PREMIER

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

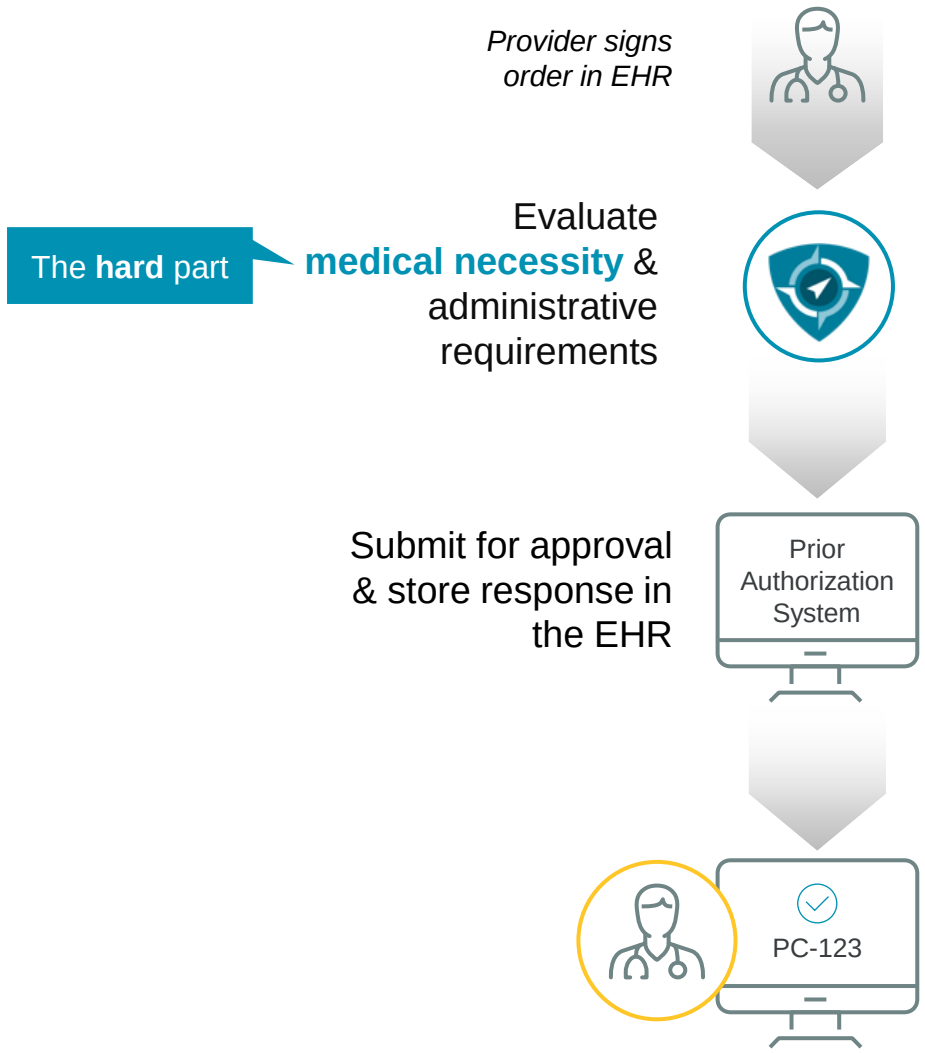
Lower costs related to utilization management

Better consistency in adjudication decisions

Overarching Prior Auth Issues and Challenges

- Labor-intensive source of administrative burden for providers and health plans
- Unintended consequences for patients, plans and providers
- Clinical and administrative workflow disruptions and inefficiencies
- Clinician administrative and reporting burdens
- Need for real time access to data within workflow and at point of care
- Lack of standards adoption and implementation
- Cumbersome and diverse PA requirements and processes
- Lack of robust, end-to-end automation
- Requires exchange and sharing of data among several stakeholders

Automated Prior Authorization Table Stakes



No portals

- Must be embedded into provider workflow
- Must be triggered automatically
- Must be at the point of decision making

