10 STRATEGIES FOR **ADVANCING YOUR UTILIZATION MANAGEMENT PERFORMANCE**

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Tip Sheet

10 Strategies for Advancing Your Utilization Management Performance

Sarah Dencker, MSN, RN, VP Care Services of Network Health, joined the Medecision team for a webinar on Advancing Utilization Management Performance. During the event, she shared some of Network Health's best practices for improving UM processes and meeting timeliness standards, including these 10 strategies.

1. **Create member communications around prior authorization**

   Prior authorization is often perceived as an arbitrary barrier to needed care. It's important to help members understand it serves an important function, as there is potential harm that can occur from unnecessary tests, procedures, and imaging.

2. **Eliminate or streamline prior authorization processes where possible**

   If procedures are rarely denied, can they be removed from the prior authorization list? If there are services that have clear clinical criteria, can auto approval functionality be applied when those criteria have been met?

3. **Conduct regular competitive analysis**

   You don't want to be an outlier in the space with a long list of prior authorization requirements where your competitors have only a few, or where you require prior authorization when no one else does.

4. **Create provider resource documents**

   Provide transparency regarding what documentation is needed for authorizations. This has the dual benefit of reducing the time and costs associated with having your UM team reach out for clinical information and missing documentation.

5. **Ensure UM professionals are operating at top of license**

   Can data entry and support tasks be completed by specialist staff while clinical review is completed by nurses, physicians and medical directors? Can an LPN assist in triaging cases that are going to RNs and be responsible for outreach when there is missing clinical information?

6. **Ensure adequate coverage to meet timeliness requirements**

   Having appropriate weekend and holiday coverage is essential to comply with requests or reviews that have 24-hour turnaround times.

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7. Continuously monitor your authorization patterns

Review your approval and denial percentages regularly by line of business and by authorization request types (skilled nursing facilities, inpatient hospitals, and various durable medical equipment, outpatient procedures, etc.) as applicable. This will help you spot trends and adjust your prior authorization list accordingly.

8. Leverage technology to streamline processes

Dencker explained Network Health has "found that the electronic submission of prior authorization requests through Aerial™ saves us a significant amount of time by not having to manually enter data into the care management platform off of faxes received. It provides efficiency for providers with standard fields, auto approval functionality, immediate decision-making even without the auto approval functionality, and [the ability to] check the status of the prior authorization directly in the portal. When requests are automatically submitted through the portal, we can get to clinical review faster, improving the timeliness of the authorization request."

9. Improve throughput where possible

Network Health increased portal usage and electronic submissions to decrease the administrative burden for providers and UM staff. They auto fire clinical review tasks based on established rules to allow their UM team to collaborate with care managers and pharmacy teams more efficiently. They leverage auto workflow rules to auto fire approval letters where possible. And they improve throughput by holding verbal reviews with medical directors twice a day. With a session in the morning and a session in the afternoon, nurses bring cases prepared that need physician review and there is a verbal discussion. The doctor then renders a decision immediately and the nurse can finish out the case.

10. Closely monitor out-of-network leakage

Requests for out-of-network care should trigger an alert to the care management team to determine if in-network options are available. Additionally, out-of-network approvals should be reviewed regularly to identify if there are any issues with access or availability that need to be addressed. For example, was a procedure approved out-of-network because there was a lack of specialty available in your own network? Or do specialists exist, but they're not taking appointments for six to nine months out? The more you understand where out-of-network leakage is occurring and why, the better you can address it.

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