Prior authorization: The current landscape

Overview

What is prior authorization (PA)?

Prior authorization (PA) is any process by which physicians and other health care providers must obtain advance approval from a health plan before a specific procedure, service, device, supply or medication is delivered to the patient to qualify for payment coverage. Other terms used by health plans for this process include "preauthorization," "precertification," "prior approval," "prior notification," "prospective review" and "prior review."

Why do health plans require PA?

Health plans often use PA to restrict access to costly services and therapies—particularly newer treatments. Health plans may also use PA to ensure that a therapy is appropriate and safe for a specific patient. For example, a health plan may require laboratory results pertaining to a patient's kidney function prior to approving use of a medication that is contraindicated in patients with renal failure.

Whatever the reason for a health plan's PA requirements, physicians usually view PA as a roadblock to patients receiving necessary treatment, in addition to an unnecessary questioning of their medical judgment and clinical expertise.

What are the consequences of PA?

The PA process is disruptive and burdensome for physicians and patients. Consequences of PA include:

- **Delayed patient access to necessary therapies**

  In a 2010 American Medical Association survey of 2,400 physicians, two-thirds of physicians reported waiting several days to receive PA for drugs, while 10 percent waited more than a week.

- **Uncompensated work for physicians and staff, which translates into increased overhead costs for practices—many of which are already financially stressed**

ESTIMATED COSTS OF PRIOR AUTHORIZATION		
1 physician hour per week 13.1 nursing hours per week 6.3 clerical hours per week[1]	Cost for prior authorization: $2,161 to $3,430 annually per FTE physician[2]	Interactions with insurers cost $82,975 annually per physician[3]

- **Disruptions in practice workflow, resulting in inefficiencies and a reduction in physician time spent providing care**

- **Nonpayment for provided services, as PA requirements are often not identified until after treatment is already completed**

1. Casalino LP, Nicholson S, Gans DN, et al. What does it cost physician practices to interact with health insurance plans? *Health Aff* (Millwood). 2009:28:w533-w543.
2. Morley CP, Badolato DJ, Hickner J, Epling JW. The impact of prior authorization requirements on primary care physicians' offices: report of two parallel network studies. *J Am Board Fam Med*. 2013;26:93-95.
3. Morra D, Nicholson S, Levinson W, Gans DN, Hammons T, Casalino LP. US physician practices versus Canadians: spending nearly four times as much money interacting with payers. *Health Aff.* (Millwood). 2011;30:1443-1450.

Current PA environment

Is use of PA increasing?

Yes, it is expected that use of PA will grow in the foreseeable future, driven primarily by health plans' desire to control the high costs associated with new, innovative therapies. For example, there are new medications available to treat cancer, hepatitis C, rheumatoid arthritis, neurological disorders and other complex conditions, with additional novel therapies currently in development. These treatments offer significant improvements in patient outcomes that were impossible even a few years ago. However, many of these therapies will come at a considerable expense, with single rounds of treatment costing tens of thousands of dollars.

Due to the high costs associated with these advanced treatments, health plan utilization of PA is expected to grow in the coming years. Published estimates predict a 20 percent per year increase in the number of drug PAs.[4] PA requirements are also expected to grow for medical services, particularly in the public sector. The Centers for Medicare & Medicaid Services (CMS) has implemented PA for a number of services, including a PA demonstration project for power mobility devices (PMD) that uses the **Electronic Submission of Medical Documentation** (esMD) system. The PMD PA program has been expanded to additional states, and its timeline extended. CMS has indicated that PA requirements will likely be broadened and applied to other service types in the future.

As health care payment transforms from the current fee-for-service system to a model based more on outcomes or value, PA usage may decline. However, this transition will take time, during which PA will continue to be a common resource utilization tool for health plans.

What is the American Medical Association doing to reduce the burden of PA?

Physicians consistently express strong concerns regarding health plans' PA programs, as they frequently witness the negative impact of PA-caused care delays on patients. In addition, both practices and their patients suffer from the time and cost burdens imposed by PA requirements.