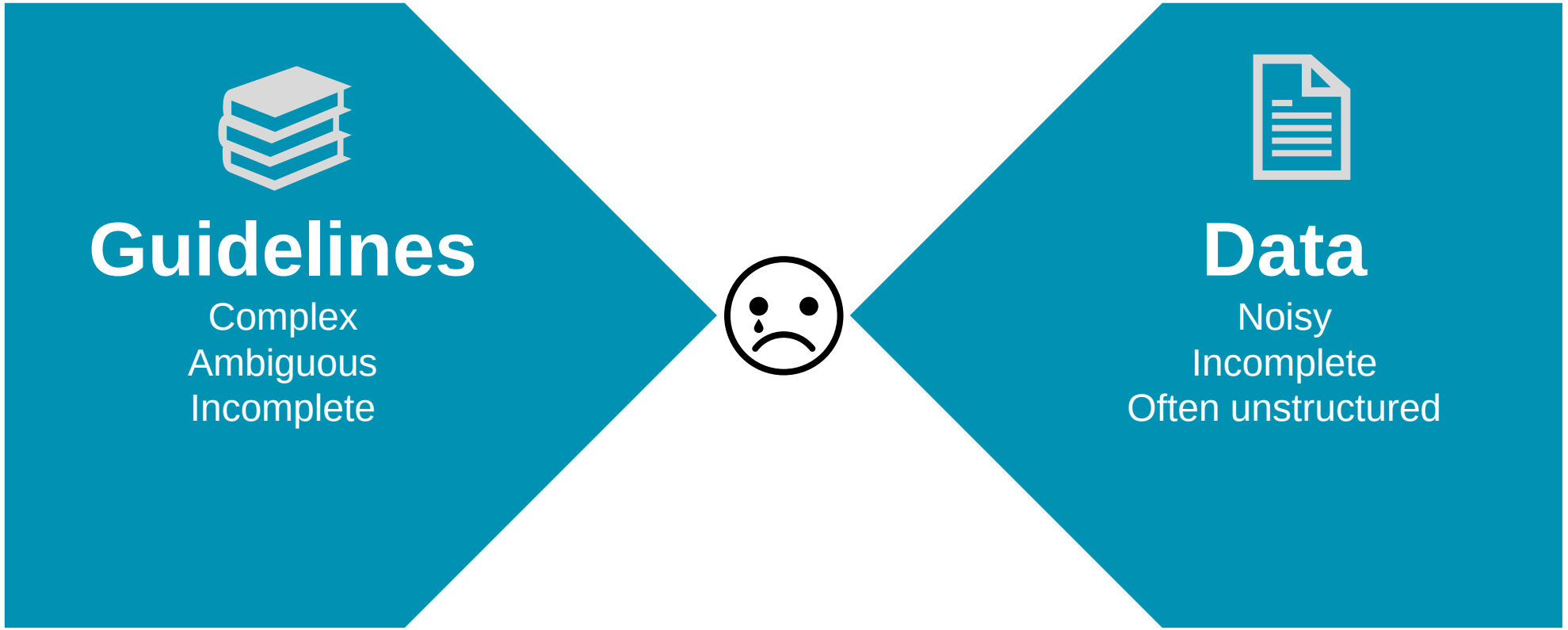
No double documentation

- Must use what's already on the chart (both structured and free-text)

