Automating Prior Authorization
Presentation to the ONC HITAC Convergence of Administrative and Clinical Data Task Force

June 9, 2020
Discussion Topics

• Experience Automating Prior Authorization
  • providers within their EHRs
  • payers in their utilization management systems
• Lessons Learned
• Recommendations
Why Automate Prior Authorization?

Patients
- Less time spent waiting for approval
- Reduces delays and interruptions in care
- Improves patient satisfaction

Providers
- Streamlines workflow - fewer phone calls, faxes, portals
- Reduced administrative costs
- Reduced administrative and reporting burdens

Payors
- Improved provider satisfaction
- Lower costs related to utilization management
- Better consistency in adjudication decisions
### Overarching Prior Auth Issues and Challenges

<table>
<thead>
<tr>
<th>Labor-intensive source of administrative burden for providers and health plans</th>
<th>Unintended consequences for patients, plans and providers</th>
<th>Clinical and administrative workflow disruptions and inefficiencies</th>
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</thead>
<tbody>
<tr>
<td>Clinician administrative and reporting burdens</td>
<td>Need for real time access to data within workflow and at point of care</td>
<td>Lack of standards adoption and implementation</td>
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<tr>
<td>Cumbersome and diverse PA requirements and processes</td>
<td>Lack of robust, end-to-end automation</td>
<td>Requires exchange and sharing of data among several stakeholders</td>
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Automated Prior Authorization Table Stakes

Provider signs order in EHR

Evaluate medical necessity & administrative requirements

Submit for approval & store response in the EHR

Prior Authorization System

PC-123

No portals
- Must be embedded into provider workflow
- Must be triggered automatically
- Must be at the point of decision making

No double documentation
- Must use what’s already on the chart (both structured and free-text)

No waiting
- Must be done in real time (both adjudication and approval)
Medical Necessity Adjudication is Hard

Guidelines
Complex
Ambiguous
Incomplete

Data
Noisy
Incomplete
Often unstructured

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Two Approaches to Auto Adjudication

Probabilistic Model
(“Black Box”)

- Uses statistical model
- Requires training data of prior approvals
- Output: likelihood of approval

Deterministic Model
(“Show Your Work”)

- Uses rules
- Requires clinicians to build rules (decision trees)
- Output: approval + provenance (i.e. exactly why the approval was made)
Guideline Codification is Complex and Time Consuming, but **Necessary**
Documentation patterns vary

- Data are often incomplete (e.g., outcomes are frequently missing), patient records are fragmented, data entry errors are common, & the timeliness or currency of the data can be difficult to establish\(^1\)
- Providers’ don’t always document before signing orders

Limited structured data

- In a recent survey of U.S. hospitals equipped with advanced EHRs, only about 35% of their clinical data was captured in structured format, & 65% in unstructured text\(^1\)

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### MRI, LUMBAR SPINE, W/O CONTRAST Evaluation

**Imaging indication**: Low back pain

**Symptom duration**: Acute LBP duration < 3 months

**Complicating feature**: Neurologic deficit, non-traumatic

**Neurologic deficit**
- Babinski/clonus
- Balance/gait abnormality
- Bladder/bowel dysfunction
- Hoffman's sign
- Hyperreflexia
- LE numbness/paresthesia
- LE weakness
- Saddle anesthesia
- UE and LE weakness
- None of the above

**Neurologic deficit duration**: Acute/new

**Contraindications to MRI**: No

CONTINUE
Can Standards Help? Yes

Integrate into provider workflow

Get patient data

Use of standards-based API and API certification criteria

Standardized set of health data classes and data elements and Standards Version Advancement Process
Surprises and Lessons Learned

Payors

• Amount of human interpretation involved in manual adjudication

• Duplicative guidelines, lack of clarity about which guidelines should apply

• Amount of similarity between guidelines from various sources
  
  *ex. 90%+ similar in some cases*

• Complications caused by assumptions inherent to existing PA process
  
  *ex. furnishing facility is known when the case is submitted for approval*

Providers

• Variability in provider prior authorization management processes

• Lengths providers are willing to go in order to streamline prior authorization
  
  *ex. One health system maintains list of questions they’ve collected over time about what payors might want to know about*

• Unexpected data gaps
  
  *ex. missing payor info*

• EHR workflow limitations
  
  *ex. Scheduled vs. ordered procedures*
Prior Auth is a means to an end – **managing appropriate utilization**. There is another way to do this: Clinical Decision Support (CDS)

CDS eliminates the admin hassle / expense related to prior auth

Paired with analytics, CDS still gives health systems a way to manage utilization, but at a lower cost
Recommendations

- Advance efforts to align and optimize existing and emerging standards and technologies.
- Address interoperability between administrative and clinical data and systems.
- Accelerate and expand development and adoption of open data and interoperability standards (APIs; CDS hooks; USCDI; FHIR).
- Ensure providers and clinicians can connect and use any third-party applications of their choosing.
Additional Recommendations

- Facilitate real-time data access for clinicians at point of care and within workflow
- Harmonize requirements across agencies (CMS and ONC) and programs (HIPAA; CEHRT; PI)
- Incentivize uses of health IT that reduce burdens and provide value to clinicians
- Recognize nuances of PA (surgeries, tests, procedures, medications)
Thank You

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