Building on these concerns, the AMA believes that PA is currently overused and urges health plans to limit implementation of these programs to true utilization outliers, rather than broadly applying coverage restrictions to all physicians. The AMA also advocates for alternative approaches to control utilization of costly services and medications that will reduce burdens on both patients and physicians. Alternatives already being implemented by some health plans include PA "gold card" or exception programs (which would exclude physicians with high PA approval rates from PA requirements), voluntary use of appropriate use criteria or clinical decision support tools, and PA "sunset" programs that remove approval requirements on services or drugs with high rates of appropriate use.

The AMA believes that when PA is used, health plans should utilize a standardized, automated process that will minimize the burden placed upon both physicians and the plans themselves. Process automation will also support the autopopulation of PA requests with patient and clinical data from the electronic health record (EHR), which should reduce the amount of time that practices spend on PA.

For more information on the AMA's PA advocacy activities, visit **ama-assn.org/go/priorauthorization**.

Status of PA automation

What is the status of efforts to automate the PA process?

There has been increasing health care industry activity to automate and standardize PA. While automation does not reduce the number of PAs, the goal is to make the processing of PA less burdensome and more uniform across health plans and pharmacy benefit managers.

For both medical services and prescription PA, automation involves the use of standard electronic transactions. Standard electronic transactions facilitate the exchange of information between health care providers and health

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4. CoverMyMeds ePA National Adoption Scorecard. Available at: http://epascorecard.covermymeds.com. Accessed Nov. 24, 2015.

plans in an efficient, specific and uniform manner. Standard transactions can benefit physicians and other providers in that they promote the uniform exchange of data across health plans and other payers.

For medical services PA, the Accredited Standards Committee (ASC) X12 278 Health Care Services Request for Review and Response is the mandated standard electronic transaction under the Health Insurance Portability and Accountability Act (HIPAA). However, this transaction has not yet been widely implemented within the industry by either health plans or providers.

For medications, the automation of PA is sometimes referred to as electronic prior authorization (ePA). The National Council for Prescription Drug Programs (NCPDP) has created standard transactions for ePA. The ePA transactions are part of NCPDP's SCRIPT e-prescribing standard and intended to facilitate integration of the pharmacy PA process into physicians' prescribing workflow. Health plans and vendors are in various stages of implementing the NCPDP ePA transactions, and physicians can ask their trading partners about the availability of this technology. Although the NCPDP ePA transactions standardize the overall PA process, they do not mandate uniform PA question sets. Health plans and other payers can still use proprietary PA questions with the NCPDP ePA transactions.

Is ePA mandatory?
State
As depicted in the following illustration, a number of states have adopted or are considering regulations requiring payers to support automated PA for medications. In most cases states explicitly require payers to establish an

Electronic prior authorization: State legislative mandates
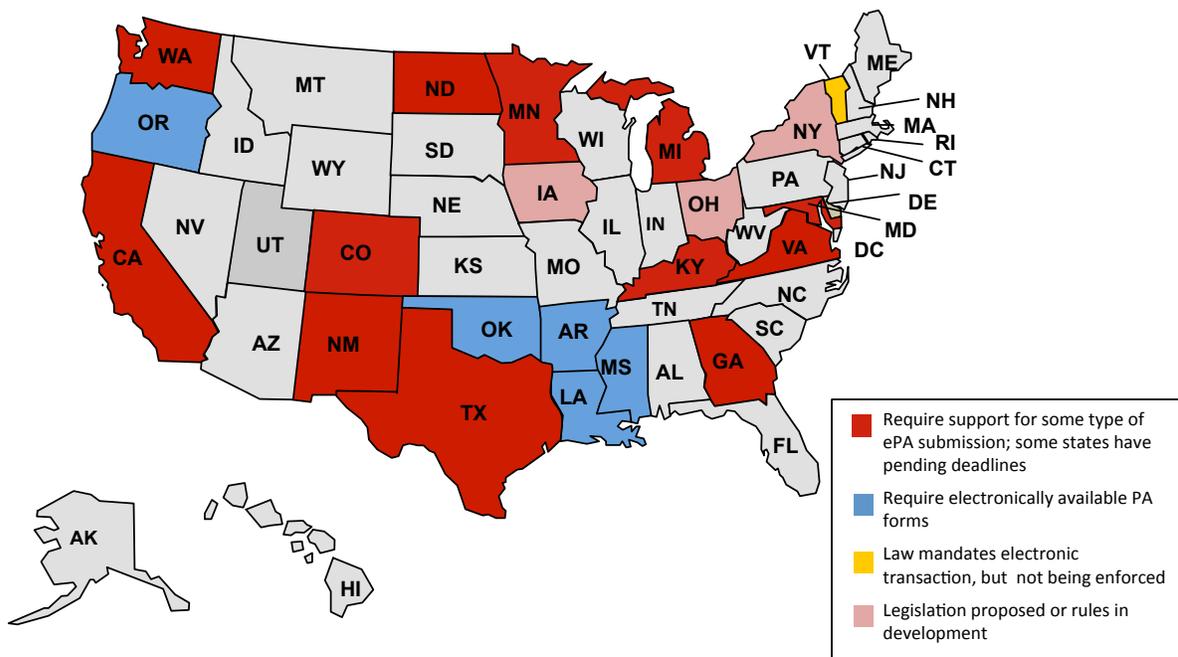
SOURCE: Point-of-Care Partners   www.pocp.com
Revised 7/15/2015
PROPRIETARY & CONFIDENTAL: Point-of-Care Partners

