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FREE GUIDE

The Prior Authorization Problem

13 Hours a Week Per Physician. Here's How to Fix It.

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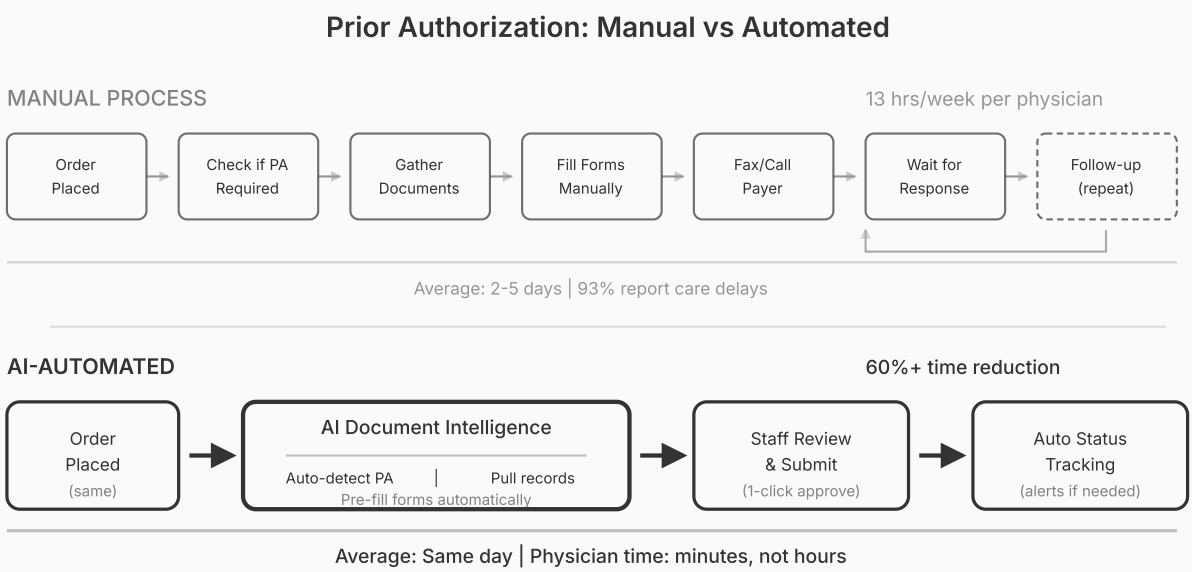
13 hrs

Weekly PA Burden

Each physician spends 13 hours per week on prior authorization paperwork.



Physicians didn't go to medical school to fill out fax forms. Yet that's what they're doing. Thirteen hours every week, per physician, spent on prior authorization paperwork.

Not treating patients. Not diagnosing. Not consulting. Filling out forms, calling payers, waiting on hold, and resubmitting the same documentation three times because someone couldn't read a field.

The AMA surveyed physicians in 2023. Ninety-three percent reported care delays due to prior authorization. Eighty-two percent said PA requirements caused patients to abandon treatment. One in three reported a serious adverse event tied to PA delays.

This isn't paperwork. It's patient harm dressed up as cost control.

The Math Nobody Talks About

Take a mid-sized orthopedic practice. Ten physicians. Each spending 13 hours weekly on PA. That's 130 physician hours per week. At a loaded cost of $200 per hour (conservative for specialists), you're looking at $26,000 weekly. Over a year: $1.35 million.

For paperwork.

But physician time is only part of the cost. Staff time adds another layer. Most practices dedicate 1-2 full-time employees per physician just to handle prior auth. These are people who could be scheduling patients, managing records, or improving operations. Instead they're on hold with Cigna.

One cardiology group tracked their numbers: 35 staff hours per physician per week on PA-related tasks. Combined with physician time, they were spending more on authorization than on some of their highest-paid clinical staff.

The revenue delay compounds everything. A patient needs imaging. PA takes two weeks. The procedure waits. The billing waits. Cash flow suffers. Meanwhile, patient satisfaction drops because they're calling to ask why nothing's happened.

Why It Got This Bad

Prior authorization started with a reasonable premise: prevent unnecessary procedures, control costs, protect patients from overtreatment. The execution went sideways.

Payers discovered that friction reduces utilization. Make something hard enough to approve, and some percentage of providers give up. Some patients abandon treatment. The payer saves money. Whether the patient needed that treatment becomes someone else's problem.

The statistics tell the story. Ninety percent of imaging now requires PA. Up from 50% a decade ago. Medicare Advantage plans require PA for services traditional Medicare covers automatically. The volume has grown faster than any reasonable clinical justification.

Electronic PA was supposed to help. It made things worse. Automated systems can reject faster than manual ones. Appeal requirements grew more complex. The burden shifted without shrinking.

What Document Intelligence Actually Does

PA fails at the documentation stage. The clinical information exists in your EHR. The form asks for specific data points. Someone has to find those data points, extract them, format them correctly, and submit them. Over and over.

Document intelligence automates that extraction and assembly.

When a PA request comes in, the system reads the requirements. It searches patient records for the relevant clinical data: diagnoses, prior treatments, lab results, imaging dates, medication history. It assembles the documentation. It formats it for the specific payer's requirements.