No waiting

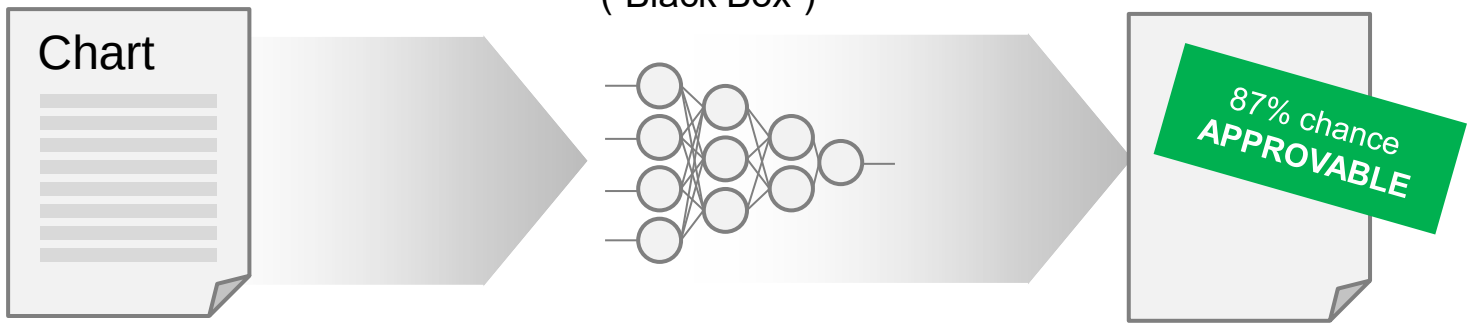
- Must be done in real time (both adjudication and approval)

Medical Necessity Adjudication is Hard



Two Approaches to Auto Adjudication

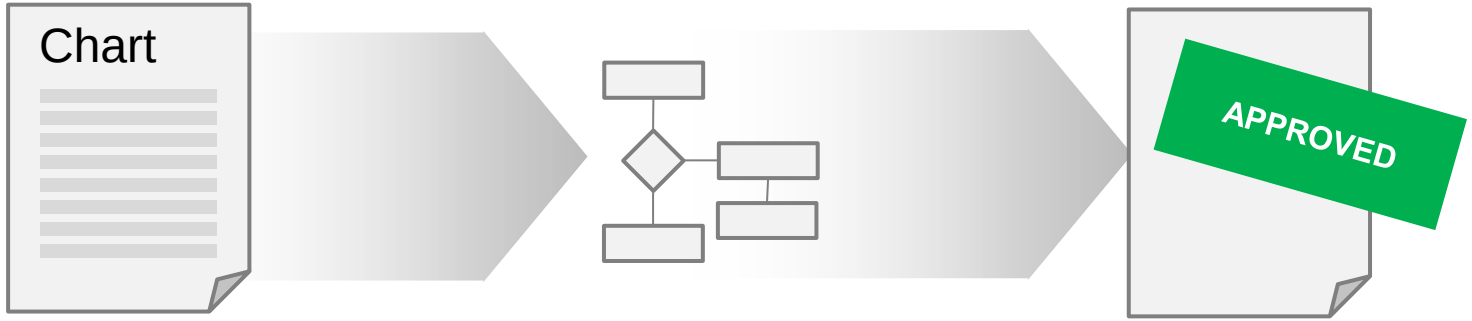
Probabilistic Model
("Black Box")



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

VS

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**

TOC

70551 – MRI Brain (includes Internal Auditory Canal)

