



Breaking Down Barriers: Addressing Utilization Review Challenges in Behavioral Health

Utilization review (UR) challenges aren't just administrative hurdles—they create real barriers to care, impact provider revenue, and strain operational efficiency. Every delayed approval, every denied claim, and every excessive documentation request disrupts the patient journey, leaving providers overwhelmed and underfunded. Behavioral health providers lose millions annually due to denied claims and administrative delays, forcing them to divert valuable resources away from patient care and into paperwork.

The good news? These challenges are solvable. With the right strategies—automation, documentation improvements, and expert teams—providers can reduce financial losses, improve cash flow, and ensure that patients receive timely, necessary care.

Utilization Review in Behavioral Health: A Roadblock to Care

Utilization review is meant to ensure patients receive necessary care, but in behavioral health, it often becomes an obstacle. Strict payer guidelines require providers to submit highly detailed evidence to prove medical necessity. These rules frequently change with little notice, forcing providers to keep up while ensuring that patients don't fall through the cracks.



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Kristina is a strategic healthcare leader with deep clinical and operational expertise here at Coronis Health. A former provider and facility owner/operator, she brings firsthand insight into behavioral health challenges. With a passion for innovation, she aligns strategy with care delivery, driving performance, patient satisfaction, and financial success to improve behavioral healthcare for communities.

Unlike other areas of healthcare, behavioral health often involves long-term or preventive treatment, which payers scrutinize heavily. As a result, providers must constantly navigate shifting regulations, extensive documentation, and frequent denials, all of which delay critical treatment.

The High Cost of Inefficiencies

- **\$3 million lost annually:** Unappealed denials cost hospitals millions, straining resources and reducing funds available for patient care.



- **Excessive administrative burden:** Providers spend countless hours per week on prior authorizations, diverting valuable time from direct patient care and adding stress to clinical teams.
- **Soaring denial rates:** Behavioral health claims face higher denial rates due to rigid medical necessity requirements, leading to lengthy appeals that delay care and reimbursement.
- **Treatment disruptions and rising costs:** Long approval times cause treatment gaps, increasing relapse risks and hospital readmissions while escalating provider expenses.
- **Single Case Agreement Delays:** Many behavioral health treatments require single case agreements (SCAs) before admission. When insurers delay approvals, patients are left waiting—sometimes at the facility—without receiving care, discouraging them from seeking future treatment.



Key Challenges in Utilization Review

- **Inconsistent Authorization Requirements:** Payers frequently adjust their guidelines, making it difficult for providers to stay compliant and efficiently process approvals.
- **High Denial Rates:** Behavioral health providers must submit extensive medical necessity documentation, and even

then, denials remain significantly higher compared to other specialties.

- **Delayed Authorizations:** Prolonged approval times not only delay treatment but also contribute to patient deterioration, increasing the need for higher-cost interventions.
- **Coordination Inefficiencies:** Poor communication between providers, payers, and patients leads to approval delays, creating unnecessary bottlenecks and administrative burdens.
- **Premature Discharges:** Managed care organizations often pressure providers to discharge patients early, claiming treatment is no longer medically necessary—even when clinicians disagree. This disrupts recovery, increases relapse risks, and ultimately leads to higher long-term costs.

Practical Solutions to Overcome UR Challenges

1. Automate and Streamline Authorizations

- AI-driven tools can reduce manual workloads, flag potential denials before submission, and speed up approvals.
- Automated tracking systems provide real-time updates on authorization status, reducing errors and enabling quicker resolutions.

2. Improve Documentation Accuracy and Standardization

- Payer-specific templates ensure claims meet all required documentation standards, minimizing unnecessary denials.
- Structured workflows for documentation review eliminate inconsistencies and improve submission accuracy.

3. Optimize Communication with Payers

- Secure digital platforms enable real-time collaboration between providers and payers, facilitating faster issue resolution.
- Dedicated UR teams with expertise in payer requirements can navigate the approval process efficiently, reducing administrative delay.



Financial and Operational Benefits of Efficient Utilization Review

A well-optimized utilization review process delivers tangible benefits, improving financial stability, operational efficiency, and patient outcomes.

- **Revenue Growth:** Faster approvals lead to quicker reimbursements, strengthening financial health and cash flow stability.
- **Lower Administrative Burden:** Standardized processes and automation reduce manual work, allowing providers to focus on patient care instead of paperwork.
- **Improved Patient Satisfaction:** Timely approvals and reduced treatment delays improve the patient experience, increasing engagement and adherence to care plans.

- **Better Compliance and Reduced Risk:** Ensuring consistent, payer-compliant documentation minimizes denials, reduces regulatory risk, and improves audit readiness.
- **Operational Efficiency:** Enhanced communication and streamlined workflows cut down approval times, allowing providers to allocate resources more effectively.

The Future: AI and Predictive Analytics in Utilization Review

Technology is reshaping utilization review, making approvals faster and more accurate.

AI and predictive analytics are helping providers anticipate denials, optimize workflows, and automate routine tasks. Additionally, telehealth and real-time analytics are enabling more efficient approvals, reducing disruptions, and improving access to care.



Beyond technology, addressing social determinants of health—such as housing stability and access to nutrition—will further improve behavioral health outcomes. Collaboration among providers, payers, and policymakers is essential to building a more patient-centered system that prioritizes care over bureaucracy.

Turning Challenges into Opportunities

Utilization review challenges are not just administrative burdens—they directly impact patient care and provider sustainability. By leveraging automation, documentation improvements, and enhanced payer collaboration, providers can transform UR from a barrier into a tool for better care, financial stability, and operational success.



**Contact us for simplified solutions
to complex UR challenges.**



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