

# Common Questions About Prior Authorization

The costs and challenges of prior auth for healthcare providers, and advice on how RCM automation can counter this growing administrative nightmare







## Is prior authorization a timesink for RCM staff?

12m, 7s

AVERAGE TIME FOR AUTH  
REQUEST SUBMISSION AND  
STATUS CHECK

[AKASA](#)

Prior authorizations are the second most time-consuming task in the revenue cycle, according to a new AKASA survey of healthcare financial leaders.

This means your team is spending more and more time manually submitting authorization requests and following up with payers on the status of those requests, and less time on other tasks that generate revenue and improve the patient experience.

84%

PHYSICIANS THAT SAY PRIOR  
AUTHS HAVE INCREASED IN THE  
PAST FIVE YEARS

[AMA](#)

Prior auth is an expensive process — the average manual prior auth [costs roughly \\$11](#). When you're working with razor-thin margins and struggling to offer competitive wages, every dollar counts.



# 02



## What are the primary challenges associated with prior authorization?

A [Medical Group Management Association](#) poll identified several key prior auth challenges: inconsistent and vague payer rules, frequent requirement updates, slow payer responses, and increased claims for peer-to-peer reviews and denials.

There's also the recurring issue of retro authorizations, often the result of codes added after a surgery or test is performed. There are some common supplemental or secondary diagnosis codes you can add during the initial auth. But you can't predict what additional codes might result from discoveries during a procedure. This leaves your team scrambling to get codes from clinicians and run retro auths. Providers typically have no more than 2–3 days to handle retro auths. This makes retro authorizations especially challenging to manage.

Staying on top of payer rules and running retro authorizations are different issues, but with the same requirement: more people. However, most RCM teams are understaffed, with existing employees having to focus on the most pressing accounts and time-consuming tasks (like prior auth).

# 03

## What can healthcare providers do about the rise of prior auth requests?

Thorough registration is the first line of defense against prior auth and denials. Ensuring your patient registration process is accurate allows RCM staff to submit prior auths quickly with complete and correct information.

It's also essential to have clear communication and processes between patient access and clinical teams, especially for handling codes added after the fact. You can't entirely prevent retro authorizations, but you can cut down on the time it takes for your RCM staff to get the information they need in a timely manner.

Ideally, you could throw more people at the problem to counter rising prior auth requirements. But staffing in RCM is difficult, and budgets are tight right now.

The most effective and efficient answer is bringing in AI-powered automation.





# 04

## How can providers reduce retro auths and denials?

In light of rising prior auth demands, it's vital to establish best practices ensuring thorough and accurate auth requests. With the right workflows in place, you can reduce denied requests, retro auths, and claim denials.

First, it's essential all required medical records are included when submitting an auth request. This requires diligence from clinicians, who must add relevant medical information into the system for your prior auth reps. If this isn't happening efficiently today, work with leaders in the clinical department to establish best practices.

Also worth noting: payers have different documentation requirements. Make sure your team notes which ones are required for which payer to prevent auth denials.

Reducing opportunities for retro auths is another great defense against post-service claim denials. Start by making it a standard practice to have RCM staff include typical supplemental or secondary diagnosis codes that commonly go together with a primary procedure when submitting an initial auth request.

Close collaboration between the clinical team and RCM staff is key for retro auths. If the clinical team is slow to get codes to your revenue cycle department, they could miss the window for retro auth submission entirely. Collaborate with the clinical team leaders and make sure there are guidelines in place for both them and the RCM teams to foster timely collaboration.



# How can prior authorization be automated?

With rising prior auth requirements and difficulty staffing, it's only natural that many organizations are turning to RCM automation:



Prior auth automation is possible, but many vendors use technology based on scripts and bots with limited capabilities. Some vendors leverage rules-based engines to inform RCM staff of which accounts require auth, or offer portals that the team can use to streamline the submission process. While more efficient than nothing, these solutions still burden your staff with learning a new tool and handling the actual submission themselves.

AKASA Authorization Management runs on robotic process automation (RPA), enhanced by advanced AI and machine learning (ML) and backed by a dedicated team of RCM experts. The end result: holistic prior auth automation.

Authorization Management is capable of everything from auth determination to initiation to status checks to inpatient notifications — all without interruption to existing workflows, added training, or burden for your staff. Using advanced AI, Authorization Management can navigate changing payer rules and portals, add common supplemental diagnosis and procedure codes during initial auth to reduce retro auths, and find and attach required medical records for requests.

**With it, you can:** resolve more prior authorizations, improve turnaround time, ease staff burden and frustration, and enable timely patient care.

