surescripts

A recent Physicians Practice survey looks at how prior authorizations are handled by providers and how new technology can streamline the process to improve patient care while saving time and money.

Survey Results Prove Healthcare Providers Would Benefit From
Electronic Prior Authorization

Time consuming and frustrating. These words describe how most providers feel about getting prior authorization for medication prescriptions.

A recent survey conducted by Physicians Practice found that most providers use manual prior authorization, which requires paper forms, faxes and/or phone calls. Of the more than 300 respondents, more than half were physicians and mid-level providers, and many were office managers. More than 40 percent of the responses were from primary care provider practices, the largest specialty group.

The survey uncovered that providers are extremely frustrated with the cumbersome manual prior authorization process. Physicians are annoyed that it takes "multiple phone calls for each prior authorization" and "it ties my nurse up on the phone and pulls her away from clinical duties." Thoughts shared in the survey such as,

"They [insurers] don't read what we send them and they ask for what we already sent them" also speak to the irritation physicians and their support staff feel.

One respondent summed up the feelings of many by saying, "I almost always get it authorized based on good treatment rationale. I find it wasteful to 'jump though the hoops' to get patients the appropriate medications for their conditions."

Respondents also expressed frustration because there are "no standard guidelines" for prior authorization, and there is "very different criteria for each insurance."

How did we get to this place and how we can take prior authorization to the next level with a real-time electronic solution? Read on to find out.

When is **Prior Authorization** Required?

Health plans require prior authorizations to ensure patients get the correct and most cost-effective medications for their conditions.

Health insurers usually have formulary files, and medications that are not on the list may be denied or require prior authorization from the insurer. A health insurer may require a patient to try a less expensive drug first. If the drug proves to be ineffective, or is not well tolerated by the patient, the physician may then be authorized to switch the patient to the originally requested drug.

Health insurers implement prior authorizations for:

- brand name medications with generic equivalents
- expensive medications, including specialty medications
- medications with age limits (e.g. Retin-A)
- drugs used for cosmetic reasons
- lifestyle drugs (e.g. Viagra, Cialis, etc.)
- drugs not usually covered by the health plan or pharmacy benefit manager (PBM), but deemed medically necessary by the doctor
- drugs that are covered by the health plan or PBM, but are being prescribed in a higher than "normal" dose
- off-label usage

Each health insurer has its own set of prior authorization criteria, which can vary by drug, indication, gender and other factors.
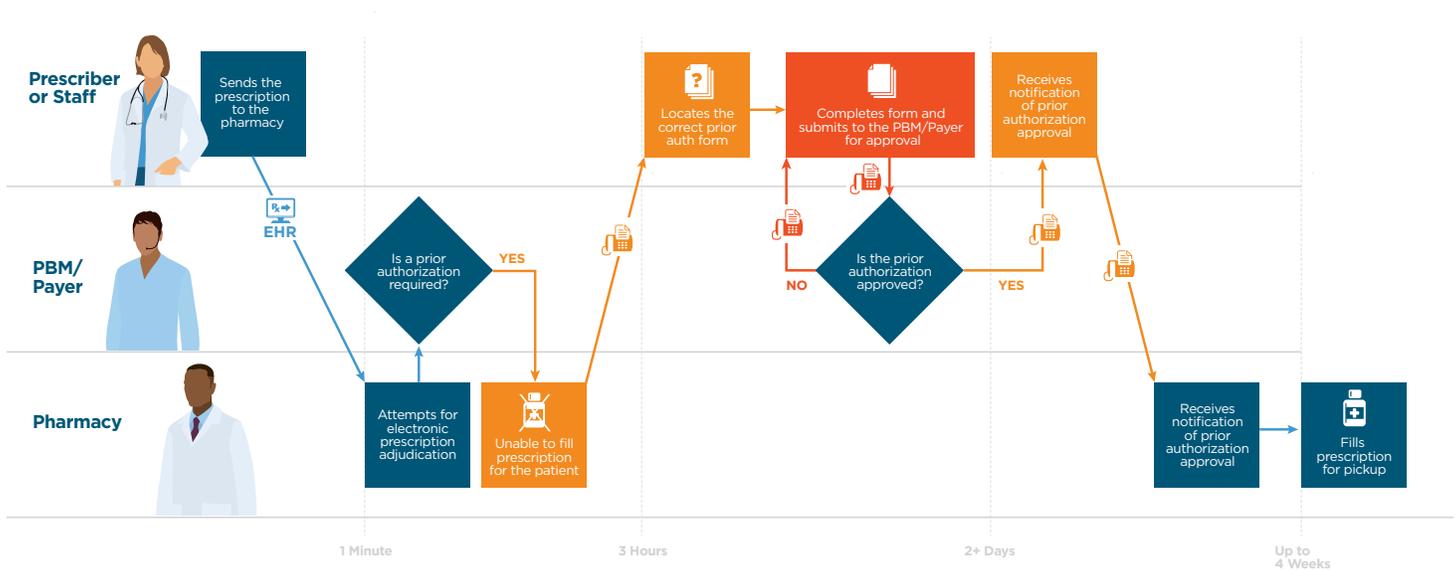
Manual Prior Authorizations Are a Pain

Despite electronic prescribing and the use of EHRs, getting prior authorization is often a time-consuming paper fax-based process. According to half of the survey respondents, the current process takes about one to two hours per day of support staff time per provider. For many practices this is due to the fact that prior authorization is a retrospective process that starts after prescriptions arrives at the pharmacy. A third of the respondents reported that more than 50 percent of prescriptions requiring prior authorization were delayed nearly two days before being filled.