online system to receive drug PA requests electronically. However, the meaning of "electronic" PA can vary widely from state to state and mean anything from standard electronic transactions to health plan portals to even faxes. The number of states mandating electronic PA is expected to grow rapidly as PA utilization continues to increase.

Is ePA mandatory?

Federal

At the federal level, the ASC X12 278 is the HIPAA-mandated electronic standard for medical services PA. This standard has been available for a number of years, but, as mentioned previously, it is not widely used in the industry for several reasons. First, many health plans' PA processes involve manual review. Without automation of the overall PA process, health plans have no incentive to use the X12 278 transaction. Similarly, physician practices often find that they must complete the PA process via manual means even after submitting an initial PA request electronically; this reversion to fax or phone PA discourages physician adoption of the electronic transaction. Increased stakeholder interest, automation of health plan backend review processes, and adoption of ASC X12 278 operating rules may facilitate more widespread uptake of this transaction.

The NCPDP SCRIPT ePA transactions are expected to be mandated as the standard for pharmacy PA under the federal Medicare Part D program, which covers prescription benefits. While such a mandate would technically only apply to PA for Part D prescriptions, the ePA transactions, like the SCRIPT e-prescribing standard, would become the de facto industry standard for pharmacy PA automation. Once the NCPDP ePA transactions are mandated as the pharmacy PA standard, health plans and other payers will have several years for implementation before they are required to offer this technology to physicians and other providers. All health plans will be required to offer the ePA transactions upon physician request by the effective date of the regulation or be subject to enforcement and/or penalties. However, the efficiency gains offered by the NCPDP ePA transactions, rather than the threat of regulatory enforcement, should be the primary driver behind adoption of this new capability.

Visit ama-assn.org/go/priorauthorization for additional information.

Tips to help physicians reduce the prior authorization burden in their practice

In today's physician practice, prior authorization (PA) is usually a manual, time-consuming process that siphons valuable resources away from patient care. Moreover, PA can delay treatment and impact optimal patient health outcomes. To reduce these negative consequences for both patients and physicians, the AMA strongly advocates for health plans to minimize services requiring PA and to offer automated, streamlined processes when PA is used. Learn more about the AMA's ongoing advocacy to reduce PA burdens at **ama-assn.org/go/priorauthorization**.

Given the fact that health plans will likely continue to use PA as a resource utilization control for the foreseeable future, the AMA offers you and your staff the following tips to help minimize the impact of PA on your practice in the current environment. These suggestions can help you streamline practice workflows to reduce the number of "touches" required for PA and leverage emerging opportunities for PA automation. Because of differences in the PA process and workflow between medical services and prescription drugs, some of the tips are specific to service type. While these tips cannot completely eliminate the administrative hassles associated with health plans' PA requirements, they can help you and your staff improve practice efficiency and effectively manage the PA process.

TIP NO. 1:
Check PA requirements before providing services or sending prescriptions to the pharmacy

BENEFITS:
- **Prevent medical service claim denials and lost payments due to unmet PA requirements**
- **Ensure that the pharmacy will not be delayed in filling a prescription due to unmet PA prescription requirements as well as prevent medication nonadherence**

Medical services: For frequently performed medical procedures and services, a practice often knows from past experience whether PA is required. However, even if you are familiar with PA requirements for a particular service, it is best to monitor health plan provider newsletters, bulletins and websites for any updates, as health plans frequently change their PA programs. The safest way to ensure compliance with PA requirements is for you or your staff to check with the health plan at the time of ordering the service, either via a standard electronic eligibility request through your practice management system (PMS), through the health plan's website or by telephone.