CPT Codes:
70551, 70552, 70553 – Brain MRI
70540, 70542, 70543 - IAC

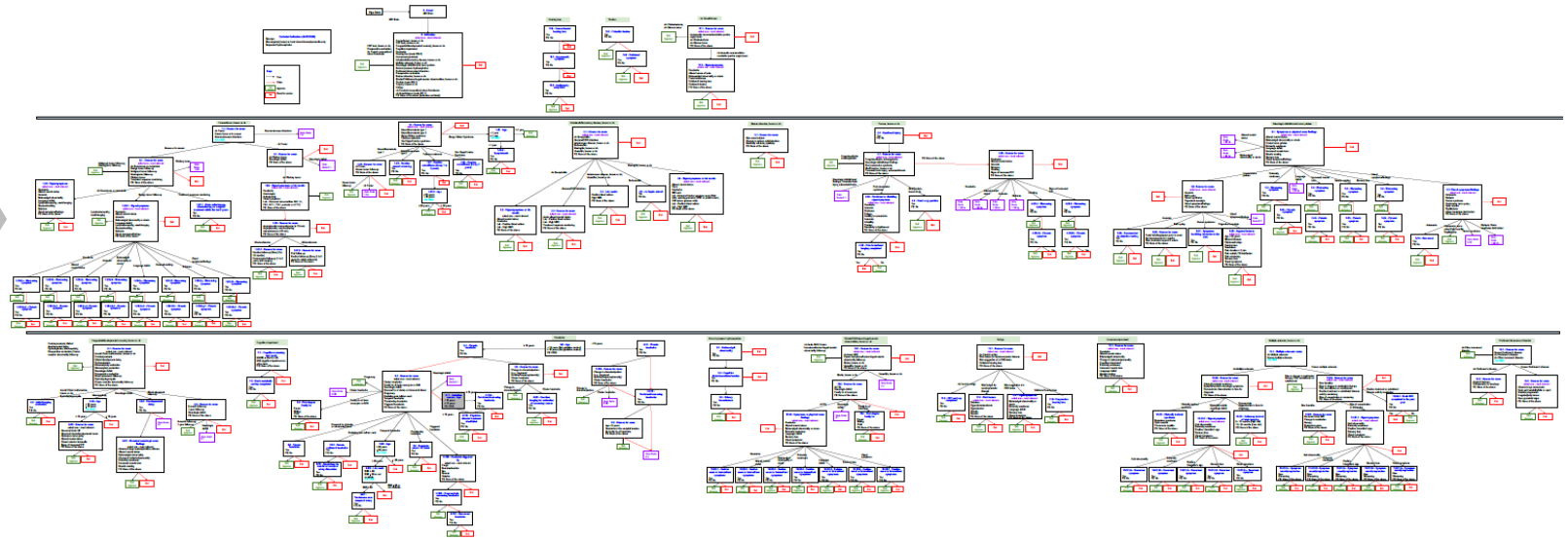
INDICATIONS FOR BRAIN MRI:

For evaluation of suspected multiple sclerosis (MS):
(CMSC, 2018; Traboulsee, 2016; Thompson, 2017)

- For evaluation of patient with neurologic symptoms or deficits suspicious for MS with
  - A clinically isolated syndrome (optic neuritis, transverse myelitis or brain stem syndrome) OR
  - Recurrent episodes of variable neurological signs or symptoms not attributable to another cause
- To demonstrate dissemination in time for diagnosis (6-12 months for high risk, 12-24 months for low risk)

For evaluation of known multiple sclerosis (MS):
(CMSC, 2018)

- To establish a new baseline (no recent imaging, postpartum, or 6-12 months after switching disease modifying therapy)
- Prior to starting or switching disease-modifying therapy



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]

1. Meystre SM, Lovis C, Bürkle T, Tognola G, Budrionis A, Lehmann CU. **Clinical Data Reuse or Secondary Use:** Current Status & Potential Future Progress. *Yearb Med Inform.* 2017;26(1):38–52. doi:10.15265/IY-2017-007

Natural Language Processing and Machine Learning

"65 yo M pt with worsening LBP & sciatica since 5/1/2018. He has tried pt for 3 weeks. Reports no pain radiating to L hip. On Lisinopril/Benicare.

65 yo AGE | M FINDING | pt with | worsening STATE | LBP FINDING | & | sciatica FINDING | since | 5/1/2018 TIMING | . he has tried | pt TREATMENT | for 3 weeks TIMING | . reports | no STATUS | pain FINDING | radiating to | L RELATIVESITE | hip ANATOMICSITE | . on | Lisinopril MEDICATION | / | Benicar MEDICATION | .