When asked to rank their current prior authorization process on a scale of 1 – 10, with 1 being not at all a pain point, and 10 being a major pain point–think of the pain scale used with patients–the average response was 6.9. When asked what they liked least about prior authorizations, nearly half of the respondents focused on the time wasted.

Below is an example of a typical prior authorization process:

Manual Prior Authorization

Prescriber or Staff — Sends the prescription to the pharmacy

PBM/Payer — EHR · Is a prior authorization required? — YES · Is the prior authorization approved? — NO / YES

Pharmacy — Attempts for electronic prescription adjudication · Unable to fill prescription for the patient

Locates the correct prior auth form · Completes form and submits to the PBM/Payer for approval · Receives notification of prior authorization approval · Receives notification of prior authorization approval · Fills prescription for pickup

1 Minute · 3 Hours · 2+ Days · Up to 4 Weeks

One or more of the following results from this back and forth communication:

- The authorization is approved, the pharmacy is notified and the prescription is filled.
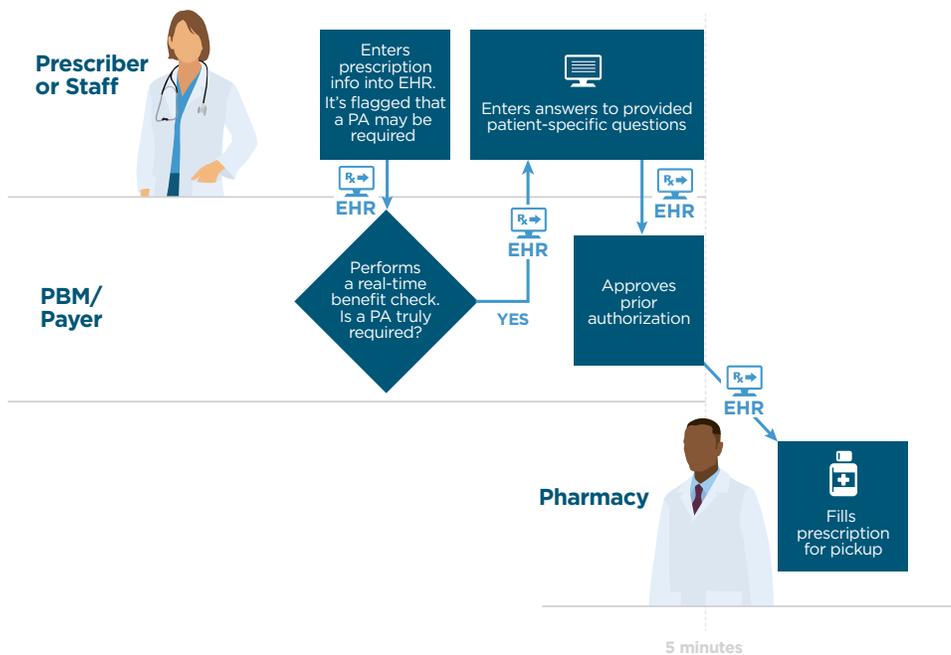- The insurer asks the provider to clarify information in the prior authorization.

- The authorization is denied and time-intensive correspondence between the provider and insurer ensues.
- The patient becomes frustrated due to delays in receiving the medication.
- The patient does not fill the prescription and his/her condition worsens.

Fully Automated Prior Authorization: How it works

Compared to the current manual prior authorization process, the time required for prescription approvals goes from days to minutes. With a fully automated prior authorization solution, the patient leaves the office with a valid prescription, and the provider team saves time, improves patient care and uses staff more effectively. The entire process is completed before the patient leaves the office, instead of a lengthy and tedious process with little promise of success.

1. A provider prescribes a medication, which is submitted electronically to the patient's insurance provider in real time.

2. The patient's insurance provider requires prior authorization in order to fill the prescription, and responds to the provider in real time requesting additional information.

3. The provider can immediately respond with the supplemental information (i.e. live online chat) or ask the clinical/administrative support team to handle the live chat while the provider completes the patient visit.

4. When the patient leaves, the prior authorization process is complete and the prescription has been electronically sent to the pharmacy.