Investing the time to determine PA requirements before a service is provided is well worth it, as most health plans will not pay for services if PA was not appropriately requested in advance of treatment. As with everything else in your practice, documentation here is also key: be sure to document PA information (save and file the newsletter, print out the Web page, note the details of any phone calls, etc.) so that any later claim denials based on unmet PA requirements can be appealed with supporting documentation.

Prescriptions: Proactively checking PA requirements for prescriptions also makes good business sense, as it eliminates pharmacy phone calls about prescriptions requiring PA before they can be filled. Discovering PA requirements after prescriptions have been sent to the pharmacy not only disrupts the physician practice workflow, but it increases the chances that patients will be delayed in receiving prescribed medications— or even worse, never receive them at all.

Ideally, physicians are alerted of PA requirements at the point of prescribing through formulary data in the electronic health record (EHR). Physicians may also be aware of PA requirements because they frequently prescribe a particular medication, use a reference source or contact the payer. Unfortunately, the physician often won't know that PA is required until after the patient has taken the prescription to the pharmacy to be filled. Current industry efforts to improve EHR formulary data accuracy to support pharmacy electronic PA (ePA) processes may help address this issue and allow physicians to quickly assess PA requirements at the time of prescribing.

TIP NO. 2: Establish a protocol to consistently document data required for PA in the medical record	BENEFITS: • Avoid delays in patient therapy • Prevent potential follow-ups with patients for additional information • Minimize physician time needed in PA process

Medical services: PA almost always requires submission of documentation to support medical necessity and indicate any prior care that has been provided to the patient. Having concise, complete information readily available in the medical record speeds PA completion. It also minimizes physician involvement in PA, as other staff can retrieve the needed information from the medical record and submit it to the health plan on the physician's behalf. Finally, quality documentation prevents follow-up patient contact or additional appointments in order to obtain information needed to fulfill PA requirements.

Prescriptions: : Prescription PA criteria often involve "step therapy" in which other medications must first be tried with suboptimal outcomes before a health plan will approve payment for a particular drug. Having documentation to support the patient's care plan, including a complete medication history, speeds the approval process and again minimizes the amount of physician involvement needed in the PA process.

TIP NO. 3: Select the PA method that will be most efficient, given the particular situation and health plan's PA options	BENEFITS: • Reduce the time your practice spends on PA • Minimize workflow disruptions by selecting the best available PA option

With mounting concerns regarding the administrative burdens, costs and inefficiencies associated with PA, the health care industry has begun to explore a variety of approaches to reduce PA burdens. The AMA supports an automated PA process that utilizes standard electronic transactions to increase uniformity across health plans and streamline practice workflows.

While there is growing interest and activity in the health care industry to adopt PA standard electronic transactions, these automated solutions are not yet widely available. The table below can help practices evaluate the various existing PA methods and choose the option that will best fit their workflow and the particular situation and health plan.