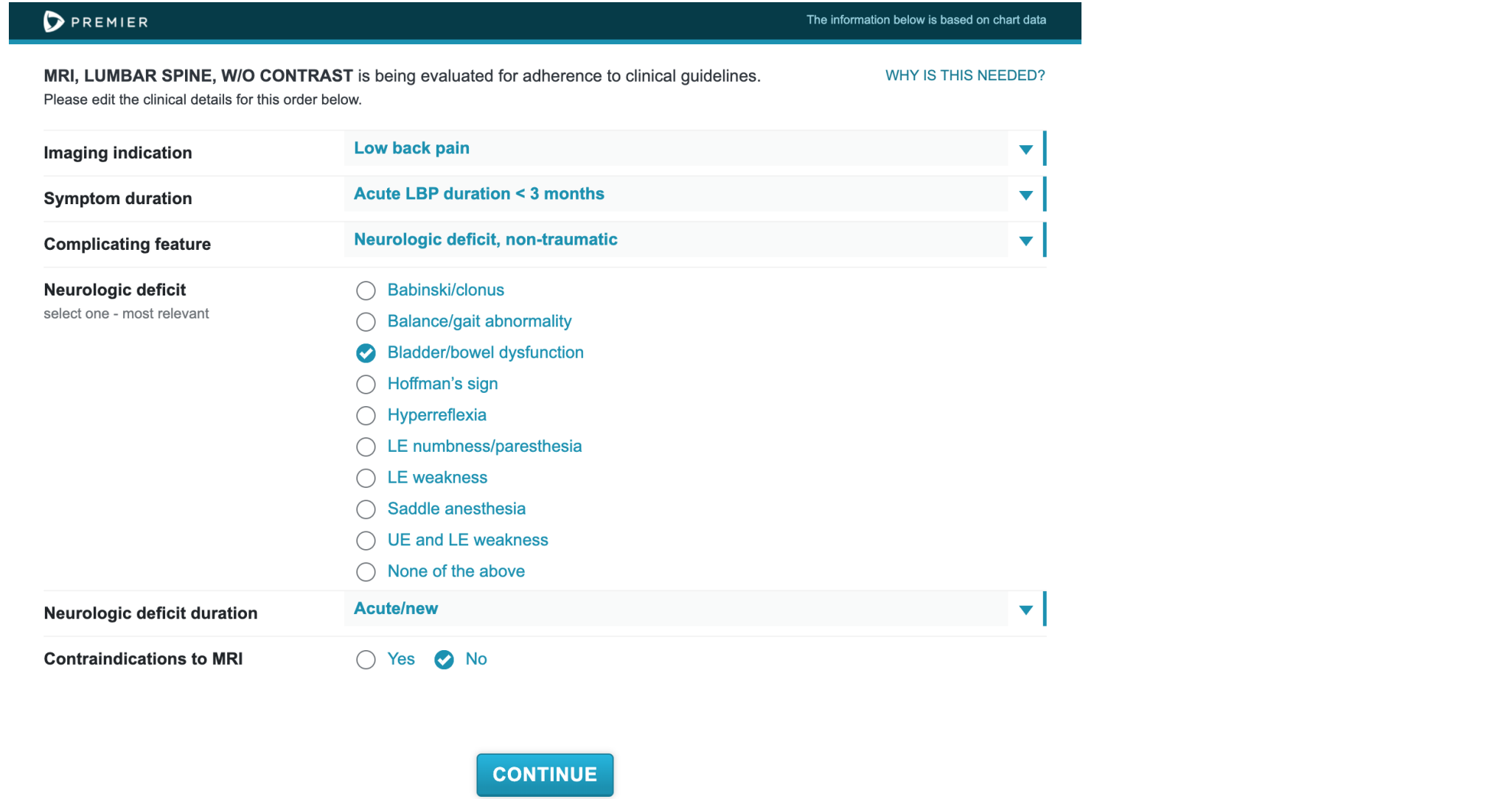
Fact Extraction Universe:

113K	Symptoms / Diagnosis
43K	Treatments
32K	Anatomic Sites
28K	Medications / Med Classes
14K	Lab Tests
13K	Diagnostic Tests
10K	States: Progression, Severity, etc.
760	Relative Sites
660	Timings

Fact Inference:

27	Problem List Diagnoses

Provider Interaction is Sometimes Necessary



Can Standards Help? Yes

CDS HOOKS™

Integrate into provider workflow

FHIR

Get patient data

Use of standards-based API and API certification criteria

USCDI

U.S. Core Data for Interoperability

2019 • VERSION 1

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

Is Automating Prior Auth the End State?

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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