CompletEPA Electronic Prior Authorization

Prescriber or Staff

Enters prescription info into EHR. It's flagged that a PA may be required

Enters answers to provided patient-specific questions

Rx→ EHR

Rx→ EHR

Rx→ EHR

PBM/ Payer

Performs a real-time benefit check. Is a PA truly required?

YES

Approves prior authorization

Rx→ EHR

Pharmacy

Fills prescription for pickup

5 minutes

Providers Rank the Benefits
of Electronic Prior Authorization

Respondents ranked specific potential benefits of having electronic prior authorization capabilities on a scale of 1-7, with 1 being the most important, and 7 being the least important. Here are the average ratings.

Benefit	Rating
More efficient workflow	3.17
Save time	3.30
Reduce administrative burden	3.57
Improve patient care	3.89
Improve patient satisfaction	4.07
Accelerate response time of prior authorizations	4.17
Integration into your EHR workflow	5.02

1   2   3   4   5   6   7

It makes sense that "more efficient workflow," "save time" and "reduce administrative burden" were the most important benefits because almost half the respondents said the biggest pain point of prior authorizations was time wasted. The fact that "integration into your EHR workflow" was ranked as least important is an indicator that end-users do not understand how to effectively implement and use EHR technology. This has been an industry-wide problem since EHRs were introduced more than 20 years ago.

It has been long understood that the healthcare industry underutilizes much of its already-implemented technology.

A study found that organizational adoption and investments in software ranges from 30 to 40 percent of the IT budget. Technology changes what is feasible, but because change is often disruptive, costly and time consuming, the first instinct is to fit new technology into existing workflows, rather than redesign them entirely.

Imagine how much time will be saved if physicians have immediate access to accurate, patient-specific benefits information and can prescribe drugs from an approved list, or request and receive prior authorizations electronically in real time. Not only will the provider save time, but the patient will leave the office confident that his/her prescription will be filled.

Improving Medication Adherence
While Saving Time and Money

One consequence of the manual prior authorization process is prescription abandonment, which falls under "non-adherence" and costs the healthcare industry billions of dollars annually. In recent years, abandonment of prescriptions has increased. Together, health plan denials and abandoned prescriptions leave more than 14 percent of prescriptions unfilled. A more serious problem is the delay caused by the current prior authorization process, which results in abandonment nearly 40 percent of the time.

Patients and caregivers are increasingly concerned about starting the most appropriate and effective prescription drug therapy in a timely manner. Delays in starting prescription drug therapy can result in higher healthcare costs and premature deaths. According to research, the U.S. healthcare system spends billions of dollars each year on avoidable complications, emergency department visits, and hospitalization—all due to medication non-adherence, including abandonment.

Patients are frustrated by the perceived and real administrative hassles that delay therapy. Failed trips to the pharmacy and playing phone tag with the physician's office, which makes up 30 percent of incoming calls, to determine why a prescription hasn't been filled creates dissatisfaction with the provider alone. Many patients don't know about formularies until their pharmacy and/or provider raises the issue of prior authorization denial.

Many people wonder why health plans and PBMs still use prior authorization programs when more than 90 percent of all prior authorization requests are eventually granted. Implementing real-time electronic prior authorization solutions for EHR systems would ease many patients' frustrations, while improving care and reducing total healthcare costs.

Imagine the positive impact of an electronic prior authorization process. A 2012 study by the Center for Health Transformation shows that e-prescribing significantly increases the odds of a patient picking up a medication at the pharmacy indicated by a consistent 10 percent increase in patient first-fill medication adherence (i.e., a new prescription that was picked up by the patient). This was observed among physicians who adopted e-prescribing technology compared with physicians who did not. An electronic prior authorization process would eliminate the common two-day delay in patient treatment.

The savings associated with increased patient adherence was an astonishing $140-$240 billion over ten years. The Center for Health Transformation study indicates medication non-adherence contributes to 125,000 premature deaths annually, as well as to other patient safety concerns that cost the healthcare system an estimated *$290 billion annually in the form of increased hospitalizations* and costly complications.

The Bottom Line

There's no doubt that manual prior authorizations negatively effect providers and patients alike, and that means it's time for a change. Standardization and real-time electronic prior authorization can fix most of the issues raised by survey respondents. Implementing a consistent workflow with the same set of data requirements for handling prescriptions across all insurers is the first step in automating the prior authorization process. Just as the industry standardized insurance claim forms for all insurers, a standard prior authorization solution will deliver savings and greater satisfaction to all participants.

The ability to make a real-time authorization request at the point of care is the other component in eliminating hassles. Instead of waiting for the medication claim to be rejected at the pharmacy, providers and patients can leave each appointment confident that the correct medication has been approved. Plus, insurers can establish criteria for medication authorization to eliminate manual reviews, which will increase the insurer's efficiency as well.

Standardization and real-time decision support are the hallmarks of efficiency and cost savings. The healthcare industry has demonstrated this in the medical insurance claim process and can learn from that model as it begins to implement electronic prior authorization solutions.