PA method	Service type	Advantages	Disadvantages
Standard electronic transactions	Medical (Standard: Accredited Standards Committee [ASC] X12 278)	• Where available, integrated into the EHR workflow • Can submit PA request electronically • Proof of approval (e.g., authorization number) can be used for claims submission • Standard process used across health plans	• Solutions integrated into the EHR workflow are not widely available • Can be more time consuming than telephone because of follow-up questions (health plan follow-up may not be electronic) • Response may not be in real time due to manual health plan processing and review
	Prescription (Standard: National Council for Prescription Drug Programs [NCPDP] SCRIPT ePA transactions)	• Where available, integrated into the EHR and e-prescribing (eRx) workflow • Alerts the prescriber to PA requirement before issuing the prescription, allowing PA to be completed before prescription is sent to pharmacy and reducing chances of patient medication nonadherence • PA questions are presented onscreen for prescriber or staff • Conditional logic ensures that physician only answers relevant questions • Average approval time can be dramatically reduced • PAs can be electronically appealed and cancelled	• Pharmacy ePA solutions integrated into EHR workflow are not yet widely available; some state mandates require availability in early 2016 • PA requirement is not always known at the point of prescribing due to inaccuracy/incompleteness of EHR drug formulary data • Response may not be in real time due to manual health plan processing and review **TIP:** Ask your eRx/EHR vendor when integrated ePA capability will be added to the EHR workflow. You can also check the **CoverMyMeds ePA National Adoption Scorecard** for information about vendor readiness
Payer portal	Medical and prescription	• All required information presented in one place • Often less time consuming than manual processes (fax and phone) • If drug PA approval is immediate, prescription can be sent to pharmacy and filled without delay	• Outside of EHR/eRx workflow • Requires separate login/password for each health plan website • Information from EHR must be re-typed onto web forms • Few payers support prescription PA via portal; most require faxed forms **TIP:** Keep a list of health plan portal logins/passwords (store in secured place)
Multi-payer portal	Medical and prescription	• Single login/password for multiple payers • All required information available in one place • Often less time consuming than manual processes (fax and phone) • If drug PA approval is immediate, prescription can be sent to pharmacy and filled without delay	• Outside of EHR workflow • Information from EHR must be re-typed onto web forms

PA method	Service type	Advantages	Disadvantages
Fax	Medical and prescription	• Most widely available method of PA submission • Library of payer forms can be developed	• Forms must be filled out by hand • Potential confusion in selecting correct PA form, given the large volume of PA documents • Outside of EHR workflow • Potential for delays as a result of additional information requests • Fax is not encrypted for security • No feedback loop for prescription PA; provider may not be informed if the drug PA is approved **TIP:** Keep all documents and records regarding faxed PA documents, including date and time stamps from fax machine
Telephone	Medical and prescription	• In many cases (e.g., step therapy) all information can be reported verbally and at one time • Reduce or eliminate delay in receiving approval • Appeal can be begun immediately, if needed	• Long hold times frequent • Interrupts regular EHR workflow • Transaction is not automatically documented in the EHR • May be difficult to later "prove" conversation, particularly if practice does not have the full name of health plan staff • Will still require supporting documentation/clinical record to be faxed • Approval must be relayed to the pharmacy for prescription PA **TIP:** Keep a record of the first and last name of the person spoken to, date & time in case future appeal is necessary
Secure email	Medical and prescription	• Enables submission of necessary information as email attachment • May be in the EHR workflow • Establishes an electronic audit trail • Protected health information is encrypted for security	• Potential delays as a result of additional information requests • Secure messaging may be outside EHR workflow • Health plans and pharmacy benefit managers generally don't support secure email • Cost to practice for secure email

TIP NO. 4:
Regularly follow-up to ensure timely PA approval

BENEFITS:
- **Prevent delays due to information "lost" or not received by payers**

Because the PA process is primarily manual, there are a number of steps in which the PA request could be lost or delayed. As a result, it is critical for practices to track PA requests and to follow-up when decisions are not communicated in a timely manner.

Medical services: Dated and time-stamped PA submission materials, along with a formalized follow-up process, ensure that submitted PA requests don't fall through the cracks. Many practices find "tickler" (i.e., reminder) files helpful in triggering follow-up with health plans regarding delayed responses.

Prescriptions: For manual drug PA processes, the same date/time-stamping and follow-up protocols mentioned above will prevent unnecessary processing delays. In addition, the ePA process includes a computerized audit capability to confirm when information has been received by the health plan. Practices can also view a list of electronically submitted and pending prescription PAs in their EHRs.

TIP NO. 5:
When a PA is inappropriately denied, submit an organized, concise and well-articulated appeal with supporting clinical information

BENEFITS:
- **Increase chances of appeal success and reduce treatment delays for your patients**

Under the Affordable Care Act, all health plans are required to have an appeal process for denied PAs. If the health plan upholds its initial decision, an external appeal by an independent third-party reviewer may be requested. Physicians can request an urgent or expedited review of PA appeals, with decisions complete within 72 hours or sooner, depending on the medical urgency of the situation. Many states have appeals requirements that are even more stringent than federal law. For more information on state laws pertaining to PA, see the **AMA's National Managed Care Contract**.

