time to focus on creating a better patient financial experience and driving engagement.

Engaged patients are more likely to pay their bills, take prescribed medicine, and ultimately have a higher quality of care. These factors positively impact your bottom line and patients' health outcomes. In other words, engaged patients can translate to more payments and healthier patients.

When you have time to focus on patient engagement, everyone wins.

In summary: Understaffed teams, increasingly complex payer rules and requirements, having to dedicate staff entirely to prior auth, and retro auth scenarios are all eating into your organization's precious time and bottom line. Fortunately, there's automation.

6 Ways to Improve Prior Auth Efficiency With Automation

Time is precious, especially in an environment rife with staffing challenges and increasingly tight margins. Prior authorization isn't going away, and your team can't ignore it. But automating this workflow isn't easy — payer rules are complex and frequently change, clinicals are difficult to include in auth requests, prior auth is notorious for requiring human input, and payer follow-ups are an increasing time sink.

Fortunately, today's advanced healthcare RCM automation is capable of handling prior authorization, freeing your team up to focus on more revenue-generating and patient-facing tasks. Automating prior auth can also reduce denials and errors on the back end, leading to more timely reimbursements.

Here's how to start:

01 Identify the highest-volume payers and service lines

When automating prior authorization, it's easy to fixate on the most problematic payers — those that take longer to respond or generally require more back and forth. But it's better to focus on the highest-volume payers and service lines.

This approach allows your automation to knock out the largest quantity of work possible, giving your team time to focus on the more urgent and challenging, lower-volume payers and service lines.

When looking at your high-volume payers, note which ones have portals. Which ones have complicated clinical requirements and questionnaires? Do they have portals for different service areas, too? Do any run on the same portals? This kind of information can help you inform your automation vendor and allow them to automate more efficiently out of the gate.

02 Know where the work of people and automation intersects

There's always a handoff with automation. So, while automating prior auth will save your team valuable time and allow them to focus on more high-value tasks, the occasional human touch is still required. This is why it's important to note where the work of people and automation intersects.

For instance, AKASA Automation Management uses advanced AI and machine learning (ML) to automate prior auth. It decreases the number of denied auth requests due to missing member benefits or clinical information, ensuring requests are complete and accurate. If an auth request requires follow-up, our automation notifies your team — meaning someone must be available to handle the communication. In the case of critical clinical information missing in the EHR, our automation will again notify your team, and someone will be required to follow up. And there's still a claim to handle after the authorization itself is obtained.

Keep in mind: When you automate prior authorization and nothing else, you're automating one piece of a more extensive front-end process. For instance, a benefit of automating your prior auth workflows is that you can significantly reduce denials due to missing authorizations. If you get everything right on the front end and ensure prior authorization requests are complete and accurate, you're saving your back-end team time and effort.

Look at your current workflows and think about how they will change with prior authorizations automated. Where will staff who once focused on securing prior auths and working auth-related denials be most effective in your workflow?

03 Keep your team in the loop regarding automation and team changes

Change management, the practice of successfully managing change within an organization, is critical to any successful RCM automation strategy.

Once you're moving forward with an automation vendor, communicate any upcoming changes to your team. Will their roles be shifting? Will workflows be adjusted?

Automation presents a great opportunity to elevate your staff and allow them to work on more challenging, revenue-driving tasks. This will improve employee engagement, satisfaction, and retention by re-adjusting workloads, reducing burnout, allowing staff to work at the top of their skill set, and empowering your team to do the work they love.

Communicating these changes and this opportunity allows your team to not only buy in on the decision to implement and deploy automation, but also increases the chances of a smooth transition once everything is live.

Following automation, prior authorization specialists have an opportunity to move into other patient access functions and engage more with patients. Make this known to your team and gauge their interest so you can start thinking about who would be a great fit for any new roles.

04 Conduct a digital audit

You can't automate what's not digital.

Automation requires data to function. If the majority of documents essential to prior authorization — physician notes and orders, imaging results, auth reports — aren't digital, they're not discoverable during an audit for automation. Ask yourself what is and isn't captured by digital portals, and fill in the gaps.

Digitize as much as possible before partnering with an automation vendor. While not necessary, it will allow your vendor to automate faster, improve efficiencies, and reduce the chances of your team having to hunt down clinicals and documents even after automation is in place.

For example, AKASA's AI-powered Authorization Management suite will search your system for relevant clinical information and documentation to include in the authorization request and actually submit to payers. This helps reduce back and forth with payers by ensuring required clinical information is incorporated right from the beginning. But if files aren't digitized, they won't show up in the audit during automation implementation.