What took a staff member 45 minutes per request takes the system under a minute.

The physician still reviews. Still signs off. Still exercises clinical judgment. But they're reviewing pre-assembled documentation instead of hunting through charts and filling out forms from scratch.

How Practices Are Cutting PA Time by 60%

A regional neurology practice implemented document intelligence six months ago. Their results:

- PA submission time dropped from 38 minutes to 11 minutes per request
- First-pass approval rate increased from 67% to 84%
- Appeals decreased by 41%
- Staff dedicated to PA reduced from 8 FTEs to 3

The first-pass improvement matters more than the time savings. Every denial creates rework. Every appeal means someone reviewing the case again, finding what was missing, resubmitting. When you get it right the first time, the downstream work disappears.

The system learns what each payer wants. Blue Cross requires different documentation than Aetna. Medicare Advantage plans have their own quirks. The system tracks approval patterns and adjusts submissions accordingly.

One pain management practice saw their Humana approval rate jump from 58% to 89% after training the system on six months of successful and denied requests. The documentation didn't change. The presentation did.

Integration Without Disruption

Nobody wants another system to log into. The practices that succeed integrate PA automation into existing workflows.

Epic integration means the PA tools live inside the EHR. When a physician orders a procedure requiring authorization, the system automatically gathers documentation. No switching applications. No copying and pasting between windows.

Cerner works similarly. So do most major EHRs. The technical connection matters less than the workflow integration.

Payer portals present a different challenge. Each payer has their own submission system. Some accept electronic submissions. Others still want faxes. A few require their own web portals with their own formatting requirements.

Good PA systems handle this routing automatically. The practice submits once. The system formats and sends to the right destination. No manual translation between systems.

That said, implementation isn't trivial. EHR integration requires IT involvement. Payer connections need configuration. Testing takes time. Plan for 8-12 weeks from contract to full deployment. Practices that rush this phase create problems they spend months fixing.

The Hard Part: Getting Physicians to Trust It

Technology exists. Adoption is the constraint.

Physicians have seen automation promises before. Tools that were supposed to save time created new problems. Systems that required more oversight than they saved. Errors that landed on the physician's desk.

Building trust requires visible proof. Start with a small pilot: one physician, one payer, one procedure type. Track everything. Show the results. Let skeptics see the before and after.

Transparency helps. Physicians should be able to see exactly what the system submitted and why. Black boxes create anxiety. Clear documentation of what was sent and what was approved builds confidence.

Keep physicians in the loop on exceptions. When a request gets denied, the physician needs to know immediately. When documentation is incomplete, flag it before submission. The system assists; it doesn't replace clinical judgment.

ROI That Gets CFO Approval

The business case writes itself once you have the numbers.

Start with current state: how many PA requests monthly, how long each takes, what you're paying in staff and physician time. Most practices underestimate this because they've never measured it carefully.

Projected savings come from three sources:

Direct time reduction. If you process 500 PA requests monthly at 40 minutes each, that's 333 hours. Cut that to 15 minutes and you're at 125 hours. At blended cost of $50/hour for staff time, that's $10,400 monthly savings just in labor.

Improved approval rates. Every avoided denial saves the appeal cycle: 2-4 additional hours of work, plus potential delay costs. A 15-point improvement in first-pass approval on 500 requests

means 75 fewer appeals. At 3 hours each, that's 225 hours avoided.

Reduced revenue cycle delays. Faster approvals mean faster procedures and faster payment. For a practice with $500K in monthly imaging revenue, reducing approval time from 14 days to 5 days accelerates $167K in cash flow per month.

Implementation costs are real but bounded. Setup fees, integration work, training time, subscription costs. For a 10-physician practice, expect $25K-50K in first-year costs. Payback typically occurs within 6 months.

What to Look for in a Solution

Not all PA automation is equal. Key questions when evaluating vendors:

EHR integration depth. Surface-level integration means copying data between systems. Deep integration means the tool works inside your existing workflow without extra steps.

Payer coverage. Which payers does the system support? How quickly do they add new payers? A tool that covers 80% of your volume leaves 20% manual.

Learning capability. Can the system learn from your approval and denial patterns? Generic rules help. Practice-specific optimization helps more.

Exception handling. What happens when the automation fails? Good systems flag problems early and provide clear paths to resolution. Bad systems create more work when they break.

Support and training. Implementation requires hands-on help. Ongoing support matters when

payers change requirements or new staff need training.

The Bigger Picture

PA automation solves an immediate problem. The bigger opportunity is what happens after.

Physicians who aren't drowning in paperwork can see more patients. Staff freed from PA work can focus on patient experience, quality improvement, or revenue cycle optimization. The practice can grow without proportionally growing administrative overhead.

Some practices find they can take on additional payer contracts once PA burden is manageable. Others use the freed capacity to expand services. The constraint loosens, and options appear.

The healthcare system has structural problems that technology alone won't fix. Payers have every incentive to maintain friction. Regulations favor complexity. But within that reality, practices can choose how much of the burden they absorb versus automate away.

Your physicians went to medical school to practice medicine. Document intelligence lets them do more of that.

Ready to see what PA automation could look like for your practice? Schedule a conversation or explore our healthcare solutions.