Unfortunately, the appeal process usually results in delays in patient care. Worse yet, the patient may abandon the prescription before the appeal is resolved and never receive therapy. Alternatively, the physician may decide to order a different therapy rather than pursue a lengthy appeal process. This alternative therapy may not achieve the same outcome as the physician's initial selection. Whether therapy is delayed, changed to a suboptimal choice or abandoned altogether because of the lengthy appeal process, the patient's health will be negatively impacted. Despite these challenges and negative impacts on patient care, physicians should exercise their PA appeal rights when they believe that the denied medical service or prescription is medically necessary. The following suggestions can help improve your success in appealing health plans' PA denials.

Medical services: Supplying data that may have been missing with the initial PA request may be sufficient to overturn the denial. The appeal request should contain all supporting clinical information. Additional AMA resources to help physicians and practice staff successfully navigate the appeals process are available at **ama-assn.org/go/appeals**.

Prescriptions: In addition to following the suggestions above for medical services PA appeals, prescription PA appeals can be further streamlined with ePA technology. The standard prescription ePA transactions enable physicians to submit appeal requests and supporting information electronically through their eRx/EHR system. By adopting ePA technology in their practices, physicians can automate the PA appeal process for prescriptions.

The future of prior authorization: Remaining challenges and how to prepare your practice

Unfinished business: Remaining challenges in PA

In recent years, there has been considerable industry activity to improve and automate prior authorization (PA). The introduction and implementation of standards for PA electronic transactions, the integration of PA into electronic health records (EHRs) and a growing number of state mandates all signal the changes underway to improve the PA process and reduce administrative burdens on physician practices. However, even with these promising developments, the industry must still address several unresolved issues to truly improve the PA process and bring relief to physician practices.

1. **Reduction in PA utilization**

   Although the AMA does support the automation and streamlining of the PA process, this is a secondary goal. The harmful treatment delays that can result from PA requirements make an overall reduction in PA programs the AMA's ultimate advocacy priority. The administrative burdens and costs that PA places on all industry stakeholders also underscore a need for a more judicious use of PA.

   Other forces in the current health care environment support reduced PA requirements. As health care moves from volume-based to value-based payment models, utilization controls such as PA are expected to decrease. Requirements on health plans to minimize administrative costs in favor of spending dollars on patient care also encourage reduction in expensive and time-consuming payer processes such as PA. Finally, new practice technologies may drive movement away from health plan PA programs to use of EHR features such as clinical decision support (CDS) tools that encourage appropriate resource use. Many of today's PA questions are or can be included in the CDS tools that are embedded into the EHR workflow.

   Due to the significant impact on both patient care and overall health system costs, the AMA urges the industry to reduce PA programs and explore alternative approaches to encouraging appropriate resource use. Possible strategies to reduce PA utilization include:

   - **PA sunset programs** in which health plans lift PA requirements on drugs or services for which a significant majority of PA requests are approved. Requiring PA in cases where resource utilization is overwhelmingly appropriate results in administrative waste for both payers and providers.

   - **"Gold card" programs** under which physicians with high rates of PA approvals over a specified period of time are exempt from PA requirements. This is a mutually beneficial approach: health plans meet resource utilization goals and reduce PA administrative burdens, and physicians following health plan criteria are excused from PA.

   - **PA waivers** for physicians using approved, clinically based appropriate use criteria (AUC) and CDS. When physicians use AUC and CDS, clinical necessity for procedures and medications is demonstrated without separate health plan review.

2. **PA requirement transparency**

   Ideally, physicians should be aware of all PA requirements at the time they are ordering a service or medication. However, it can currently be difficult for physicians to determine PA requirements at the point of care.

   For prescription PAs, the formulary information available in many EHR systems is incomplete, inaccurate or dated. Recognizing that the availability of accurate, real-time formulary data is key to a

maximally efficient PA process, the industry is developing a new standard to support a Real-Time Pharmacy Benefit Inquiry (RTPBI) for prescriptions. It will likely take several years for the RTPBI standard to be finalized and implemented by pharmacies, payers and EHR vendors. However, once this capability is available, physicians and other prescribers will be able to obtain real-time information about a patient's pharmacy benefit coverage, formulary, co-pays and other financial responsibilities and PA requirements at the point of care. Similar to the prescription benefit data available at the pharmacy, the RTPBI will enable physicians to determine what a patient's drug coverage is at the time of prescribing. Having this information available at the point of care will dramatically improve the patient experience and also improve outcomes by ensuring that patients receive the physician-selected therapy without delay, as PA requirements can be met before prescriptions are sent to the pharmacy.