05 Review existing workflows and metrics

Just as staff roles may change after implementing prior auth automation, your workflows will also likely change. Again, when you're automating prior auth and only prior auth, you still have the bigger picture to consider. With prior auth significantly removed from the picture, will it make more sense to break workflows down by payer? Will your days-out goals shift?

The right automation vendor should integrate into your existing workflows without interruption. AKASA Authorization Management is capable of intelligently navigating complex workflows and processes. Powered by our Unified Automation® platform, the AI continuously learns from the responses and results of submitted prior authorizations, flagging our RCM experts to handle edge cases and train the AI on new complexities, ensuring tasks get done. In addition, there's no disruption to your current workflow. Our AI works alongside your existing systems and third-party tools, optimizing prior authorization processes.

All of this allows your team to continue doing the work they know so well while the automation ramps up. Then they can seamlessly pivot into more elevated, engaging tasks.

AKASA Authorization Management

Fully automate your prior authorizations

Authorization Determination & Initiation	Authorization Status Check	Inpatient Notifications
Determine if prior authorization is required and submit authorization requests, along with any required medical documentation	Check the status of submitted auth requests via payer portals and document the results in EHR	Notify payers of inpatient admissions, attach medical records as required, and document the notification in the EHR

06 Find the right vendor

All automation vendors aren't equal — both in approach and technology. Many utilize dated automation approaches, or focus solely on one area of the revenue cycle or certain payers, while others promise out-of-the-box functionality and leave the onus of maintenance on you.

The wrong vendor can result in a poor experience, interrupt workflows, lead to costly IT bills, and cause more harm than good.

When looking for the right automation vendor, ask about their implementation process and what's required on your end. Will your IT team be doing the heavy lifting? Or none at all?

To truly automate the complexities of prior auth, you need a vendor that offers a fully automated, holistic prior authorization solution. Look for someone who understands the unique workflows of this stage of the revenue cycle and has technology purpose-built for healthcare.

Prior auth is nuanced. You need a vendor with advanced, AI-powered automation technology. It's the only way to intelligently navigate complex authorization processes and ensure auth requests are complete and accurate with required clinical information and documentation.

Plus, you need a vendor capable of handling frequent changes to payer portals and authorization forms and questionnaires, keeping up with prior authorization's volume and ever-changing requirements.

At AKASA, our platform starts with computer vision-based RPA and enhances it with modern AI, ML, and revenue cycle experts to deliver automation that can solve for complex, non-linear tasks with efficiency, accuracy, and resiliency.

Our core technology is revenue cycle-specific — not scripts and RPA bots that could be applied to virtually any task or industry. To solve clients' prior authorization challenges, our automation identifies payer requirements, submits requests, and checks statuses — freeing your staff from tedious prior authorization tasks.

> "Machine-learning-based technologies such as AKASA have been critical to ensuring our teams can provide rapid turnaround for verifying eligibility and covered benefits, and securing an authorization."
>
> **CYNDE MCCALL**
> Director of Patient Access and Health Information at Methodist Health System

Save Time With AKASA and Authorization Management

Always expect the unexpected in the revenue cycle. How often are codes added following a test and authorization request? When was the last time a patient rescheduled or had to have a procedure moved up? These unexpected events make it harder to stay on top of auth. The right prior auth automation can help you counter the unexpected and find breathing room.

When you're working accounts and getting authorizations days or weeks out, not the day before, you're setting your organization up for success — even with these frequent, albeit unexpected events.

Prior authorization is a time-consuming piece of the healthcare revenue cycle. You can't get rid of it entirely, but with AKASA Authorization Management, you can cross "time-consuming" off the list.

Our Authorization Management solution fully and holistically automates prior authorizations, handling everything from authorization determination to initiation to status checks to inpatient notifications. Our advanced AI-powered technology determines if prior authorization is required, gathers the necessary information and clinical documentation from your EHR, submits the authorization request, checks on the status of those requests, and documents the results in your EHR. Additionally, we notify payers of inpatient admissions, attaching medical records as required.

The result: more timely reimbursement and patient care, with fewer staff frustrations.

> As a leader in the revenue cycle, you often hear the reasons behind problems — why denials are rising or queues are piling up. But it's hard to focus on these problems when dealing with prior auth. Automation allows you to be more strategic and hyper-focused on previously neglected areas — enhancing patient experience, working with physicians on coding best practices, and working on accounts more than two days out. **Now you're seeing clearly, thanks to automation taking out the noise.**

AMY RAYMOND
VP of Revenue Cycle Operations at AKASA

Learn more about how AKASA and Authorization Management can help your team work more accounts, more days out, with less effort.

Watch a video to see our technology in action

Schedule a consultation

AKASA™ VISIT AKASA.COM