



Comparing Manual & Automated Prior Authorization Approaches

How to reduce staff time, cost, and avoidable denials

According to an AMA Study, 88% of physicians agree that prior authorization processes are “very or extremely burdensome” in their practices. Similar findings have highlighted that prior authorizations consume a staggering 14 hours – almost two full business days – of physician and staff time per week. To address this challenge and the associated time, revenue, and patient care implications, healthcare organizations should prioritize streamlined prior auth and referral management processes by leveraging automation.

When you empower healthcare staff with greater workflow visibility and efficiency, you create more time for what’s most important – patient care. Let’s compare the different prior authorization processes and identify the most common roadblocks to staff productivity, submission verification, and value-based care, regardless of setting.

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Prior Authorization Process Comparison

A Manual Approach

1. Evaluation of Medical Necessity:

A healthcare provider assesses the patient's medical condition and determines the need for a specific treatment, procedure, or medication.

2. Reviewing Insurance Eligibility and Benefits:

Staff checks the patient's insurance policy to understand coverage details, including any prior authorization requirements. All health plans have different rules and requirements, and **calling to verify can result in significant wait times.**

3. Identification of Prior Authorization Requirement:

If the proposed treatment, procedure, medication, or equipment requires prior authorization, the provider and/or staff identifies the specific authorization requirements outlined by the insurance company (payer)– **forms vary by plan and procedure.**

4. Completion of Prior Authorization Request Form:

The provider's office completes a prior authorization request form from the payer. This may be a fax or web form and typically includes patient, provider, and insurance information, details about the proposed treatment or medication, relevant medical history, and supporting documentation like medical records, test results or clinical notes. It is usually typed, written, or copied and pasted from an EHR, the most common source of errors. **An error with a single digit can cause a denied prior authorization or claim after service.**

5. Submission of Prior Authorization Request:

The completed prior authorization request form and any required supporting documents are submitted to the insurance company after determining how the payer prefers to receive the prior authorization for approval. **This may be directed to the payer's website, through a third-party administrator website or phone call.**

6. Waiting for Approval:

The provider's office waits for the payer to review the prior authorization request. **This process can take anywhere from a few days to several weeks.**

7. Status Checking:

During the waiting period, the **provider's office** continuously **checks** the patient's **insurance company website daily** – throughout the day in urgent cases – and often communicates via phone with the payer, providing additional information if requested.

8. Prior Authorization Request Decision:

The payer will either approve or deny the prior authorization request. If approved, the provider or staff usually returns to their EHR to remove the prior authorization from the work queue, saves proof of approval in the EHR or document management system, and can proceed with the recommended course of action. If denied, the provider may need to call the payer, explore alternative options, appeal the decision, or work with the payer to address any issues.

9. Appealing Denial Decisions:

Because manual prior authorization processes are more error-prone, **there's a higher likelihood of receiving a denied prior authorization**, or worse, a denied claim after healthcare has been provided. Data shows that close to **11% of claim denials are typically appealed**, directing additional physician resources away from immediate patient care.

10. Notification to Patient:

The patient is informed of the outcome of the prior authorization process. If approved, the patient is provided information about the next steps.

An Automated Approach: Best Practice

1. Evaluation of Medical Necessity:

A provider assesses the patient's medical condition and determines the need for a specific treatment, procedure, or medication.

2. Real-Time Eligibility Verification:

Advanced automation provides real-time eligibility verification through bi-directional data integration. This allows providers to quickly confirm patient coverage, verify benefits, and identify prior auth needs, **expediting the process**.

3. Integration with Electronic Health Records (EHR):

EHR data, including patient and payer details, is seamlessly transferred to a prior authorization automation solution. This integration, akin to a claims clearinghouse, **streamlines the process without manual input**.

4. Automated Criteria Assessment:

The automation solution pre-populates the payer fax or web form based on prior experience with each payer plan. **This saves time and eliminates data entry errors**.

5. Automated Prior Authorization Request Submission:

Staff submits prior authorization, including patient and treatment info, electronically through a single online portal linked to all payer sites. Sending automatically via the payer's preferred connection **expedites approval and minimizes denial risk**.

6. Real-Time Status Checking:

The automation solution consistently monitors prior authorization status, updating changes within the secure portal. Staff can quickly confirm statuses for all payers in the same portal, **eliminating manual follow-ups and website checks**.

7. Notification to Physician:

Staff receives prior authorization decision notifications via the same submission portal, enabling prompt action on approved treatments or addressing denials. Approved documentation is uploaded to EHR, **closing the work queue seamlessly**.

8. Recordkeeping & Reporting:

The automation solution records prior authorization process details like transaction records, approvals, denials, and communications. This data **facilitates reporting, auditing, and tracking** across the healthcare organization.

9. Payer Change Updates:

Automated prior authorization solutions streamline payer updates within one platform, eliminating the need for extensive IT involvement. This ensures up-to-date information for processing, **minimizing denial risks**.





Automate With Valer

Valer removes processing prior authorizations through individual payer fax and web portals and replaces them with a single portal. Within Valer's single portal you'll find each payer's web and fax forms pre-populated with patient and insurance information automatically uploaded from your EHR.

After Valer verifies the correct information, it will:



Automatically submit
prior authorizations



Continuously check the
status of each authorization
automatically



Verify payer
decisions



Automatically download
decisions to your EHR with
proof of authorization

Eliminate the repetitive, error-prone, unnecessary tasks of your manual workflow.

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