Physicians face similar challenges in determining PA requirements for medical services. While the electronic eligibility transaction allows health plans to indicate the specific procedures and services for which a patient must have PA, health plans are currently not required to provide this level of granularity in eligibility responses. This means that plans usually respond with general coverage information, even if a physician includes a specific procedure code in an eligibility request. Practices must often call the health plan to determine specific PA requirements for medical services.

AMA advocacy in action: The AMA strongly advocates for the provision of accurate, specific information regarding PA requirements at the point of care. When physicians can determine and address PA requirements when they are ordering medications or procedures, patients receive the care they need as quickly as possible, and the practice workflow is not interrupted. The AMA is actively involved in industry efforts to improve PA requirement transparency in both the prescription and medical services arenas.

3. **Autopopulation of information from EHRs into PA information requests**
Even today's most advanced and automated PA options require data to be extracted from the EHR and manually entered into PA request forms. The PA process will not be truly automated or streamlined—nor will practice time be optimally minimized—until patient demographics and basic clinical information can be automatically pulled from the EHR and populated into PA question responses. Ideally, the PA of the future will involve the automatic population of PA questions from clinical data in the EHR, such as medication history, procedure history, lab results and patient vital signs. Physicians or their delegated staff would just need to review and approve the information prior to PA submission.

Health plans and vendors are beginning to explore new PA approaches that leverage the capabilities of EHR technology. Several health plans are piloting a proactive PA process in which they monitor claims activity and predictively advise physicians that PA is required for services to-be-ordered. The goal is to provide a "click here for PA" button within the workflow that does not require the physician to type any additional information. All the data needed by the health plan would be contained within the EHR; by clicking a button, the physician would authorize the health plan to access that information.

AMA advocacy in action: The AMA urges health information technology vendors and health plans to prioritize the true kind of PA automation detailed above. Use of codified, structured data in PA requests will also allow for full automation of the PA process in health plans' systems, as data could be machine-read and processed instead of requiring human review. Leveraging technology advances to minimize the number of human touches required in PA processing can dramatically reduce administrative burdens and costs across all stakeholders.
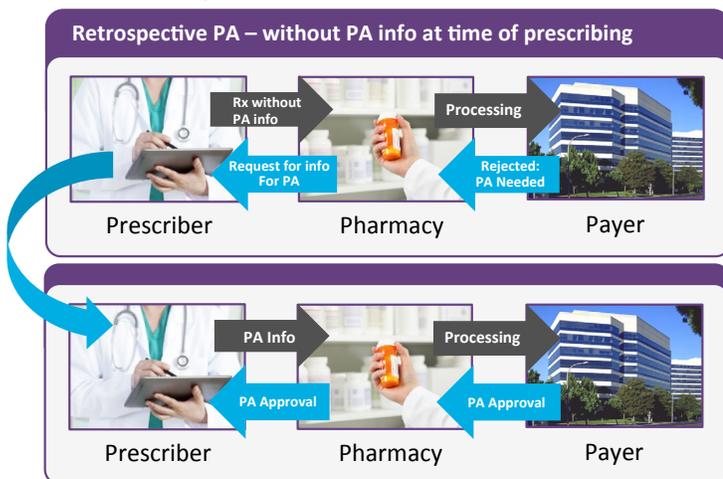
Get set: Prepare your practice for the future of PA

As PA transitions to an electronic workflow, your practice may need to make some adjustments to reap the maximum benefits from this new technology. Determining your EHR vendor and health plans' timeframes for PA automation will also be important in preparing for this transition.

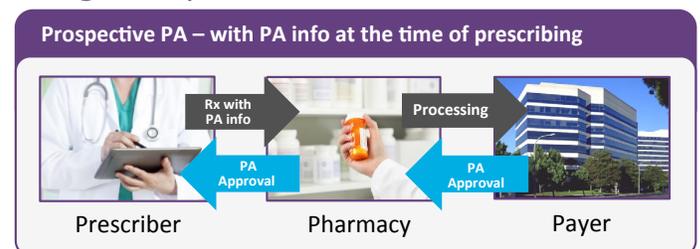1. **Review and adjust practice workflow to support prospective prescription electronic PA (ePA)**

   - **Retrospective PA:** Most prescription PAs today are retrospective. In other words, PA requirements are only identified after the prescription is sent to the pharmacy, when the drug claim is rejected. The patient must then wait to receive his/her medication until (a) the physician is alerted to the PA requirements, (b) the physician submits the PA request to the health plan and (c) the health plan reviews the required PA data and makes a determination. Not until after all of these steps and PA approval does the patient finally receive the needed prescription. Unfortunately, many patients never return to the pharmacy after a failed initial attempt to fill a prescription. Retrospective PA can therefore lead to medication nonadherence and suboptimal patient outcomes.

Two-Step Process

Retrospective PA – without PA info at time of prescribing

Prescriber — Rx without PA info → Processing → Payer
Payer — Rejected: PA Needed → Request for info For PA → Prescriber

Prescriber — PA Info → Processing
PA Approval ← PA Approval
Prescriber — Pharmacy — Payer

   - **Prospective PA:** Prospective PA, in which all PA requirements are discovered and addressed prior to sending a prescription to the pharmacy, represents the preferred PA workflow of the future. In prospective PA, the provider knows that PA is required at the time of prescribing. In most cases, the prescription will not be sent to the pharmacy until the PA process is complete, thus delivering a "clean," fillable prescription to the pharmacy. Once the PA is approved, notification (or a PA number) is sent to the physician. The prescription is then released to the pharmacy, and the patient's prescription is ready for pickup when he/she arrives at the pharmacy.

Single-Step Process

Prospective PA – with PA info at the time of prescribing

Prescriber — Rx with PA info → Processing → Payer
PA Approval ← PA Approval
Prescriber — Pharmacy — Payer

   - **Practice workflow changes:** While the efficiency and patient outcome advantages of prospective PA are clear, this new process will require some workflow adjustments in the practice. Physicians will need to consistently check PA requirements when they are prescribing. They will also need to complete (or delegate to staff) PA questions and/or information requests before sending prescriptions to the pharmacy. Practices may also need to work with pharmacies to identify the best patient communication strategy. For example, who will contact the patient once the PA is approved and the prescription can be filled at the pharmacy? Identifying preferred workflows and communication practices will ensure that your practice smoothly transitions to a prospective PA process.

2. Create demand for PA automation

Vendors and health plans often point to poor physician adoption as a reason for not building the technologies needed for automated processes. Take the following steps to let the importance of automated PA to your practice and patients be known.

- **Reach out to health plans and request that they offer PA automated tools that will integrate with your practice management system (PMS) and EHR—and use them**

  - Payers create their list of technology development priorities based upon demand from their stakeholders. When they experience high utilization of existing tools, payers justify expanding capabilities to further automate the process. Conversely, low physician use of a health plan's automated tools discourages further investment in technologies that will benefit physicians.

  - Ask for these services when talking to health plans, and then be sure to use them regularly once they become available.

- **Request that your PMS/EHR vendors create ePA features and functionalities for prescription PA that will fit in your practice's workflow**

  - Similar to payers, software vendors prioritize which new features to build based upon demand from their customers. If interest is demonstrated in automation of PA, vendors will enhance their software to include it. Let your vendors know that you are interested in this technology, and then become an early adopter when it's available. You can also access the **CoverMyMeds ePA National Adoption Scorecard** to find more information about vendors' ePA implementation status.

- In addition to requesting ePA capability, you will also want to inquire about related features. Be sure to ask about the currency and accuracy of the vendor's formulary data; the company should be able to tell you how often it updates EHR formulary files. Push your vendor for ePA enhancements, such as software that will autopopulate PA requests with data from the EHR.

Conclusion

The treatment delays, manual processes and administrative costs associated with PA today make it a major source of frustration for physicians. In this time of industry change and emerging health information technologies, physicians can take advantage of growing opportunities to improve the efficiency and success of the PA process in the current environment. Meanwhile, the AMA will continue to urge the health care industry to minimize the impact of PA on physician practices and patient care through judicious use of utilization controls, optimal automation and streamlined PA workflows.

Visit ama-assn.org/go/priorauthorization for additional information.